PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

COMMUNITY CONFINEMENT FACILITIES

Date of report: August 16, 2017

Auditor Information			
Auditor name: Demetrius Henderson			
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Telephone number: 803-565-9742			
Date of facility visit: June 14, 15,16, 2017			
Facility Information			
Facility name: Sussex Community Corrections Center, Sussex Violation of Probation			
Facility physical address: 23207 North Dupont Blvd, Georgetown, Delaware 19947			
Facility mailing address: (if different from above) Click here to enter text.			
Facility telephone number: 302-856-5790			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☒ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: William Oettel			
Number of staff assigned to the facility in the last 12 months: 78			
Designed facility capacity: 250			
Current population of facility: 145			
Facility security levels/inmate custody levels: Level 4 Quasi Incarceration			
Age range of the population: 18-53			
Name of PREA Compliance Manager: Lt. Scott Ceresini	**Title: PREA Compliance Manager**		
Email address: scott.ceresini@state.de.us	**Telephone number: 302-856-5790**		
Agency Information			
Name of agency: Delaware Department of Corrections			
Governing authority or parent agency: (if applicable) State of Delaware			
Physical address: 245 Mckee Road, Dover, Delaware 19904			

Mailing address: (if different from above) Click here to enter text.	
Telephone number: 302-857-3234	
Agency Chief Executive Officer	
Name: Perry Phelps	**Title:** Commissioner
Email address: perry.phelps@state.de.us	**Telephone number:** 302-857-3234
Agency-Wide PREA Coordinator	
Name: Michael Records	**Title:** PREA Coordinator/ACA Accreditation
Email address: michael.records@state.de.us	**Telephone number:** 302-857-5389

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) Audit for the Sussex Community Corrections Center Violation of Probation, (SVOP) Community Confinement Facilities Summary Report began May 2017 with the notice that the Delaware Department of Corrections through the American Correctional Association (ACA) scheduled a PREA Audit with a tour date of June 14-16, 2017. PREA Certified Auditor Demetrius Henderson was notified by ACA through e-mail of his appointment as the PREA Lead Certified Auditor and PREA Certified Auditor Michael A. Radon as Team Support Auditor.

The audit process initiated with contact from Mike Records, Agency-Wide PREA Coordinator of Delaware Department of Corrections who mailed a hard drive (hereafter referred to as USB Flash Drive) to the auditors. The USB Flash Drive contained documentation for the audit including; the daily facility count, identified the daily population, the Department and Facility Mission Statements; Memo confirming no detained Residents solely for Immigration purposes; ACA previous audits; PREA previous audits; Camera Surveys; Floor plans and the PREA Audit Pré-audit Questionnaire Community Confinement Facilities. The Pre-audit Questionnaire provided the necessary information to complete a good portion of the PREA Audit: Auditor Compliance Tool, Community Confinement Facilities, and PREA Compliance Audit Instrument Checklist of Policies/Procedures and other Documents, Community Confinement Facilities in advance of the site visit. The Questionnaire provided a lot of material that was comprehensive, specific, and very helpful to the auditors. The PREA Resource Audit Instrument used for Community Confinement Facilities was furnished by the National PREA Resource Center. To summarize, there are seven sections, A through G, comprised of the following: A) Pre-Audit Questionnaire; B) the Auditor Compliance Tool; C) Instructions for the PREA Audit Tour; D) the Interview Protocols; E) the Auditor's Summary Report; F) the Process Map; and G) the Checklist of Documentation. Following the protocols of making contacts, and checking on the posting of notices (posting was initiated through the American Correctional Association (ACA) and the facility, Sussex Community Corrections Center Violation of Probation. The auditor began the review of the Pre-Audit Questionnaire and the materials sent prior to discussion and the audit visit. Each item on the thumb drive was reviewed. Of particular interest to the auditor was the detailed information in the Pre- Audit Questionnaire completed by the facility's PREA Compliance Manager (PCM), and the PREA Agency-Wide Compliance Coordinator. Also, in this preliminary review, special interest was taken in the compliance documentation provided for each standard. The information from the standards files was used to complete a good portion of the information on the PREA Compliance Audit Instrument Checklist of Policies/Procedures and other documents in advance in order to identify additional information that might be required.

The Lead Auditor contacted the PREA Compliance Manager three (3) weeks prior to the scheduled site visit. Subsequently, scheduling the facility to post notices 6 weeks before the on-site visit was not confirmed until interviews with facility staff and residents. During the interview process, several staff members and residents informed the auditors that PREA signs were posted 6-8 weeks ahead of the visit notifying them that a PREA audit was scheduled for the week of June 12, 2017, through June 16, 2017. The PREA Auditors also observed PREA notices and contact information for any PREA concerns in the intake areas, administrative areas and all housing units. There were no correspondences as a result of the notices from staff or residents to the auditors prior to the on-site visit.

The Auditors stayed in Seaford, Delaware and were transported to SVOP daily by staff to the facility. The SVOP on-site visit began at noon on Wednesday, June 14, 2017. The Auditors, PREA Compliance Manager and the PREA Statewide Coordinator, and SVOP Management Staff attended an orientation and discussed the intent of the audit, agenda, and plans for the on-site visit. A site visit of SVOP followed immediately after the orientation meeting. The on-site tour started with a visit to the intake/booking area. It is important to note that the booking and intake area is

for all Level IV facilities in Sussex County. The booking and intake area at the SVOP site is centrally located across from the control center. Two full glass front holding cells are visible from the control center in order for staff to monitor residents. Upon arrival to SVOP residents are processed in the booking area. The booking and intake area for both men and women did not exhibit any blind spots and bathrooms had privacy. During intake process each resident is photographed, an intake staff conducts inquiries about statistical data and a medical screening is completed. The medical screening assesses the residents' physical, dental, behavioral, mental health, and PREA needs. Once booked and screened, a resident is transferred to one of four programs (home confinement, crest program, work release or violation of probation). The auditor observed a resident being booked and intake staff utilizing the PREA screening process prior to the resident being assigned to housing.

The housing units separate male housing from female housing. The auditor notice one blind spot in the male housing unit and this was brought to the attention of the PREA Coordinator. The auditor was advised that a mirror would be installed to eliminate this potential risk. While viewing the housing units, the auditor conversed with a female staff member assigned to the male pod. The female officer informed the auditor that any time she is assigned to the male unit she announces her presence before entering the unit. The auditors observed that bathrooms have privacy. Afterward, the auditors visited the healthcare area, recreational areas, cafeteria, and work and program areas. The work areas are located outside the housing building but on the grounds of the SVOP and Work Release facilities. These areas were constantly supervised by staff. The supervision ratio in the working areas is usually no larger than 6 to 1 resident to staff. The SVOP has a total of 53 operational cameras to eliminate blinds spots. The official on-site visit to review the facility was completed on Wednesday, June 14, 2017. There was a follow-up with a revisit to the facility on Thursday, June 15, 2017, to complete the interviews and to review documentation. The interviews included dialogue with medical and mental health staff, security staff, and investigative staff.

After the site review, the PREA auditors continued with interviews on Thursday, June 15, 2017, and Friday, June 15, 2017. The auditors' random selection of resident interviews originated from a June 14, 2017, list of all residents provided by the facility. 11 of 153 (7.2%) residents were selected to be interviewed by the auditors. Based on the interview with the PREA Manager and a review of the PREA pre-audit questionnaire SVOP does not incarcerate youthful residents. The facility reported to the auditors that no youthful, gay, transgender or intersex residents currently resided in the facility. One targeted resident that were interviewed included a self-identified lesbian resident. Subsequently, all other residents interviewed identified as heterosexuals. Interviews of residents were conducted in the probation and parole office area.

The PREA auditors conducted interviews with both random and specialized staff. A total of 24 interviews with staff members were completed. These interviews included 10 randomly selected security staff for all three working shifts and 14 specialized staff. Specialized staff included intermediate or higher-level facility staff, medical and mental health staff, administrative staff, intake staff, leadership (Executive Director, Warden, Assistant Warden, the PREA Manager, the State-wide PREA Coordinator, and Human Resources), volunteers and contractors, investigative staff, staff that perform screening for risk of victimization and abusiveness, incident review team members, and staff charged with monitoring retaliation. In addition, interviews were conducted with the Director of an outside victim's advocate organization called Connections Community Support Programs, internal criminal investigators at the facility and external criminal investigators from the Delaware State Police. After interviews with residents and staff, there were 7 randomly selected resident record files chosen by the auditors for a review of compliance to include one file of a resident reporting previous victimization, and there were 7 randomly selected record files of SVOP staff members for compliance review.

Interviews, documentation review, and observations included meeting directly with each of the auditors' randomly selected residents, staff, on-site observation, reviews of screening materials, documents, and both resident and staff files. This process re-emphasized to the auditors, SVOP commitment to PREA standards. On the last day of the site

visit, the auditors reviewed the 39 PREA Standards with the facility's PREA Facility Manager and PREA State-wide Coordinator. A final review of the PREA Audit: Pre-Audit Questionnaire and the PREA Compliance Audit Instrument Checklist of Policies/Procedures will complete the audit process.

There were no issues rising to the level of PREA noncompliance. The auditors concluded the interviews and completed an exit interview. During the exit interview, the auditors communicated to the leadership that there were no issues on the site visit that raised a level of PREA noncompliance. The auditors communicated that a final review of the PREA Audit: Pre-Audit Questionnaire and the PREA Compliance Audit Instrument Checklist of Policies/ Procedures will complete the audit process. The auditors were impressed with SVOP's commitment to the PREA audit process.

DESCRIPTION OF FACILITY CHARACTERISTICS

The mission of the Delaware Department of Corrections is to "Protect the public by supervising adult residents through safe and human services, programs and facilities." The mission of Bureau of Community Custody and Supervision is: "to promote public safety through the effective supervision of residents placed under community supervision".

The Delaware Department of Corrections (DOC) manages the Bureau of Community Corrections (BOCC) and the Sussex Community Corrections Center (SCCC) which consist of the Sussex Violation of Probation Center (SVOP). The Sussex Violation of Probation Center (SVOP) is located in Georgetown, Delaware. This facility is classified as Level IV (4) confinement in a community custody program. SENTAC Levels I-IV Facilities provide supervision, programs and treatment services that promote long-term, self-sufficient, law abiding behavior by residents and support efforts that make victims whole in accordance with Delaware law.

The Sussex Violation of Probation Community Corrections Center (SVOP) design capacity is a 250-bed community-based supervision facility with an operating capacity of 300 residents in a two story building. Located in Georgetown, Delaware, SVOP houses males and females separately. SVOP primarily house residents who have violated the terms of their probation. These residents have not committed any violent crimes during their probation in the community. They have committed "technical" violations that could include failing to report to their probation officer, changing residence without notifying their probation officer, failing a drug test or failing to abide by a curfew.

SVOP provides a military-style, highly regimented program of discipline, behavior modification, and community service. Time spent at SVOP gives residents a chance to adjust their attitudes and change their behaviors so they are better able to abide by the terms of their probation once released back into the community. Residents rise daily at 5 a.m. for community service or institutional assignments. Work duties include maintaining their personal living space, cleaning the common areas of the facility and working in the kitchen. Residents also participate in community service projects that benefit towns, churches, non-profit organizations, American Legions, senior and recreation centers, schools and cemeteries. Residents are expected to participate in community service projects until the residents' movement is court ordered. SVOP keeps residents from being returned to a prison population where more serious residents are incarcerated. This frees up higher security beds for the more serious criminal offenders.

The physical plant consists of one large main building and nine outside program/work buildings. The perimeter has a single security fence. There are no towers. A motion detection fence alarm system is in place to alert security if a person or object comes in contact with the fence. There are 53 digital closed circuit video cameras throughout the facility. The cameras are located strategically around the facility and outside the buildings. Video recording is maintained for 60 days and is monitored from the duty office/control center.

This facility has 84 authorized positions and during the audit, there were 78 filled (92.8%) and 6 vacant (7.2%) positions. The facility has 50 (86.2%) male and 8 (13.8%) female security staff and operates three eight-hour shifts. The ratio of security staff to a resident is approximately 6:1 residents to staff. The First shift operates from 12:00 a.m. to 8:00 a.m. with nine (9) security staff; second shift operates from 8:00 a.m. to 4:00 p.m. with ten (10) security staff and third shift from 4:00 p.m. to 12:00 a.m. with eight (8) security staff. Depending on the work crew and outside projects scheduled; additional security staff members are brought in to supervise these activities.

There are eight (8) male housing units each with a capacity to house up to 25 residents. Two (2) of the housing units are sanction units. When a resident receives sanctions for inappropriate behavior he/she is transferred to this unit. There are two (2) female housing units with one being a sanction unit. The facilities were clean and in good repair. The facility has an intake booking area that comprises of a section that is designated for medical and mental health staff to complete medical exams and mental health assessments. Residents admitted to the facility are escorted to this specified area to complete their initial medical examinations as part of the intake process. Residents having medical or mental health concerns while residing at SVOP can be referred for treatment and seen in the designated medical area. A resident with more serious health care issues that requires an inpatient facility may be admitted to the Sussex Community Corrections Center infirmary located on the grounds of SVOP.

During the last calendar year, the SVOP's population has routinely been under the design capacity with an average population of 182. The date of 6/14/2017 SVOP census was 153 residents. These residents consist of 130 males and 23 females.

Facility demographics:
Rated capacity: 250
Actual capacity: 153
Age range of population: 18 – 65
Average length of stay: Sentenced 46 days and detention 34 days Security: Level four Quasi-incarceration
Number of full-time staff: 78; 58 Security, 2 Administrative, and 18 Support

SUMMARY OF AUDIT FINDINGS

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The Delaware Department of Corrections established a Department Prison Rape Elimination Act (PREA) Policy #8.60 to ensure compliance with PREA Standards. The Policy #8.60 update is dated July 17, 2016. The #8.60 policy, SVOP supports and administers a program of education, prevention, detection, response, investigation, and tracking of all reported acts of sexual assault and harassment. Punishment for the perpetrator is enforced. This policy requires Delaware Department of Corrections to maintain a zero tolerance for resident-on-resident sexual assault, staff sexual misconduct and sexual harassment toward residents. Every allegation of sexual assault, misconduct, and harassment is thoroughly investigated. The Prison Rape Elimination Act Policy is an essential component to the operations at SVOP and is adhered to at all times to ensure continuity and professionalism throughout the system as confirmed by observations, review of documentation and interviews with staff, contractors, volunteers, and residents.

The auditor received the agency's written policy mandating Zero Tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct. The policy defined the designation of staff for PREA activities; resident treatment and services; resident screening and assessment; reporting allegations; investigations; training and education; and data collection. The policy states the agency shall designate a PREA Agency-Wide Coordinator to oversee agency efforts to comply with PREA standards. Each facility (minimum security and above) assigns one staff member as the facility PREA Compliance Manager with the overall responsibility for coordinating facility efforts to comply with PREA standards. Mike Records is the Agency-Wide PREA Coordinator. Lt. Scott Ceresini is the facility PREA Compliance Manager and per review of the organizational chart, Lt. Scott Ceresini reports directly to the Director of the facility. It should be noted that Lt. Scott Ceresini, the facility PREA Compliance Manager, has accepted another position two weeks ago. Lt. Scott Ceresini replacement Lieutenant Stephen Rogers also participated in PREA audit. The State-wide PREA coordinator and SVOP's new PREA Compliance Manager were interviewed using the structured PREA Audit Tools. During the auditors' interview with the PREA Coordinator, the coordinator advised of his responsibilities of ensuring that facilities under the department and contracting facilities are achieving PREA accreditations and following any PREA third-party reporting, collecting, analyzing and trending PREA data for performance improvement for all facilities. The PREA Coordinator further reported sufficient time and authority to complete all PREA activities; the agency organizational chart shows that the PREA Coordinator reports to the Director of the Agency. The PREA Manager reported sufficient time and authority to develop, implement, and oversee agency

efforts to comply with the PREA standards in all of its community confinement facilities. From the interview, it was found that the PREA Manager's responsibilities are primarily PREA activities which include following-up on any PREA complaints, investigations, training, report writing, and ensuring no retaliation.

During the review of the facility, PREA posters in both English and Spanish were displayed throughout the building and were visible to all staff, residents, and visitors. These posters provided residents with a method to contact an outside source for residents or third-party reporting sexual abuse and sexual harassment.

Several staff and residents interviewed were able to convey with authority zero tolerance of sexual abuse and sexual harassment policy and procedures in place on reporting sexual abuse. Security staff members and residents were able to identify the PREA Manager and responsibilities. The Director, Warden, and Assistant Warden confirmed during their interviews that the PREA Manager's responsibilities are primarily ensuring the facility is PREA compliance.

The Zero Tolerance Policy is posted in the housing units and PREA is a major part of training to new staff, existing staff, and residents. This observation is based on lesson plans reviewed, training modules, attendance sheets and interviews with both residents and staff. Each resident and staff interviewed was knowledgeable and was able to provide details on both initial and ongoing training updates. Through discussions with staff and residents, observation of bulletin boards, posters, handouts and materials, review of residents and staff handbooks, and personnel policies, it is clear that Sussex Violation of Probation, (SVOP) is committed to Zero Tolerance of sexual abuse and sexual harassment

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware Department of Corrections has a contract agreement for the confinement of residents with New Expectations Program, located at 34 Continental Avenue, Newark Delaware. New Expectations is operated by Connections Community Support Programs (CSP). The Delaware Department of corrections (DOC) provides funding to the program via a grant project. New Expectations was PREA accredited through a USDOJ PREA audit in November 2015. The auditor reviewed a copy of New Expectations PREA report and there were no findings or corrective actions. For the purpose of Standard 115.212, on May 19, 2017, the Statewide PREA Coordinator conducted a review using the PREA Auditor Compliance Tool for Community Confinement Centers as a guide. The auditor reviewed the PREA Coordinator audit report and there were no findings or corrective action required. New Expectations is required to be PREA accredited. The auditor reviewed the agreement that states the contractor will

agree to be in compliance with PREA standards; fully cooperate with any investigation on sexual abuse and participate in PREA training. The Statewide PREA Coordinator communicated in an interview that New Expectations receives funding from the Department of Corrections and communicated that they were PREA certified in 2015 with zero(0) corrective action or findings. SVOP demonstrates compliance with PREA standard 115.212

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The Delaware DOC Staffing Policy #1.4 mandates the Department provide sufficient staff to ensure efficient operations consistent with its mission. Department Facility Security Policy # 8.28 states that space is designated for each facility for a 24 hour continuously staffed secure control room for monitoring and coordinating the facility's security. The SVOP is a female and male community-based supervision facility that house violation of probation level four (4) residents with staffing and perimeter security outlined in the description of the facility. This facility has 84 authorized positions and during the time of the audit, there were 78 filled (92.8%) and 6 vacant (7.2%) positions. Deputy Warden and PREA Manager informed the auditor that staffing shortage is not impacting their ability to ensure a safe and secure environment. Deputy Warden specified that whenever there is a staffing shortage staff is pulled from the other two facilities (Sussex Corrections and Work Release) located nearby to ensure adequate staffing and a safe environment. Interviews with Deputy Warden, PREA Coordinator, and Human Resources have assured staffing according to the needs and priorities set by the agency. Staffing is assessed and evaluated annually to confirm staffing and supervision in the monitoring residents. The Sussex Community Correction Center Violation of Probation, in the last 12 months, had an average daily population of 182 with the capacity at 250. The average resident to security staff ratio for the last 12 months was approximately 6:1.

The Department routinely reviews the staffing plan and recruitment policies, and institutional needs to assure the safety of staff and residents. Video monitoring with 53 cameras assist staff in protecting residents against sexual abuse. Interviews with ten (10) residents confirmed they felt they were in a safe and secure environment. Ten (10) residents viewed the facility to be safe from sexual abuse and assault and believed there is a high level of close supervision at the facility. Interviews with ten (10) random security staff confirmed residents are monitored and closely supervised through electronic or physical surveillance.

On-site visit to the facility, review of documents/logs, interviews with staff confirmed that this standard is a priority. Review of log documentation demonstrates that residents are consistently being monitored on the units. On site observation of the control room displays visibility by cameras throughout the facility.

The auditor reviewed compliance documents including DCOC #8.6; the SCCC Staffing Plan; daily population for the 1st, 10th, and 20 in the past twelve months; 12 months average population of residents; observation of staff and cameras. During the past PREA cycle, SVOP installed addition 10 cameras. It is evident SVOP prioritize supervision, monitoring, safety and security, and prevention of sexual abuse.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

A review of Delaware DOC Policy #8.60, Cross Gender Supervision of Residents #8.75 and Contraband: Searches, Seizures and Disposition #8.32 addresses limits to cross-gender viewing and searches. The policy states when the gender of the housing unit changes to the opposite gender a notification will be made to residents announcing the staff member's presence when entering the housing unit, a resident shall be able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing them except in exigent circumstances, strip searches and visual body cavity searches will be conducted by gender specific staff and cross-gender strip searches shall be documented. All staff received training in conducting counts, proper and respectful search and pat downs, and unannounced rounds to help assure compliance with the standard that limits cross gender viewing and searches. The auditor reviewed training record logs on searches and pat downs. The documentation demonstrates 100 (%) percent of all security staff received this training. Interviews with three (3) security staff members monitoring the units and ten (10) residents confirmed the facility is adhering to the standard. The residents stated that when the opposite gender security staff is entering their units they announce their presence. Several interviewed residents informed the auditor that searches and pat downs are completed in a respectful manner. Conversely, one male resident did inform the auditor that a particular security staff searches were disrespectful and intrusive. After further investigation documentation showed the resident's allegation to be unsubstantial. However; as a result, to reduce risks, the Warden set in place a policy that strip searches will be completed with a minimum of two security staff present.

Policy, procedures, and training governing cross gender viewing and searches were reviewed as well as observations of actual searches conducted. The policy does allow for cross gender strip and cross gender visual body cavity searches of residents in emergency situations. Since SVOP has female residents, if a female officer is not available to search a female resident, then a female officer will be requested from the Sussex Correctional

Institution, a prison located adjacent to SVOP. However, no cross gender viewing or searches were conducted absent exigent situations. Interviews of ten (10) residents and three (3) security staff members, on the units, confirmed there were no cross-gender pat searches being done. There were no transgender or intersex residents held at SVOP.

Interviews, observations, and review of sign-in training document, policies, procedures, and training curriculum confirmed that security staff members of the opposite gender announce their presence when entering the resident housing. It was confirmed by interviews with security staff members and residents that residents can execute bodily functions, change clothing and shower without a staff of the opposite gender completely viewing them. Residents reported there is a confident sense of privacy.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware DOC Policy #8.60, BOCC #2.5 and SVOP #8.60 provides disabled residents and limited English 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. SVOP does not allow resident interpreters, resident readers, or other types of resident assistants. SVOP has established procedures to assist limited English proficiency or disabled residents to have an equal opportunity to participate in or benefit from all aspects of the agency's zero tolerance sexual abuse and harassment policy. In the past 12 months, there has been zero (0) use of resident interpreters, readers or other types of resident assistants.

Interviews with security staff and residents confirmed through their statements that SVOP provides disabled residents and limited English residents 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. Intake Staff confirmed that should there be a need for assistance they would notify the shift supervisor and contact Interpretation and Translation services to provide the resident with interpretation and translation services. At the time of the audit, there were no disabled or limited English residents detained at SVOP.

The auditor's review of PREA documents in Spanish and brail confirmed that disabled and limited English proficiency residents are provided with 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. The auditor also reviewed documentation of past residents' training that identified a hearing impaired resident who was provided with

interpreter services. The documentation showed that interpreter services were provided to the resident for the PREA training.

Review of the state's contract for translation services, instructions for accessing telephone interpreter services and a memo from management reiterated that residents are not to be used to translate confirms that SVOP is adhering to standard 115.216.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware DOC #8.60 pertaining to criminal background checks, promotions, the hiring of employees and contractors, and policy concerning criminal background checks of current employees and contractors was reviewed by the auditor. The policy affirms the Department does not hire or promote anyone who may have had inappropriate contact with residents and does not enlist the services of any contractor who had inappropriate contact with residents, or who has engaged in sexual abuse in any institution, been convicted of engaging or attempting to engage in sexual activity in the community or has been civilly or administratively adjudicated of engaging or attempting engage in sexual activity in the community. The Auditor's interview with Human Resources confirmed that before the hiring of any new employee a criminal background check is completed. Additionally, SVOP policy requires criminal background record checks be conducted at least every five years and that there is a system in place to thoroughly complete the records background checks. New hires and staff who are promoted are required to complete and sign documents on information inquiring about previous sexual misconduct, in writing on the application and/or interviews, for hiring or promotion. Material omissions regarding such misconduct or the provision of materially false information are grounds for termination. Only one new employee was hired in past 12 months (eleven (11) months ago during this audit period) and documentation review of this employee record demonstrated criminal background checks were being completed. Another file review of a contractor verified background checks were being completed. A third file was a review of an employee applying for promotion further confirmed background checks were being completed. SVOP confirmed the employee had not engaged in any sexual abuse or were convicted of any sexual abuse or civilly or administratively adjudicated before the promotion. It was evident that the agency policy and the PREA law were being followed concerning hiring, promotional decisions, and background checks.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Per DOC policy #8.60 indicates that when purchasing and deploying the new video monitoring equipment, the Department considers what impacts these upgrades and purchases would have on SVOP's ability to protect residents from sexual abuse. The agency head indicated that the Warden assesses SVOP at least yearly to determine the need for additional staffing and video monitoring. The Critical Incident Review Team evaluates the need for new video monitoring after each substantiated and unsubstantiated PREA investigation.

SVOP has not attained any new facilities or made any substantial expansions or modifications of existing facilities during the past PREA cycle. SVOP understands and demonstrates through its compliance form that any RFP, design, architect, and/or construction company must be familiar with the mandates of PREA and that any design to new or renovated buildings shall eliminate blind spots or areas where abuse may likely to occur. This design is supplemented by video monitoring technology to allow residents to be viewed at all times except when changing, showering, or performing bodily functions.

The Agency Director, Oettel, fluently discussed how the bidding and contract process, along with the initial meetings with architects and contractors, ensures that these groups are familiar with PREA and the best practices in the industry for creating safe design structures. The Agency Director further confirmed that any new construction or renovations will be designed to reduce or eliminate blind spots in areas where sexual abuse may be likely to occur. The agency head confirmed the process of requesting building designs be supplemented by video monitoring technology to allow staff and inmates to be viewed at all times possible, when not in a state of undress. During the interview process, Director Oettel, further reported that the Warden is able to assess the facility, at least yearly, to determine the need for additional staffing and video monitoring; identified the process for Critical Incident Review teams coordinated efforts to assess the need for new video monitoring after each Substantiated and Unsubstantiated PREA investigation and was able to fluently identify processes for contacting the respective Bureau should additional needs arise.

Three (3) security staff in the video control room was interviewed and reported that they constantly monitor the video screenings to prevent sexual abuse and harassment from both residents and staff. The PREA State-wide Coordinator and the Assistant Warden interviewed confirmed that critical reviews are conducted to determine how to prevent a reoccurrence using technology and training methods. The PREA State-wide Coordinator and the Assistant Warden also advised of that each year a staffing plan is devised and technology cameras are considered to eliminate blind spots at the facility. Review of documents revealed that SVOP purchased and installed new cameras

in the culinary arts building and approved a purchase order to install cameras in the classrooms. SVOP currently has 53 working cameras. The auditors' observation found that no cameras directly interfered with residents' ability to shower, dress, and perform bodily functions without privacy. Constant supervision and limited access to blind spots or unsupervised areas assist with prevention of sexual assault/sexual abuse. It is evident SVOP is following standard 115.218.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference department/agency/policy/procedures of Delaware DOC Policy #8.60, Bureau of Community Corrections Policy #8.60 and #2.5, and Sussex Community Corrections #8.60 requires the facility to maintain or attempt to enter into MOU or other agreements with community service providers who are able to provide residents with confidential emotional support services related to sexual abuse. These policies assure PREA trained investigators follow a uniform evidence protocol through the use of the Sexual Abuse Checklist operating memorandum. Emergency medical healthcare along with forensic examinations by SANE/SAFE staff are procured from Beebe Health Care where SANE/SAFE staff are available 24/7. The Support Auditor interviewed two SANE nurses, one contracting burse at the facility and one located at the near hospital. Both nurses confirmed the policy was being followed for when sexual assaults occur. The facility offers all residents who experience sexual abuse access to forensic medical examinations without financial cost to the victim. There was one forensic medical examination by SANE/SAFE staff for an SVOP resident during the past 12 months. The auditor reviewed the resident's file and confirmed that after the resident's allegation of sexual assault policy and procedures were followed. A SANE was completed on this case at Beebe Medical Center; potential evidence was collected; video surveillance tapes were reviewed, and the Delaware State Police was contacted. Based on information provided to the auditor, the findings from the examination and the Delaware State Police investigation concluded that the resident's allegation to be unfounded.

Although the Department of Corrections has an agreement with ContactLifeline to provide victims with confidential emotional support services and the ability to report sexual abuse to an outside third party agency, during the auditors' interview with the PREA Manager, concerns were generated about Contact Lifeline's ability to provide face-to-face confidential emotional support services to victims. Subsequently, SVOP entered into an agreement with Connections Community Support Programs (CSP) and New Expectations to provide victims with confidential emotional support services.

The auditor interviewed three (3) staff; one (1) investigation staff, one (1) medical staff and one (1) mental health staff. The investigative staff was able to report the processes for when a sexual assault occurs. The investigative staff discussed the processes of separating the victim from the perpetrator, interviewing the victim and the perpetrator, preserving evidence, and starting the investigation. The investigative staff said once they conclude their investigation they would present to the Warden for him to make a decision to pursue criminal or administrative charges. The medical staff was able to discuss processes when a sexual assault occurs, such as preserving evidence, interviewing the victim and referring the victim to the local hospital to receive SAN/SAFE. During this process, the victim is also referred to victim's advocate group for emotional support and referred to mental health for assessment and treatment. Each interviewee was able to discuss procedures and actions for sexual assault and identified specialized training received on sexual assault. Based on the information provided to the auditor, interviews with staff and reviews of documentation, SVOP has developed and implemented the necessary policies for this standard. Document reviews and interviews confirmed that the policies are being followed.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference department/agency/policy/procedures of Delaware PREA Policy #8.60 ensures that administrative investigations of sexual abuse, and/or sexual harassment of a resident is considered an emergency incident and is conducted promptly and thoroughly and is followed through until a determination of substantiated, unsubstantiated, or unfounded can be made. All investigations are documented in standardized reporting format utilizing the DACS incident and investigation.

Based on the interview with the investigator, resident-on-resident sexual abuse and harassment are assigned to a facility investigator to investigate each allegation (s). Documentation of a training log demonstrated that the investigators have each completed PREA investigator courses. The investigator stated that if it appears at least by a preponderance of the evidence that a case of abuse can be substantiated the Delaware State Police are brought in to investigate and move to prosecute. The investigator further reported that if a staff person is involved in an incident then Internal Affairs investigators are also assigned to the case. Based on information from the investigator, an Incident Report marked "PREA", begins the investigation and each investigation is followed to a conclusion of substantiated, unsubstantiated, or unfounded. Thereafter, a Critical Incident Review is completed on each completed investigation. After completion, the investigations are kept in the DACS (Delaware Automated Correctional System) operating system and are used to report yearly to the USDOJ.

When allegations are referred to the Delaware State Police for criminal investigation, the SVOP PREA Manager will monitor the case until it is determined to be substantiated, unsubstantiated, or unfounded.

The number of criminal and/or administrative investigations of alleged inmate sexual abuse and harassment that were received in the past 12 months was five (5). During the past 12 months, the number of allegations resulting in administrative investigations was four (4) and during the past 12 months, the number of allegations referred for a criminal investigation was one (1). Agency policies and the facility procedure comply with PREA requirements relating to allegations and the investigation of such. See above reference to case documenting SVOP following procedures for investigations. The agency and facility both document all allegations of sexual abuse and referrals of allegations of sexual abuse and sexual harassment for criminal investigation. Review of policies and procedures substantiating compliance with this standard; documents of the one case in the past twelve (12) months; interviews with three (3) staff and the Supervisor of Delaware State Police confirm SVOP is meeting the requirement of this standard.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference department/agency/policy/procedures of Delaware's Department of Correction's PREA Policy #8.60 shows that policy addresses all ten points of the PREA Employee Training Standard. The facility provided a copy of the Orientation Manual for all new DOC Staff, Volunteers and Contractual Staff to the auditor for review. Ten (10) Staff member interviews indicated they were extensively trained in PREA. The staff is knowledgeable about the Zero Tolerance Policy for sexual abuse and sexual harassment. The staff was clear on how to perform their responsibilities in detection, reporting and responding. Interviews with ten (10) random security staff and fourteen (14) specialized staff revealed their ability to identify the Department's policy on Zero Tolerance and the requirement of Coordinated Response to an Incident of Sexual Abuse for First Responder and Supervisory Staff.

Based on documentation reviews, the employee training covers information and notices that detailed Zero Tolerance Policy for sexual assault/abuse, red flags suicide prevention and response techniques. All the information provided emphasized and supported the training efforts for SVOP correctional staff. During past twelve months all staff, currently, employed by the facility, and who have contact with residents were trained or retrained on the PREA requirements. Fourteen (14) specialized staff, Ten (10) random staff interviews, and ten (10) random resident interviewers clearly indicated an extensive and consistent training program. The auditor reviewed the PREA basic 4-hour classroom or 45 minutes on-line training module; correction officers' cross gender supervision

3-hour training module; LGBTI 2-hour training module; Medical and Behavioral Health specialized training module; Specialized Investigations PREA training module; First responders training model; and update PREA refresher training module. The auditor reviewed a complete list of all SVOP employees receiving PREA training. A review of signed training logs acknowledged that training was completed by employees. A detailed review of randomly selected employee personnel files and interviews with staff members further confirmed that training was completed and SVOP is adhering to the standard 115.231.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference department/agency/policy/procedures of Delaware Policy #8.60 demonstrate that all DOC staff, contract staff, and volunteers are trained and understand the agency's Zero tolerance for sexual abuse or harassment and retaliation against a resident or employee in any form as a result of reporting an allegation of sexual abuse/harassment. SVOP uses volunteers and Contractors and this standard was reported to be a priority for the facility and was confirmed by the auditor. The auditor reviewed SVOP's "A Guide To The Prevention and Reporting of Sexual Abuse and Misconduct with Residents", requiring contractors, vendors, and volunteers to read, acknowledge and sign the documentation to demonstrate an understanding of the policy. Based on information from interviewees a security clearance application prior to coming in to contact with residents at SVOP must also be completed. The auditor reviewed Volunteers, Contractors, and Vendors PREA training modules and post-test. Volunteers, contractors, and vendors are required to complete and sign documents on information inquiring about previous sexual misconduct in completing an application for employment and/or during interviews for hiring or promotion. Material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination.

The auditors interviewed one (1) volunteer and (4) contractor categories (1) medical, (1) mental health staff, (2) teachers and the interviews confirmed they have been trained in their responsibilities and requirements of the zero tolerance policy. Interviewees confirmed that medical staff members are first responders and have been trained to respond to sexual assaults. Medical and mental health staff, teachers and volunteers have been trained to report any allegations of sexual assaults or harassments. Medical and mental health staff members are mandatory reporters. During the interview process, the volunteer did not communicate with confidence on the subject of PREA. Although the volunteer received training 18 months ago, SVOP agreed to provide refresher training to the Volunteer. The auditor reviewed a list of training logs on the volunteers and contractors receiving PREA training. The facility's volunteers, contractor, and vendor were 100% trained in PREA training.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of the cross reference department/agency/policy/procedure of Delaware DOC PREA policy #8.60 affirms that every resident receives a written copy of DOC's orientation material during the assessment and reception process which comprise of both verbal and written information about sexual abuse and harassment, agency's Zero tolerance standard, prevention/intervention, self- protection, how to report acts or suspicions of sexual abuse, assaults or harassment by residents or staff to include reporting utilizing the offender PREA hotline. Residents are required to view a comprehensive video on the Department's zero-tolerance of sexual abuse and sexual harassment. Documentation of residents attending the training was reviewed and is maintained by the facility.

The Resident's Orientation material and the PREA Handbook for Residents was reviewed by the auditor. Interviews conducted with ten (10) residents concluded that each of them received training and information about the Zero Tolerance Policy and how to report instances of, or suspicions of abuse or harassment. These residents stated that training was received at intake and during the orientation. Residents interviewed also reported that handouts along with video training were also provided during the orientation process. The interviews confirmed that the residents receive the PREA handbook and verbal training on the zero-tolerance policy was conducted. The auditor also reviewed a very informative video which was included in the training. All residents interviewed were able to verbalize the purpose of PREA, how to report a PREA incident, Zero tolerance of sexual abuse and assault, no retaliation, and third party reporting. Over the past 12 months the total number of residents who completed intakes at the facility were 2774 or 100 (%) percent. The number of residents transferring from another facility in the past 12 months was 365. All residents coming from another facility or coming in from the community received PREA education materials during the intake process. Resident's PREA education is available in different formats to accommodate all residents. Key information about the agency's PREA policy is continuously and readily available through posters, handouts, and other written formats.

The auditor was impressed that all residents interviewed could articulate the meaning of PREA, steps to report sexual abuse or harassment, no retaliation, reporting to outside entity and third party reporting. Documents provided by SVOP and reviewed by the auditor included; Policy #8.60, Residents' Orientation Posters (English and Spanish), PREA Training for Offenders, Photos of Displayed Posters. The agency documentation of residents' participation in PREA education and residents' interviews confirmed PREA education.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference department/agency/policy/procedures of Delaware DOC policy #8.60 show requirements that specialized training is provided for employees who may respond as part of their job duties to report incidents of sexual assault. Interviews with two (2) investigative staff members confirmed that the specialized training includes; techniques for interviewing 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 or prosecution referral.

Review of cross reference of agency/department policy/procedures shows the Department Policy Investigative Responsibilities and Assistance from Delaware State Police #8.35 allows the Department to request the assistance of the Delaware State Police to supplement the Department's investigatory powers, when necessary. Initial inquiries into allegations of criminal or institutional misconduct and initial investigation into such allegations are the responsibility of institution where an event occurred. The warden or designee ensures that contact with Internal Affairs or Delaware State Police is made when required. The auditors reviewed Delaware policy, along with investigators' specialized curriculum personnel certificates and four (4) staff training records which reflected investigators are trained in conducting sexual abuse investigations in confinement settings and training is documented. The auditors' interview with Delaware's State Police confirmed their investigation responsibilities to SVOP and specialized training to complete criminal investigations on sexual assaults. The auditors' interviews with SVOP's investigators confirmed specialized training and their complete understanding of interviewing victims and perpetrators, collections of evidence and when to pursue criminal or administrative investigations.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference department/agency/policy/procedures of Delaware DOC PREA policy #8.60, requires mental health and medical staff be trained to detect and assess signs of sexual abuse and/or predation, preserve evidence of sexual abuse, respond to sexual assault victims and be fully knowledgeable of DOC procedures in regard to PREA. A comprehensive PREA power point presentation from Medical Services is part of the training requirement. The auditor reviewed specialized training modules and lesson plans for Medical and Mental Health staff. The auditor also reviewed training records on all health and mental health staff and confirmed that one hundred (100%) percent of staff received specialized training. Interviews with specialized staff revealed staff must complete the annual PREAs on-line training and pass a post-test with at least an 80% score.

The medical and mental health staff members are contracted employees who work regularly at the facility. Based on information from the training logs reviewed by the auditor all staff members interviewed received the training required by policy. The agency retains documentation showing that medical and mental health practitioners have completed the required training. Observations, review of documentation and interviews with 2 medical; 1 mental health confirmed SVOP is following policies and procedures and is compliant with this PREA standard.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of department/agency/policy/procedures of Delaware PREA Policy #8.60, Medical Service Receiving Screening-Intake #11-E-02, Mental Health Screening #11-E-02.1 and Intra-System Transfer Screening #11-E-03 shows that the SVOP address the 8 areas of this standard and require all residents be screened during intake and upon transfer to another facility, for their risk of being sexually abused, or being abusive toward other offenders.

This screening occurs within 24 hours, but not longer than 72 hours after the arrival of the resident using the Department's Sexual Victimization/Abusiveness Quickscreen tool. Within 21 days of the resident's arrival at the facility, the resident is reassessed using the Department's more detailed Sexual Victimization and Abusiveness screening tool. The auditor observed an intake process and confirmed the screening is being completed per policy. The intake process was conducted and the auditor observed the process. The intake process conforms to PREA standards. The form/checklist for screening included questions regarding mental, physical and developmental disabilities and whether or not the resident is gay, lesbian, bisexual, transgender, intersex or gender nonconforming, and whether or not the resident previously experienced any sexual victimization. The residents own perception of vulnerability was also pursued. The screening/intake process was well managed and thorough. This information was used in consideration for housing and program placements. The Auditor observed the screening process which included questions used to assess for risk of victimization or abusiveness. The auditor interviewed the intake/

screening staff who demonstrated the process during an actual booking of a resident. The screening process was documented in the electronic records. The intake security staff retrieved the screening form and was able to complete the screening process.

The auditor interviewed 10 residents who confirmed the PREA screening process at intake and a follow-up screening within 21 days. All residents interviewed reported they felt safe in their environment. The residents interviewed stated they received a complete PREA orientation and comprehensive PREA education within 30 days of their stay at SVOP. The auditor's review of three (3) residents records demonstrate SVOP's compliance with PREA screening, appropriate housing based on potential perpetrator or victim and a reassessment within 21 days of their stay.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of Delaware DOC PREA Policy #8.60 considers the screenings confidential, only to be used by staff to assist in the placement and protection of residents from abuse. The policy requires the facility use information from the risk screening evaluation in accordance with PREA Standard in order to inform staff making housing, work, education and program assignments with the goal of keeping residents at risk of being sexually victimized separate from those at high risk of being sexually abusive. The screening information is collected as data on an Assessment Form and used for residents' housing assignment.

The auditor observed an actual intake/booking process. Based on this observation, when the initial PREA risk assessment is completed the assessor will give a score to indicate the potential of abuse or victimization. Based on the score the resident will be housed in an appropriate place. Potential victims are not housed in areas of residents that are likely to perpetrate sexual abuse. Potential victims may be placed on units where rooms are in close proximity to the security officer's station. The auditor reviewed the PREA housing logs and confirmed that screening information is used to perform housing, bed, work and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.

The auditor's interviews with one (1) intake security staff, two (2) medical and one (1) mental health staff supported by interviews with ten (10) residents as well as observations and reviews of documentation support the use of the screening information as being consistent with appropriate custody and security. Interviews with two (2) medical staff members revealed that everyone being booked into SVOP is given a medical screening which includes PREA questions regarding sexual victimization and abuse. If there is a history or fears of being victims of sexual

abuse or history of perpetrating sexual abuse, the resident receives an examination, and a referral is routinely generated to mental health. During the audit; there were no transgender or intersex residents held at SVOP. The auditors did interview one lesbian resident and she confirmed that during the screening process questions were asked regarding sexual orientation, past sexual abuse and feelings of being safe were considered when placed on housing unit. All ten (10) residents interviewed communicated their feelings of being in a safe environment and communicated no concerns of being sexually abused or harassed.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference agency/department/policy/procedures of the Delaware DOC PREA Plan Policy #8.60 shows that Delaware DOC has established procedures allowing for multiple internal ways for residents and staff to report privately to agency officials and take appropriate measures to protect residents from retaliation. Additionally, SVOP residents' each receive orientation training and a handbook that provides information on sexual assault awareness, facts for the residents who sexually assault other residents, rape avoidance and what to do if you are sexually assaulted. Residents may report allegations directly to Warden, staff, victim support organizations that are not under the jurisdiction of SVOP, facility investigators, family members or by submitting a grievance. Third parties reporting include: fellow residents, staff members, family members, attorneys, and advocates shall be permitted to assist residents and request for administrative remedies relating to an allegation of sexual abuse. Emergency grievances alleging substantial risk of imminent sexual abuse may be filed. This information is attainable in residents' handbooks, posters, bulletin boards, information handouts, libraries and through staff.

The auditor interviews with ten (10) residents revealed their knowledge in steps to reporting sexual abuse and sexual harassment and all residents interviewed were well informed of their rights under PREA. The residents confirmed that signs are posted with a telephone number to report sexual abuse. Residents were able to communicate to the auditor the various ways of reporting sexual abuse including: reporting to security staff on the units; notifying the Shift Commander; third party reporting sexual abuse on behalf of the resident; contacting outside victim advocate (New Expectations); contacting the State's rape crisis center and notifying the PREA coordinator.

The auditor observed PREA posted signs that provided a contact number for third party reporting residents who are victims of sexual abuse. The auditor also reviewed two (2) resident files that report sexual abuse allegations. The auditor confirmed through documentation that SVOP is following reporting policies by investigating the allegations, completing critical incidents reports, following up with residents, providing or offering medical and

mental health care, and reviewing critical incidents for performance improvement and prevention of reoccurrences. Based on the documentation reviewed both allegations reported were determined to be unfounded.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference agency/department/policy/procedures the Delaware DOC PREA Plan Policy #8.60 shows that DOC has established procedures allowing for multiple internal ways for residents to report privately to agency officials and appropriate measures to protect residents and staff from retaliation. Additionally, SVOP resident's orientation training and handbook for residents are issued to each resident and they are provided sexual assault awareness documents, documents on facts for the resident who sexually assaults other residents, documents on rape avoidance and what to do if you are sexually assaulted. Residents may report allegations directly to Warden, staff, entity that is not part of the agency, Shift Commander, facility investigator, family members or by submitting a grievance. Third parties, including fellow residents, staff members, family members, attorneys, and advocates, are permitted to assist residents and request for administrative remedies relating to an allegation of sexual abuse.

Emergency grievances alleging substantial risk of imminent sexual abuse may be filed. This information is attainable in resident's handbooks, posters, bulletin boards, information handouts, libraries and, of course, through staff.

The auditor's interviews with ten (10) residents revealed their knowledge in utilizing various methods of reporting sexual abuse and sexual harassment. The residents were able to articulate how well informed they are of their rights under PREA. Residents were also knowledgeable on their rights and procedure to appeal a decision on PREA complaints or investigations. In the past 12 months, zero (0) grievances were filed alleging sexual abuse. During this audit cycle, a SVOP memo was reviewed that stated they did not have any PREA reports through administrative remedies.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of agency/department/ policy/procedures of Delaware PREA Policy #8.60 require the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents address, telephone numbers for local, state, or national victim advocacy or rape crisis organizations with toll-free hotline numbers when available. Also, the Policy requires SVOP staff to inform the resident prior to giving access to victim advocates the extent to which communications will be monitored and the extent to which reports will be forwarded to authorities in accordance with mandatory reporting laws.

Residents are given access to outside confidential support services information when they arrive at the facility and view the PREA video, posters shown in the facility and a PREA handout given when entering the facility. The auditor observed PREA number to access outside confidential support services posted throughout the facility. During the auditor's interviews with ten (10) residents; they were able to communicate their rights to outside confidential support services and identify mechanisms to access these supports. The auditor's review of residents' records indicated one resident who made sexual abuse allegations was provided with outside access to support services. Review of records revealed the only other sexual abuse allegation was retracted by the resident after the investigation showed the allegation to be unfound.

The auditors' interview with the PREA Manager did raise some concern about the ContactLifeline ability to provide face-to-face confidential emotional support services to victims. Subsequently, it was reported by the PREA State-wide Coordinator that SVOP entered into an agreement Connections Community Support Programs (CSP), New Expectations to provide victims with confidential emotional support services.

There was a Memorandum of Understanding (MOU) or agreement, drafted between Delaware Department of Corrections and Connections Community Support Programs (CSP) New Expectations to satisfy the 115.253 requirement of SVOP abilities to provide resident-victims with confidential emotional support services, and the ability to report sexual abuse to an outside third-party, pursuant to the Prison Rape Elimination Act. Compliance documentation provided by SVOP and reviewed by the auditor included copies of MOU draft. Review of an MOU draft documentation confirmed that residents will have access to outside confidential support services.

The department also has an MOU with ContactLifeline that provides access to outside confidential supports, via telephone and mechanisms for residents reporting sexual abuse and for third party reporting sexual abuse.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware PREA Policy #8.60 mandates the facility to provide a method to receive third-party reports of resident sexual abuse or sexual harassment. These methods include reporting; verbally, in writing, anonymously and publicly. SVOP distributes information on different methods of reporting resident sexual abuse/harassment on behalf of residents. The auditor observed SVOP posted advertisements with this information in the facility, developed curriculum used in mandatory PREA training, brochures, pamphlets, handouts and displays of this PREA information on the agency's website.

During the auditor's interviews with ten (10) residents; each was able to communicate the mechanisms for third-party reporting sexual abuse. Residents informed the auditor that the PREA poster gives a number for third party reporting by contacting ContactLifeline. The auditor observed these posters on the housing units and intake/ booking area. Residents also stated that family, friends, or anyone can contact the third party number; Prea Manager, State Prea Coordinator or Warden to report sexual abuse on their behalf. Review of resident's records, critical incident reviews, and interviews with two (2) investigators; PREA Manager; and PREA Coordinator revealed one third-party reported sexual abuse was investigated and determined to be unfounded.

The SVOP provided confirming documentation that third-party reporting is included in the resident's orientation and copies of signed document by the resident. Resident interviews, the auditor's observation, and review of documenting the process from the intake, notification to other facilities and investigations confirmed SVOP is adhering to this PREA standard.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of cross reference department/agency/policy/procedures DOC PREA Policy #8.60 show the requirements that all staff are to report immediately and according to agency policy, any knowledge, suspicion, or information they receive regarding an incident of sexual abuse/harassment that occurred in a facility whether or not it is part of the agency. Staff must also, per policy, report immediately and according to policy retaliation against offenders or staff who reports incidents, and any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation. The 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. Delaware Internal Affairs (IA) keeps a log of all calls to the PREA hotline. A copy of this log is provided to the facility PREA Compliance Manager each month.

Interviews with three (3) security staff revealed staff's knowledge and commitment to reporting sexual abuse and harassment. Staff interviewed was able to communicate with authority policy and procedures for reporting sexual abuse and harassment. These staff members acknowledged to the auditor that they signed documents agreeing to adhere to Zero tolerance and reporting abuse. The security staff reported that this was reinforced in the facility's policy and PREA training. The auditor interviewed two (2) Nurses; one (1) Mental Health Professional; two (2) Teachers; and one (1) Paralegal. Each interviewee informed the auditor that they received training on reporting abuse, signed documents to adhere to Zero tolerance policy and reporting abuse, and by professional standards acknowledged that they are mandatory reporters of abuse. Review of Delaware PREA policy, training records and signed forms confirmed that staff members are well-informed of policy and procedures and are aware and follow Agency policy for staff reporting duties as required by the PREA and professional standards.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware DOC PREA Policy #8.60 requires staff to take immediate action to protect the resident immediately when knowledge, suspicion, or information is received regarding an incident of sexual abuse/harassment. SVOP intake screening reveals the potential risk of sexual abuse perpetration or victimization of residents and residents are housed in units based on their scoring or beliefs that they can become victims of sexual abuse. One (1) resident interviewed stated that he verbalized his concerns of being a victim of sexual abuse during intake and was housed in a unit that placed his room near the desk of the security officer in order to monitor the resident closely. Based on SVOP reporting logs and review of seven (7) resident screening intakes determined that no residents were subjected to be a substantial risk of imminent sexual abuse during the past twelve (12) months.

A review of the record from the two (2) residents reporting sexual abuse allegations show SVOP responded immediately to protect the alleged victims. The auditor's interview with three (3) security staff members, including a unit staff member, demonstrated their knowledge in their protection duties when a resident is subject to imminent sexual abuse or risk of imminent sexual abuse. Staff was able to discuss separating the victim from the perpetrator and preserving evidence. Staff members, resident interviews, and review of documentation confirmed the PREA standard is taken seriously and is being followed.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware DOC PREA Policy #8.60 requires upon receiving an allegation that a resident sexually abused while confined at another facility, it is required by Delaware DOC the Warden of the facility that received the resident must immediately notify the facility, no later than 72 hours, where the sexual abuse is alleged to have occurred. The auditor's interview with intake revealed staff was knowledgeable about the procedures for when a resident report an allegation of abuse from another facility. Two (2) security staff members were able to communicate to the auditor each step that a resident would take if a resident alleged sexual abuse. Staff reported that if a resident was sexually abused they would report abuse to the Supervisor, PREA Manager, Shift Commander or Warden. During the past 12 months, SVOP reported the number of allegations the facility received that a resident was abused while confined at another facility was six (6). The allegations of abuse at other facilities occurred within the past 12 months; however, two residents received medical exams and mental health referrals based on the allegations. The two (2) resident records confirmed medical and mental health referrals and the Warden contacting the other facilities where the alleged abuse occurred were completed.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware DOC PREA Policy #8.60 and SVOP Policy #8.6 requires that upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall require; separating alleged victim and abuser; preserve and protect crime scene; collect any evidence; if time allows, collect and protect evidence and advise resident to not take any action that could destroy evidence. Guidelines for Delaware Department of Correction (DDOC) Sexual Assault Response Team (SART) established a team that ensures the coordination of a consistent, respectful, victim-centered response to cases of sexual abuse.

In the past 12 months five (5) residents alleged that they were sexually abused. In All five (5) alleged abuses the victim and abuser were separated. Of the five (5) alleged cases of abuse, only one (1) notified the facility in a time period that allowed for collections of evidence. Review of the training module, logs, and interviews with (3) security staff; two (2) nurses; one (1) mental health staff and two (2) investigators confirmed that staff members are informed of first responder duties and are prepared to respond according to the PREA Policy. During staff interviews, staff was able to communicate the procedures for first responders including separating victims and perpetrators; collecting and preserving evidence and ensure that residents do not take any actions to destroy evidence.

The auditor's review of alleged sexual assault incident logs, incident reports; and one (1) resident's file who alleged sexual abuse revealed that SVOP is following policy and procedures for first responders. The file disclosed the resident receiving medical attention, mental health referral, clothes confiscated for evidence, information and opportunity to contact ContactLifeline and the investigation was brought to the attention of the Delaware State Police. The investigation concluded with the allegations being unfounded.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

A review of Delaware DOC PREA Policy # 8.60 dictates responding to an allegation of sexual abuse requires a coordinated effort between unit first responders, security staff, investigators, medical and mental health services and facility administrators. Procedures have been outlined to provide a systematic notification in the response process following a reported sexual abuse incident. The auditor reviewed guidelines and strategic plan for Delaware Department of Correction Sexual Assault Response Team (SART). The SART team consists of security staff (first responder representative, institutional investigator, PREA Compliance Manager, treatment/classification unit, medical and mental health. SART teams are established to: meet the needs of the victim through crisis intervention and support services, provide a medical exam for sexual assault victims, provide a joint, effective, sensitive approach to victims of sexual assault, conduct an investigation of the reported sexual assault, document and preserve forensic evidence for potential prosecution, and communicate progress to the victim. SART meetings are held, at a minimum, in conjunction with each Critical Incident Review. The SART Plan details coordinated actions to be taken in response to an incident of sexual abuse. The auditor reviewed the training module and lesson plans for SART teams. Interviews with the one (1) investigator, one (1) medical and two (2) mental health staff indicated a detailed understanding of roles and responsibilities in response to sexual abuse incidents. The auditor's review of alleged sexual assault incident logs, incident reports; and one (1) resident file who alleged sexual abuse revealed that SVOP is following policy and procedures for coordinated response to sexual abuse. The file disclosed the

resident receiving medical attention, mental health referral, clothes confiscated for evidence, information and opportunity to contact ContactLifeline and the investigation was brought to the attention of the Delaware State Police. The investigation concluded with the allegations being unfounded.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The auditor reviewed Delaware's DOC and merit Employee Compensation Unit 11 Bargaining Coalition agreement for July 1, 2016-June 20, 2018 that states "when employees continued presence on the job poses a threat to the safety or security of staff, residents, the public operation, they may be suspended immediately with or without pay pending completion of an investigation". Delaware's DOC and merit Employee Compensation Unit 10 Bargaining Coalition agreement collective bargaining agreement for July 1, 2015-June 20, 2018 states "when an employee continued presence in the workplace would jeopardize the safety and security interest of the State, any individual, or the public confidence, they may be reassigned or removed from the workplace immediately without loss of pay". "Prior to removing an employee without pay, the State agrees to provide the employee and the Union with the basis for the action and an opportunity to respond".

According to the interview with the Assistant Warden, he or designee is permitted to remove DOC staff from the workplace during any criminal investigation or serious administrative investigation and DOC staff can be placed on paid or unpaid suspension pending an investigation. This was confirmed by the auditor upon review of the agreement. The auditor interviewed one (1) resident who alleged that security staff did an inappropriate strip search. Review of the resident file revealed that the allegation was taken seriously by SVOP. Prior to an investigation the alleged victim and alleged perpetrator were separated. According to documentation and the interview from the investigation resulted in the allegations to be unfounded. Even so; as a method to reduce potential risks and allegations, the Warden communicated that he immediately sent out a memo stating that at least one other security staff need to be present when a security staff is doing strip searches.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of The Delaware DOC PREA Policy #8.60 dictates the protection of all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by staff or residents. Also, personnel policies covering sexual harassment and discourteous conduct of a sexual nature, general rules of conduct, sexual misconduct with residents, discrimination in the workplace are also protected against retaliation. There is a 90-day monitoring time period for retaliation review. A resident's 90-day monitoring form confirmed SVOP commitment to monitoring and preventing retaliation for reporting sexual abuse. The SVOP PCM is designated to be the monitor for retaliation at SVOP. The auditor reviewed documentation demonstrating monitoring and keeping the residents updated on the progress of alleged sexual abuse reporting. There were no reports of retaliation on reports of sexual abuse or sexual harassment during the previous twelve months.

The auditor was informed in an interviewed with the PREA Manager that the PREA Manager is responsible for follow-up for at least 90-days to ensure there is no retaliation for reporting abuse. An interview with one (1) resident, who reported sexual abuse, in the past, confirmed the facility monitors alleged victims closely to ensure there is no retaliation for reporting sexual abuse. The resident interviewed state there was no retaliation for reporting sexual abuse.

A review of a resident's record substantiates that SVOP follows their policy of taking actions when a sexual abuse incident occurs. The documentation validated the alleged sexual abuse incident; critical incident review; referral to medical and mental health; facility investigation; referral to outside investigation (Delaware's State Police); separation of victim and perpetrator; and close monitoring to ensure no retaliation and communicating the progress of the case with the victim.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware Policies DOC PREA #8.60, Investigations Responsibilities and Assistance from Delaware State Police #8.35, and Internal Affairs # 8.37 addresses investigations under general considerations. The policies follow: 1) a uniform evidence protocol to investigate sexual abuse and sexual harassment, 2) sexual investigations shall be conducted promptly, early, and objectively including third-party and anonymous reports, and 3) the use of

investigators who have been specially trained in sexual abuse investigations pursuant the Delaware policy. Policy #8.35 requests the assistance of the Delaware State Police to supplement the Department's investigatory powers when necessary initial inquiries into allegations of criminal or institutional misconduct and initial investigation into such allegations are the responsibility of the institution where the event occurred. Additionally, the agency's policy requires reporting incidents/crimes to Internal Affairs. This policy includes the direction that allegations of misconduct which appear to be criminal are referred to the Delaware State Police for prosecution.

The auditor reviewed training log sign-in sheets for specialized training for Investigations/PREA, and training modules and lesson plans. Based on these documentations all investigators received the specialized training for Investigations/PREA. The auditor interviewed two (2) Investigators from SVOP and one (1) Supervisor for the Delaware's State Police. SVOP investigators confirmed their specialized training and were able to inform the auditor about the internal investigation process and when to refer for an external (criminal) investigation. The Supervisor for the Delaware's State Police informed that auditor of specialized training his officers was tasked to complete in order to conduct sexual abuse investigations. The auditor was informed that officer's investigated allegations in the past at SVOP.

There were two (2) substantiated allegations of conduct that appeared to be criminal and referred for prosecution since August 20, 2012. The auditor reviewed files of the two (2) residents that made allegations of sexual abuse and cases were referred for criminal investigations. Based on documentation reviewed, each written report included a description of the physical and testimonial evidence, and investigative facts and findings. The documentation illustrated the alleged sexual abuse incident. The reports demonstrated the gathering and preservation of direct and circumstantial evidence which included available physical evidence and any available electronic monitoring data. The reports further indicated the interviews with the victim, perpetrator, and any witnesses. The written reports reviewed by the auditor confirmed that when the quality of evidence appeared to support a criminal prosecution, the facility will refer to the DSP. This was evident by two (2) referrals being made for outside investigation (DSP). The documentation specified that one (1) case was unfounded and one (1) was substantiated and ongoing. The reports were thorough and complete.

Retention of records is ensured by the Office of the Internal Affairs. All written reports are maintained for as long as the alleged abuser is incarcerated or employed by the agency plus 5 years. Review of SVOP policies, complete interviews with internal and external investigators, and record reviews confirmed compliance with standard 115.27.

Standard 115.272 Evidentiary standard for administrative investigations

□ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

□ Does Not Meet Standard (requires corrective action)

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.

Review of Delaware PREA Policy #8.60 imposes a standard of preponderance of the evidence for determining whether or not allegations of sexual abuse or sexual harassment are substantiated. Interviews with specially trained investigators confirmed compliance with this PREA standard.

The auditor reviewed training log sign-in sheets for specialized training for Investigations/PREA, and training modules and lesson plans. Documentation confirmed all investigators received the specialized training for Investigations/PREA. The auditor interviewed two (2) Investigators from SVOP. SVOP investigators confirmed specialized training and were able to inform the auditor about the internal investigation process and preponderance of evidence to pursue administrative investigations.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of The Delaware PREA Policy #8.60 requires that all residents who make allegations of sexual abuse shall be informed as to whether the investigative finding was substantiated (sent to prosecution/sustained) or unsubstantiated (administratively closed/not sustained) or unfounded. Additionally, the resident victim shall be notified following the suspect assailant indictment or conviction on the related charge. Interviews with two (2) SVOP investigators confirmed that a resident who makes an allegation of being a victim of sexual abuse is informed verbally or in writing as to whether or not the allegation was determined to be substantiated or unsubstantiated or unfounded following an investigation. The auditor reviewed documentation and over the past twelve months there were ten (10) administrative investigations completed with notification sent to four (4) residents advising them that their allegations were unfounded and six (6) was found guilty of filing false PREA report. Two (2) alleged victims of sexual abuse were investigated by Delaware State Police during the last 12 months. Both alleged victims were notified of the outcomes from the investigations. Review of the Notification of Investigation Status signed by the residents confirmed the notification required by policy. The auditor's review of the two (2) victim resident files indicated the victim residents were being notified and updated on the investigation of their cases.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of Delaware PREA Policy #8.60 states that staff "shall be subject to disciplinary sanctions up to and including termination for substantiated cases of sexual abuse". Delaware DOC Policy 9.12 ensures employees are held accountable for their actions, and just cause is established for taking disciplinary actions; the appropriate penalty is imposed for behavior, and disciplinary actions are applied consistently department-wide.

The auditor's interview with the PREA Manager confirmed the facility follow-up on all allegations made on employee sexual abuse and sexual harassment. Interview with one resident (1) revealed that the resident made a PREA complaint regarding a security staff strip search. Review of the resident's record indicated follow-up with the investigation, separation of the alleged victim and perpetrator, monitoring for retaliation, a medical exam and mental health referral. According to the report reviewed and the interview with the PREA Manager, the case was investigated and found to be unsubstantiated.

In the past 12 months, there has been zero (0) staff from the SVOP that have violated agency sexual abuse or sexual harassment policies, have been disciplined, short of terminated or been terminated based on interviews with management.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of Delaware DOC PREA Policy #8.60 requires any contractor or volunteer who engages in sexual abuse be prohibited from contact with the resident and shall be reported to Delaware State Police for possible prosecution unless the activity was clearly not criminal. Delaware DOC PREA Policy #8.68 states contractors, vendors, and volunteers are forbidden from any activity associated with or promote acts of sexual conduct, including sexual harassment between them and residents.

The auditor reviewed a written list of all volunteers and contractors receiving PREA training. The auditor interviewed one (1) volunteer and (4) contractor categories (medical, mental health staff, teachers) and found all were trained in the zero tolerance policy. A review of contracts and the volunteers training list confirmed that all contractor and volunteers have been PREA trained. All contractor and volunteers were required to sign that they have received and understand Delaware DOC PREA Policy #8.68 stating contractors, vendors, and volunteers are forbidden from any activity that associates with or promotes acts of sexual conduct, including sexual harassment between them and residents.

According to PREA-State-wide Coordinator and review of Pre-Audit Questionnaire, in the past 12 months, there has been no contractor or volunteer terminated because of sexual misconduct with a resident. Review of documentations, interviews with staff, investigators and residents confirmed this standard is a priority and enforced.

Standard 115.278 Disciplinary sanctions for residents

□ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

□ Does Not Meet Standard (requires corrective action)

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.

Review of Delaware DOC PREA Policy 8.60, Grievance #4.4, and Exceptional Incident Reporting #8.8 requires residents be subject to disciplinary sanctions following an administrative finding that the resident engaged in offender-on-offender sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse. For the purpose of the disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The sanctions shall be 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. The disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The auditor interviewed ten (10) residents and all confirmed no disciplinary action for reporting any sexual abuse or harassment incidents. Interviews with PREA Coordinator and two (2) investigators confirmed no residents were disciplined for sexual abuse or sexual harassment in the past twelve (12) months. The auditor reviewed disciplinary logs of all residents and there were no disciplinary actions as a result of any report of sexual abuse or sexual harassment.

Review of documentations, interviews with staff, investigators and residents confirmed this standard is a priority and is enforced.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of Delaware DOC PREA Policy #8.60 states "victims of sexual abuse shall 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 and consistent with BCHS Policy B-05". If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to #8.60 and shall immediately notify the appropriate medical and mental health practitioners. Victims of sexual abuse are transported under appropriate security provisions to an outside emergency care facility capable of conducting sexual assault exams for treatment and gathering of evidence. Upon return from the outside emergency care facility the site Medical Director or designee immediately review the treatment recommendations for indicated treatment and testing and will offer the victim access to the outside agency advocate. The evaluation and treatment of such victims shall include, as appropriate, follow up services, treatment plans and when necessary, referrals for continued care following their transfers to, or placement in, other facilities or their release from custody.

The auditor reviewed SART training modules and lesson plans for health care providers and confirmed through examining sign-in documents that all health care providers are SART trained. Review of two (2) residents' records that alleged sexual abuse demonstrated that residents immediately received medical examinations and mental health referrals. The review of two (2) residents' intake screening records who reported sexual abuse at another facility showed that both residents received medical and mental health attention.

Interviews with two (2) medical staff and one (1) mental health staff indicated each staff members understanding of the PREA policy and procedures of providing immediate access to medical and mental health services. Medical staff was able to effectively communicate the procedures for any resident alleged to have been sexually abused. The medical staff was able to outline the process of how each resident is to be examined, treated and routinely be referred to mental health. This standard is considered a priority by SVOP and was confirmed during the audit process.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Review of Delaware DOC PREA Policy #8.6, and Policy # B-05, states and addresses ongoing care and follow-up. The policy describes the process for victims of sexual abuse being transported under appropriate security provisions to an outside emergency care facility capable of conducting sexual assault exams for treatment and gathering of evidence. Upon return from the outside emergency care facility the site Medical Director or designee immediately review the treatment recommendations for indicated treatment and testing and will offer the victim access to the outside agency advocate. The evaluation and treatment of such victims shall include, as appropriate, follow up services, treatment plans and when necessary, referrals for continued care following their transfers to, or placement in, other facilities or their release from custody.

A review of the Department's Policy Manual and additional forms included; PREA response checklist, residents guide to sexual misconduct, zero tolerance acknowledgment, progress notes- treatment follow up, treatment plans, referrals, and medical and mental health evaluation of abusers healthcare.

Interviews with two (2) medical staff and one (1) mental health indicated that each interviewee is knowledgeable in PREA policy and procedures of providing ongoing medical and mental health services to victims or abusers of sexual abuse. Medical and Mental Health staff interviewed confirmed their commitment and dedication to appropriate and personalized total health care and mental health treatment to the residents. Interviews with ten (10) residents revealed that they are well informed of the health care and mental health resources available to victims or abusers of sexual abuse. The residents were able to fluently discuss access to medical and mental health care and support for victims of sexual abuse.

The auditor observed brochures and handout materials being provided at intake; in addition, to other information in the resident's orientation documentation advising the resident population of the offerings by the medical and mental health departments concerning evaluation, treatment and ongoing medical and mental health care, as appropriate for the sexual abuse treatment of victims and abusers.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The Delaware Adult Correction Healthcare Review Committee, seven members were appointed by the Governor and confirmed by the Senate. According to Department's Policy #8.50, the committee meets quarterly and reviews Delaware's DOC critical incident review reports. The auditor reviewed the Delaware DOC annual report on its website and confirmed the department collections of critical incident reports on every facility under the DOC.

Review of Delaware DOC PREA Policy #8.60 requires the Department to conduct a sexual abuse Critical Incident Review (CIR) at the conclusion of every sexual abuse investigation. This review is prepared on substantiated, unsubstantiated, and unfounded cases and is initiated within 30 days of completion of the investigation, absent exigent circumstances.

The SVOP Critical Incident Review team includes the Warden or Deputy Warden, State-wide PREA Compliance Coordinator, facility PREA Manager, investigator, and medical/mental health. The SVOP, in the past 12 months, has reviewed five (5) administrative investigations of alleged sexual abuse or criminal investigations of alleged sexual abuse, excluding unfounded incidents with 4 receiving a Critical Incident Review within the 30 days. During the last twelve months, one administrative investigation of alleged sexual abuse was completed at the facility. The investigation was followed by a sexual abuse incident review; however, the allegation was not processed within 30 days due to exigent circumstances. The Department is responsible for reviewing the aggregate data in order to assess and improve the effectiveness of its sexual response plan and its policy. The auditor reviewed aggregated critical incident data and monthly critical incident data for January 2017.

Review of notification of Review Team meeting and documentation of sexual assault/abuse incident reviews reveals that SVOP is completing sexual abuse incidents; reviewing them, and evaluate methods to prevent reoccurrences. Interviews with Deputy Warden, State-wide PREA Compliance Coordinator, facility PREA Manager, and two (2) investigators confirmed the Review Team meets on a regular basis to review critical incidents and examine ways to prevent reoccurrences.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Delaware PREA Policy #8.60 requires SVOP to collect accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions. This data is automatically generated in the Delaware Automated Correctional System (DACS) upon completion of PREA Incident Reports from DACS the Department is able to obtain aggregated data as needed and provides this information yearly to the United States Department of Justice. The auditor reviewed the Delaware DOC annual report on its website and confirmed the departments' collections of critical incident reports on every facility under the DOC.

PREA standard 115.87 requires that SVOP ensures that contract facilities investigate on any sexual abuse allegation. The auditor's reviewed document that specified no (zero) reported allegations of sexual abuse or no (zero) investigations of sexual abuse at New Expectations.

The auditor reviewed aggregated critical incident data and monthly critical incident data for January 2017. Review of notification of Review Team meeting and documentation of sexual assault/abuse incident reviews reveals that SVOP is completing sexual abuse incidents; reviewing them, and looking at methods to prevent reoccurrences. Interviews with Deputy Warden, State-wide PREA Compliance Coordinator, facility PREA Manager, and two (2) investigators confirmed the Review Team meets to review critical incidents and examine ways to prevent reoccurrences. Interview with PREA Coordinator confirmed the Department's commitment to collecting data, aggregating data, analyzing data and trending data for the purpose of preventing reoccurrences and improving performance.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The agency PREA Policy #8.6 requires the Department to review the aggregated data in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies and training. The report includes a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse. The report is approved by the Commissioner of Correction and is available on the Department's website annually. The 2015 PREA Annual Report contained data comparisons from the previous year. The auditor visited the department's website and reviewed the Annual Reports**.** Review of documents shows that reported incidents are reviewed for identifying problem areas, corrective action, and prevention. The documents reviewed show that SVOP meets the requirements for the Department to be in compliance with this standard.

Review of Delaware DOC PREA Policy #8.60 requires the Department to conduct a sexual abuse Critical Incident Review (CIR) at the conclusion of every sexual abuse investigation. This review is prepared on substantiated, unsubstantiated, and unfounded cases and is initiated within 30 days of completion of the investigation, absent exigent circumstances.

Review of notification of Review Team meeting and documentation of sexual assault/abuse incident review reveal that SVOP is completing sexual abuse incidents; reviewing them, and looking at methods to prevent reoccurrences. Interviews with Deputy Warden, State-wide PREA Compliance Coordinator, facility PREA Manager, and two (2) investigators confirmed the Review Team meets frequently to review critical incidents and examine ways to prevent reoccurrences. The auditors' interview with the PREA Coordinator confirmed the Department's commitment to review data for corrective action.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The agency PREA Policy #8.60, Management Information System #6.5, Evaluation and Performance Measuring #6.8, Operations and Program Audit #8.7 and Exceptional Incident Reporting #8.8 ensures that the incident based information and aggregate data is collected and securely retained for at least ten years after date of initial collection unless Federal, State or local law requires otherwise, considered confidential information and is maintained by the Bureau of Management Services, Information Technology Unit. The Department makes available to the public its annual report on PREA on the agency's website. The 2015 report was reviewed by the auditor. The policy on records retention schedule and the report on records management were also reviewed. Interview with the PREA Coordinator confirmed the Department's data storage is secured in electronic records and that the publication of annual reports approved by the DOC Director and is available on the website and destruction follows PREA standards. The auditor's review of data collection on the agency's website did not reveal any personal identification information.

AUDITOR CERTIFICATION

I certify that:

☒ 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, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Demetrius Henderson.______________________________ August 16, 2017_______________

Auditor Signature Date