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

COMMUNITY CONFINEMENT FACILITIES

Date of report: August 17, 2017.

Auditor Information			
Auditor name: Demetrius Henderson			
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Telephone number: 803-565-9742			
Date of facility visit: June 14, 2017, June 15 2017, June 16, 2017			
Facility Information			
Facility name: Sussex Community Corrections Center, Sussex Work Release			
Facility physical address: 2307 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: 200			
Current population of facility: 148			
Facility security levels/inmate custody levels: Level 4 Quasi Incarceration			
Age range of the population: 19-53			
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, Sussex Work Release Community Confinement Facilities Summary Report initially started May 2017, with the notice that the Delaware Department of Corrections through the American Correctional Association (ACA) had scheduled a PREA Audit with a tour date of June 14-16, 2017. PREA Certified Auditor Demetrius Henderson was notified by ACA 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 started with contact from Mike Records, Agency-Wide PREA Coordinator (PC), 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; daily facility count and identified the daily population for the 1st, 10th, and 20th day of the month for the past twelve months; check list files for each standard including copies of compliance documents; 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 Facilites. In addition, the PREA Compliance Manager (PCM), and the PREA Agency-Wide Compliance Coordinator (PC) provided the Auditors with cross reference Department/Agency polices/procedures as it relates to PREA Standards in advance of the site visit. 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 Work Release. The auditor began to review the Pre-Audit Questionnaire and the material sent prior to the audit visit. Each item on the thumb drive was reviewed. The information from the standard file 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 to identify additional information that might be required.

The Auditors stayed in Seaford, Delaware and were transported daily by an assigned staff member of the facility. The Sussex Work Release on-site visit began at noon on Wednesday, June 14, 2017. The Auditors, PREA Compliance Manager and PREA Statewide Coordinator, and Sussex Work Release Management Staff started with an orientation and discussed the intent of the audit, agenda for the on-site visit. A review of Sussex Work Release facility followed immediately after the orientation meeting. Utilizing the PREA Compliance Audit Instrument for PREA Audit Tour the on-site review included observation of the intake/reception/screening area, all housing units, including samples of individual rooms, health care and mental health area, recreation, cafeteria, and work and program areas. The auditors observed the areas in housing, programs, medical, security staff and residents and checked for "blind-spots" in all levels of custody. The Sussex Work Release has a total of 42 operational cameras to eliminate blinds spots. After reviewing the facility; 11 random residents from each housing unit were selected to be interviewed by the auditors. The selection of residents was from a list generated June 14, 2017. 11 of 148 (13%) residents interviewed were conducted in the probation and parole office area.

Utilizing the PREA Compliance Audit Instrument – Interview Guide for Specialized Staff interviews were set up to interview specialized staff. Specialized staff members include Facility Director, Warden, (4) PREA investigators; three (3) first responders; two (2) mental health staff; two (2) medical staff ; two (2) Intake staff ; one (1) volunteer; one (1) third shift security staff; and the Deputy Warden. In addition, Five (5) randomly selected security staff members were interviewed. The security staff members interviewed represented all working shifts. There are three work shifts for security staff including; 8:00 a.m. to 4:00 p.m.; 4:00 p.m. to Midnight; Midnight to 8:00 a.m.

The PREA auditors' interviews continued Thursday and Friday. Interviews, document reviews, and observations included observing physical layout, meeting directly with each of the selected residents, specialized staff and random staff, reviewing materials, documents, and resident and staff files. This process re-emphasized to the auditors, Sussex Work Release commitment to PREA. During this process the auditors reviewed the 39 PREA Standards and the Pre-Audit Questionnaire with the facility PREA Compliant Manager. The PREA Complaint Manager provided

documents to complete with the following PREA Audit tools: Auditor Compliance Tool and PREA Compliance Audit Instrument Checklist of Policies/Procedures.

A final review of the PREA Audit: Pre-Audit Questionnaire and the PREA Compliance Audit Instrument Checklist of Policies/Procedures and other Documents confirmed Sussex Work Release provided the necessary access to documentation for the auditors to confirm that all 39 PREA Community Confinement Facilities Standards were met by the facility. The site visit raised no issues of PREA noncompliance.

On the final day of the on-site audit, June 16, 2017, an exit debriefing was held with the facility's leadership staff. The Lead Auditor summarized the auditors' preliminary audit findings. During this process, specific feedback was provided including strengths and areas of improvement as it relates to PREA standards. The auditors were impressed with SWR's commitment to the PREA audit process.

DESCRIPTION OF FACILITY CHARACTERISTICS

The mission of the Delaware Department of Corrections is "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 Sussex Work Release Unit falls under the jurisdiction of The Delaware Department of Corrections (DDOC). The Sussex Work Release Unit is one component of the Sussex Community Corrections Center located at 23207 Dupont Boulevard in Georgetown, Delaware.

The Sussex Work Release Unit is a 248 bed community-based confinement facility located in Georgetown, Delaware. The Sussex Work Release Unit is classified as Level IV (4), house arrest in a community custody program. Sussex Work Release Unit accommodates male and female residents.

The Sussex Work Release Unit (SWR) is considered a transition program that opened in 1989 for residents preparing to live in the community full-time. Residents seek employment, attend outside medical appointments and participate in mandated treatment programs. Residents return to the facility at night to sleep. A resident can be ordered by a court to participate in work release or can be classified to the program by the Department of Corrections. Some residents come to work release after a prison stay and some come directly from the community. Residents normally stay in work release less than one year with the average stay of 46 days for sentenced residents and 34 days for detention residents.

While employed full-time, residents must pay $25.00 a week for room and board and an equal amount for any court obligations that have been imposed. Residents who work part-time pay $15.00 a week and an equal amount for any court obligations.

The SWR is in a two story building housing residents in four tiers on the same grounds as Sussex Violation of Population Unit. The SWR does not have any security fences around the buildings and consist of one main building that contains the Administrative offices, security, program staff, laundry, kitchen and dining area. There are two program buildings used for sex offender treatment and substance abuse treatment. One is a chapel which is also used for groups. The facility is surrounded by 14 ft. chain link fence around the living area.

Population on the first day of the audit was 148 residents, 30 of the 148 were females. During the last calendar year the SWR's population has routinely been under the design capacity with an average population of 145. This facility has 84 authorized positions and during the time of the audit there were 78 filled (93%) and six (6) vacant (7%) positions. The facility has 59 (86.8%) male and 9 (13.2%) female security staff. Each of the three shifts has 9 security staff on duty.

SUMMARY OF AUDIT FINDINGS

Click here to enter text.

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.

Policy:

Review of cross reference department/agency policy/procedures of Delaware Department of Corrections established a Department Prison Rape Elimination Act (PREA) Policy #8.60 to ensure compliance with PREA Standards. SWR 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 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. Sussex Community Corrections Center (SCCC) Policy 10.30 says the agency shall designate a PREA Compliance Manager to oversee agency efforts to comply with PREA standards. One staff member shall be assigned as the facility PREA Compliance Manager with overall responsibility of 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 organizational charts it was noted that he has direct access to the Warden.

Observation:

The auditors received a comprehensive outline of this Zero Tolerance Policy which mandates 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 beginning with 1) administration and designation of staff, 2) resident management and services, 3) resident screening and assessment, 4) reporting allegations, 5) investigation, 6) training and education and 7) data collection. Review of Orientation Manual for all new DOC Staff, Volunteers, Contractual and Temporary Staff with specific PREA information and requirements and sign-in training logs was reviewed by the auditor.

PREA posters in both English and Spanish are displayed throughout the facility and are visible to all staff, residents and visitors. The Zero Tolerance Policy is posted in the housing units and the subject is a major part of training to new staff, existing staff and residents on a regular basis as evidenced by reporting from each staff interviewed. The auditor received a list of state facility PREA Managers names, including the PREA Manager from Sussex Work Release. Review of organizational charts showed that the PREA State-wide Coordinator reports directly to the commissioner of corrections and the PREA Manager reports directly to the Facility Director.

Interview:

Interviews with specialized and randomly selected staff confirmed staff knowledge and training in PREA zero tolerance of sexual abuse. The auditors' interviewed eleven (11) residents. Each of the 11 residents was able to identify the PREA Manager and responsibilities of the manager. The interviews with both residents and staff further revealed a comprehensive PREA training program, including zero tolerance training which is provided to all residents and staff. Of particular note was the comfort level in which both residents and staff shared their knowledge of the zero tolerance of sexual abuse and sexual harassment policy and procedures when interviewed.

by the auditor.

Interview with the Assistant Warden, PREA State-wide Coordinator and PREA Facility Manager confirmed the PREA Coordinator's primary work responsibility is PREA activities. The PREA State-wide Coordinator and PREA Facility Manager reported sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards. The auditor reviewed the organizational chart that showed the PREA State-wide Coordinator reporting to the State Commissioner. The Assistant Warden stated the PREA Manager is only responsible for implementing and meeting the PREA standards and that he reports to the Warden. The organizational chart confirmed the reporting guideline.

Summary:
The Prison Rape Elimination Act Policy is an essential component to the operations at SWR. Through discussions with staff and residents, observation of bulletin boards, posters, handouts and materials, review of resident and staff handbooks, and personnel policies, organizational charts, it is clear that SWR 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.

Policy:
Review of cross reference department/agency/policy/procedures to Delaware Department of Corrections Policy #3.5: Contractual Programs and Services stated "any contract entered into by the Department shall require such private or public agencies to be compliant with the Prison Rape Elimination ACT (PREA) standards. The Delaware Department of Corrections Policy #8.60: Prison Rape Elimination ACT stated "it is the policy of the Department of Corrections that all employees, contractor, volunteers and interns are responsible for the prevention, detection and reporting of prison rape and sexual activity". "Anyone who fails to report resident on resident sexual abuse or staff sexual abuse of any kind is subject to discipline, up to and including termination.

Observation:
The auditor reviewed a contract addendum between the Department and New Expectations and Connections Community Support Programs. New Expectations and Connections contract with the Department to provide an alternative to incarnation for pregnant women. The auditor reviewed the PREA language in the contract requiring contractors to adhere to the PREA Zero Tolerance standards, reporting any PREA incidents and employees participating in PREA training standards.

The auditor reviewed New Expectations PREA audit from 2015; and the audit performed by certified PREA Auditor, Robert Lanier showed New Expectations met all 41 PREA standards.

Interview:
The interview with Michael Records, Statewide PREA Coordinator revealed the Delaware Department of

Corrections (DOC) provides funding to New Expectations program via a grant project. New Expectations was PREA accredited through a USDOJ PREA audit in November, 2015. For the purpose of Standard 115.212, on May 19, 2017, Michael Records, Statewide PREA Coordinator conducted a review using the PREA Auditor Compliance Tool for Community Confinement Centers as a guide. The auditor reviewed the report while interviewing the Statewide PREA Coordinator. The Statewide PREA Coordinator was able to provide his audit results that ensured the contractor is complying with PREA standards. The report showed zero findings and demonstrated the contractor is in compliance with PREA standards

Summary:
Review of contract language, previous prea audit of the contractor housing residents, the PREA Coordinator's audit of the contractor and interview with PREA State-wide Coordinator demonstrated 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)

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Policy:
Review of cross reference department/agency/policy/procedures of Delaware DOC Staffing Policy #1.4; SCCC Policy 8.28 and SCCC Policy 8.28.4 mandate that SWR provide sufficient staff to ensure efficient operations are consistent with its mission.

Observation:
The auditor reviewed compliance documents including DCOC Staffing #1.4, the 2017 Staffing Plan, the Facility Plot Plan with camera locations and found adequate levels of staffing is a priority and is monitored and updated annually. The auditor also reviewed documents which demonstrate that the facility plans to add additional cameras.

SWR facility design capacity is 200 residents. The operating capacity is 248 residents. SWR's population has routinely been under the design capacity for CY 2016 (133 average residents over 12 months). The security staff to resident ratio (operational design) is approximately 6.7.1. Video monitoring with 33 cameras assist staff in protecting resident against sexual abuse.

Interview:
Interviews with several staff and residents revealed they felt safe at SWR. Several residents said the facility was safe and residents in other facilities expressed desires to serve their time at SWR because of the safe environment. The staff and residents interviewed were aware of the locations of video monitoring in the facility to protect residents and staff from sexual abuse.

The interview with Assistant Warden confirmed that at least once every year the facility reviews the staffing plan to see whether adjustments are needed to ensure compliance with staffing plan. Staffing Plans were reviewed by

the auditors which confirmed that plans are being completed annually. The Warden's interview confirmed that resources are made available to ensure adequate staffing levels are maintained. To further endorse the staffing plan, the Warden specified that should there be a shortage of staffing at any given time period; the facility will pull staffing from Sussex Community Corrections facility to accommodate for any shortage.

Summary:
Review of policies, staffing plan, observation of cameras, control center monitoring residents, interviews with Warden, security staff and residents confirmed supervision and monitoring to ensure a safe environment is in place. Interviews with staff and residents confirmed they felt safe at SWR

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.

Policy:
Review of cross-reference department/agency/policy/procedures of Delaware DOC Policy #8.60, addresses cross gender searches Supervision of Offenders #8.75 Cross Gender Supervision of Resident and Training Lesson Plan addresses Contraband and Searches: The policies state when the security 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.

Observation:
In viewing the facility housing units, the auditor observed that showers and restrooms provided privacy for residents.

Policy, procedures, and training governing cross gender viewing and searches were reviewed. The policy does not allow cross gender strip and cross gender visual body cavity searches of residents, unless in exigent circumstances. SWR has female residents and if a female officer is not available then a female officer will be requested from the Sussex Correctional Institution a prison located adjacent to SWR. Interviews of residents, staff and documentation review confirmed there were no cross-gender pat searches being conducted.

Interview:
Interview with Shift Commander revealed since SWR has female residents and if a female officer is not available then a female officer will be requested (pulled) from the Sussex Correctional Institution a prison located adjacent to SWR. SWR does this to ensure no cross gender searches or pat downs are performed. Interviews with several staff members revealed that no cross gender searches occur, opposite genders officers announce their presence when entering housing units and residents have privacy in restrooms and showers.

It was confirmed by interviews that residents can perform bodily functions, change clothing and shower without a staff of the opposite gender completely viewing them. Several residents were able to communicate a confident sense of privacy and informed the auditor that anytime the opposite gender is approaching the unit he/she announces his/her presence before stepping on the unit. Several residents interviewed state at no time is the opposite gender viewing or performing searches or pat downs.

Summary:
Review of policy, interviews with staff, residents and observation while reviewing the facility confirmed SWR meets PREA standard 115.216.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware DOC Policy #8.60 provides disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment and provide residents with limited English proficiency equal opportunity.

Observation:
During the on-site review, the auditors observed PREA documents printed in Spanish. Intake/booking security staff also displayed these documents in Braille and Spanish. Documentation reviews did not indicate any disabled or limited English speaking residents. The auditor did not witness any disabled or limited English speaking residents. The PREA pre-audit questionnaire showed zero limited English or disabled residents in the past 12 months.

The auditor reviewed the state contract for interpreter's services. The auditor reviewed the state contract for interpreter's services which confirmed the equal opportunity for residents with disabilities to have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. SWR policy does not allow resident interpreters, resident readers, or other types of resident assistants.

Interview:
Several security staff members reported in their interviews that in the past 12 months, there has been zero (0) use of resident interpreters, readers or other types of resident assistants.

Summary:
In the past 12 months, there has been zero (0) use of resident interpreters, readers or other types of resident assistants. Review of documentation, interviews with staff and residents, and observations, PREA documents in Spanish and brail resident's manual confirm that disabled or limited English residents are provided 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.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware DOC #8.60 requires criminal background checks during promotions and hiring of employees. SWR policy also requires criminal background record check on employees every five (5) years and contractors every two (2) years. The policy states the Department does not hire or promote anyone who had sexual contact with residents and does not enlist the services of any contractor who may have had sexual contact with residents, who has engaged in sexual abuse in any institution, been convicted of engaging or attempting to engage in sexual abuse in the community or has been civilly or administratively adjudicated of engaging or attempting engage in sexual abuse in the community. Material omissions regarding such misconduct or the provision of materially false information are grounds for termination. It was evident that SWR policy and PREA law were being followed concerning hiring, promotional decisions, and background checks.

Observation:
The PREA Audit: Pre-Audit Questionnaire showed there were no new hires within the past 12 months.
The interview with the PREA Manager also confirmed that background checks are required prior to promotions and hiring of employees. The auditor did review emailed documents looking into the background and inquiring about any sexual misconduct of a contracting health care employee.

Interview:
The interview revealed that before the hiring of any new employee who has contact with inmates, a criminal background check is completed. Review of three (3) security staff records substantiate staff background checks before being hired. Security staff members were able to discuss the SWR's hiring process. Each security staff interviewed reported that prior to being hired they were required to complete information on a questionnaire about any previous sexual misconduct in writing on an employment application and/or interviews for hiring or promotion.

Summary:
Review of polices, employees background checks confirmed SVR's Policy on hiring and promotion decisions. In conjunction, each staff members interviewed was able to provide informed insight into SVR's hiring practices. It is evident that this standard is followed and is a priority.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of DOC policy #8.60 states that when purchasing and deploying the new video monitoring equipment the Department considers what impacts these upgrades and purchases would have on its ability to protect residents from sexual abuse.

Observation:
There is a written contract with the Division of Facilities Management (state department) that any new construction or a substantial expansion or modification of existing facilities, the contractor will consider the effect of the design upon the agency's ability to protect residents from sexual abuse and when installing or updating video monitoring system, electronic surveillance system or other monitoring technology, the contractor will consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

The auditor reviewed documentation stating no new video monitoring was installed during this PREA cycle. SWR has 42 cameras to eliminate blind spots throughout the facility. The auditor observed cameras in the facility. Purchase orders in 2015 showed the installment of 5 new cameras at SWR. The facility added nine (9) additional cameras since the previous PREA audit. The auditor was informed and confirmed in the video control room that all video monitors were in working condition.

During the on-site review of the facility, the auditor observed no cameras directly interfering with residents' ability to shower, dress, or perform bodily functions with some privacy.

Interview:
Interview with one Critical Incident Review Team revealed the team assesses the need for new video monitoring after each substantiated and unsubstantiated PREA investigation. Interview with the Warden specified that any new upgrades and technologies must consider how such technology may enhance the facility's ability to protect residents from sexual abuse.

Summary:
Documentation, the interview with the Warden, and observation of the cameras in the facility confirm the facility uses technology to eliminate blinds spots and protect residents from sexual abuse. The facility annually assesses the need to increase technology to enhance the protection of residents from sexual abuse. SWR meets PREA standard 115.221.

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.

Policy:
Review of cross-reference agency/department/policy/procedures DOC Policy #8.60 and Sussex Community Corrections #8.60 require 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.

Observation:
Emergency medical healthcare along with forensic examinations by SANE/SAFE staff are procured from BDE Health Care in Lewis, Delaware where SANE/SAFE staff are available 24/7.

Review of PREA pre audit questionnaire showed zero (0) residents receiving showed forensic medical examination by SANE/SAFE staff BDE Health Care.

During the on-site review posters promoting victim advocates services number was observed.

The auditor reviewed a contract with New Expectations (victim support organization) for victim advocate support services.

Interview:
The Support Auditor interviewed a SANE nurse who confirmed that the facility offers victims of sexual abuse or any resident who experienced past sexual abuse have access to forensic medical examinations whether on-site or at an outside facility without financial cost. The SANE nurse was able to identify the procedure for documenting efforts when a sexual assault occurs. The SANE nurse confirmed the policy was being followed. The SANE/SAFE nurse reported that they follow National guideline and strategies when responding to sexual assaults.

The auditor interviewed an investigator who was able to communicate that SWR has a Sexual Assault Response Team (SART) that follows the Delaware department of corrections guidelines. The investigator was able to communicate guidelines such as communications to supervisor and shift commander; ensure the safety of victims; ensure victim-resident is taken out for SANE; immediately secure the scene and preserve physical evidence. The investigator confirmed during the interview that zero (0) residents in the past twelve (12) months received a SANE/SAFE examination.

Summary:
Based on the files/documentation provided to the auditor, interviews with staff and residents, and observations, SWR has developed and implemented the necessary policies and procedures to meet this PREA standard.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware PREA Policy #8.60 ensures administrative investigations of sexual abuse, and/or sexual harassment of a resident, considered an emergency incident, and 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. When allegations are referred for criminal investigation by the Delaware State Police, the Department will ensure that the cases are referred promptly and that a designated staff reprehensive follows the case until it is determined to be substantiated, unsubstantiated, or unfounded. Agency policies and the facility procedure comply with PREA requirements relating to allegations and the investigation of such.

Observation:
The agency does make public on its website alleged referrals of sexual abuse or sexual harassment.
The auditor reviewed updated policy from Delaware State Police (DSP) confirming the State Police may investigate sexual allegations upon request by the facility. Any sexual allegations must be referred to DSP. The PREA Pre-Audit Questionnaire showed one (1) allegation in the past twelve (12) months and this allegation was referred for administrative investigation.

Interview:
Interview with DSP Supervisor revealed the relationship between the two agencies. The DSP Supervisor was able to provide specific detail on the way DSP completes criminal investigations on sexual abuse allegations when initiated by the request from the facility.

Summary:
Agency policies and the facility procedure comply with PREA requirements relating to allegations and the investigation of such. 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 documentation of alleged offenses and follow-ups, interviews with staff and residents confirm PREA standard 115.222 is met at SWR.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware's PREA Policy #8.60 addresses PREA training requirements. The auditor reviewed a list of staff names that participated in PREA training.

Observation:
A copy of the Orientation Manual for all new DOC Staff, Volunteers, and Contractual Staff was provided to the auditor for review. A copy of medical staff training was also reviewed.

The Employee training covers information and notices detailing Zero Tolerance Policy for sexual assault/abuse, red flags suicide prevention and response techniques which all emphasize and support the training efforts for SWR correctional staff. Review of the training module and lesson plan demonstrates that training is tailored to the sex of the resident at the facility where the staff is assigned. Specialized training is provided for investigated staff; first responders; medical and mental health care who all conveyed they completed PREA training.

The auditor reviewed a list of names on sign-in logs attending PREA training. Eight-one (81) total staff was trained over the past twelve (12) months based on the training logs provided by the facility.

Interview:
Several security staff members interviewed were knowledgeable about the Zero Tolerance Policy for sexual abuse and sexual harassment. Each staff interviewed was clear on how to perform their responsibilities in detection, reporting and responding. Interviewed staff was able to provide detailed information regarding 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.

Interview with two (2) Medical and one (1) Mental Health staff all conveyed they completed PREA training. Each staff member reported that refresher PREA training is provided annually. The auditor reviewed the training modules and PREA training logs to confirm the training of staff. The medical staff was able to discuss the rights of residents and staff to be free from sexual abuse and harassment and identify the process for reporting. The medical staff identified the responsibility of being a mandatory reporter. The mental health staff was also able to speak specifically to the rights of residents and staff to be free from retaliation for reporting sexual abuse and sexual harassment. The mental health staff also acknowledged the responsible of being a mandatory reporter.

Summary:
The auditor's review of the list of staff participating in PREA training and review of curriculum substantiates SWR meets PREA standard 115.232.

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.

Policy:
Review of agency/department/policy/procedures of Delaware Policy #8.60 requires all 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.

Observation:
The auditor reviewed a list of staff participating in PREA training and a review of curriculum substantiates volunteer and contractor training. Eleven (11) out of Eleven (11) volunteers and contractors were trained in PREA over the past twelve (12) months.

Interview:
The auditor interviewed individuals one (1) volunteer and three (5) contractors (teachers, medical and mental health staff). The volunteer interviewed was able to identify responsibilities under the agency's sexual abuse and sexual harassment prevention, detection policy and procedures. Each contractor interviewed was well versed in acknowledging the zero-tolerance policy regarding sexual abuse and sexual harassment and the reporting steps should incidents occur. The mental health staff was able to provide insight in to reporting responsibilities. Each interviewee was able to discuss their training responsibilities and requirement of the zero tolerance policy. Medical staff reported they were also been trained to respond to sexual assaults and are first responders. Medical, mental health and volunteers reported they have been trained to report any allegations of sexual assaults or harassments. Medical and Mental Health staff members advised that they are mandatory reporters.

Summary:
The auditor's review of a list volunteers and contractors participating in PREA training and a review of training curriculum substantiates SWR meets PREA standard 115.233.

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.

Policy:
Review of agency/department/policy/procedures of Delaware DOC PREA policy #8.6 ensures that every resident receives a written copy of DOC's orientation material during assessment and reception both verbal and written 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 resident PREA hotline.

Observation:
An admission and Orientation was observed and the Resident's Orientation materials. The PREA Handbook for Residents were interviewed by the auditor. Documentation (sign-in sheets) of the residents attending the training was reviewed and is being maintained by the facility.

A review of the PREA pre-audit questionnaire showed that 529 residents were trained in PREA over the past twelve (12) months; 248 residents transferred from a different community confinement were trained in PREA over the past twelve (12) months; and the 248 residents transferred from a different community confinement received PREA refresher training over the past twelve (12) months.

PREA education is available in different formats to accommodate limited English, deaf, visually impaired and limited reading residents. Key information about the agency's PREA policy is continuously and readily available through posters, handouts, and other written formats. The policy reviewed by the auditor confirmed that residents are provided with the opportunity to take part in PREA education.

Interview:
Interviews with several residents revealed that residents receive training and information about the Zero Tolerance Policy and how to report instances of, or suspicions of abuse or harassment. Each resident interviewed was able to identify the process of reporting sexual abuse. The auditor was impressed that all residents interviewed could discuss PREA; how to access victim assistance; third party reporting sexual abuse on behalf of the resident, and the zero tolerance policy.

Summary:
Interviews, observation, the confirmation of residents receiving training at intake, handouts, and documentation of logs demonstrating video training during orientation confirmed the facility meets the PREA standard 115.234.

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.

Policy:
Review of cross-reference agency/department/polices/procedures of Delaware DOC policy #8.60 required specialize training to be provided for employees who may respond as part of their job duties to report incidents of sexual assault.

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 the event occurred. The Warden or

designee will make contact with Internal Affairs or Delaware State Police when required.

Observation:
A review of email documentation demonstrates that investigators are not allowed access to the DACS unless they have the proper PREA investigation training. A list of names and certificates was provided by the facility on staff members receiving specialized training and this was reviewed in detail by the auditor.

The auditor reviewed the facility's 8-hour lesson plan: Specialized Investigations/PREA manual. The documentation noted that eight (8) out of eight (8) investigators received this training.

Interview:
Interview with SWR investigative staff 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. The SWR investigator was able to discuss that Garrity warnings applying to administrative investigations, while Miranda applies to criminal.

The auditor interviewed Delaware's State Police Supervisor and one (1) SWR Investigators who confirmed their investigation responsibilities to SWR and specialized training to complete criminal investigations on sexual assaults. The Delaware's State Police Supervisor was able to report the process of receiving referrals from the facility and the investigative process. The SWR Investigator was able to recite the process for investigating sex abuse cases such as collecting evidence, interviewing victims, perpetrators and witnesses before turning the evidenced over to the Warden for a decision to pursue administrative or criminal charges.

Summary:
The auditor's interview with Delaware's State Police and SWR Investigator confirmed their investigation responsibilities to SWR and focus on specialized training to complete criminal investigations on sexual assaults.

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.

Policy:
Review of cross-reference agency/department/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, preserve evidence of sexual abuse, respond to sexual assault victims and be fully knowledgeable of DOC procedures in regard to PREA.

Observation:
As confirmed by sign-in sheets; 100% of medical and mental health care practitioners have received the training as

required by policy. The facility maintains documentation (names and sign-in sheets) authenticating that medical and mental health practitioners have completed the required training. Based on documentation presented and then reviewed confirmed thirteen (13) out of thirteen (13) medical and mental health staff received specialized training over the past 12 months.

Interview:
Medical and mental health staff were able to identify their training in response to sexual assaults as first responders; reporting of any allegations of sexual assaults or harassments; preservation of evidence of sexual assault; and sign and symptoms of detecting sexual abuse. Medical and mental health staff members stated they are mandatory reporters of sexual abuse by their profession. The Medical staff was able to recite the process for reporting sexual abuse and showed knowledge in the policy. The mental health staff was able to recount the referral process for both victim and perpetrators and acknowledged their responsibility to provide treatment. During the interview process, medical and mental health care staff reported they completed PREA training modules on the computer and must score at least 80% on their post-test in order to pass the PREA training. Training of staff members was confirmed by a review of training logs.

Summary:
Observations, review of documentation and interviews with staff confirmed SWR is following policies and procedures and is in compliance with PREA standard 115.235.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware PREA Policy #8.60, show Medical Service Receiving Screening-Intake, Mental Health Screening, and Intra-System Transfer Screening inquiries about mental, physical, developmental disabilities; physical built; previous incarceration; criminal history nonviolent; prior convictions of sexual assault is or perceived to be LTBI or gender nonconforming; previous sexual victim; and own perception of vulnerability. The standard requires all residents to be screened during intake and upon transfer to another facility for their risk of being sexually abused or being sexually abusive toward other residents.

Observation:
The auditor observed screening using QUICK SCREEN assessment. This assessment occurs within 24 hours using the Department's Sexual Victimization/Abusiveness Quickscreen tool. Questions in the assessment addressed: mental, physical, developmental disabilities; physical disabilities; previous incarceration; criminal history-nonviolent; prior convictions of sexual assault; is or perceived to be LTBI or gender nonconforming; previous sexual abuse victim; and own perception of vulnerability. The screening assisted in the placement of housing for residents being booked into the facility.

Interview:
Interview with intake security staff revealed that a screening is completed on every resident coming through intake/booking and is used for housing and to prevent sexual abuse and sexual harassment. Intake staff reported that within 30 days (usually 21 days) the facility does a more detailed follow-up review to prevent sexual assaults and sexual harassment.

Interviews with several residents confirmed that they were queried about prior convictions of sexual assault; is or perceived to be LTBI or gender nonconforming; previous sexual victim; and own perception of their vulnerability of being incarcerated. Several residents reported follow-up PREA questions with 30 days of their stay at the facility. Eleven (11) residents were interviewed. Eleven (11) of the Eleven (11) residents interviewed reported that they felt safe in their environment and were aware of PREA and how to report PREA incidents. Each resident was able to recite the process for reporting PREA incidents.

Summary:
The intake process conforms to PREA standards. The screening/intake process was well managed and complete. SWR is in compliance with PREA standard 115.241.

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.

Policy:
Review of cross-reference agency/departments/policy/procedures of Delaware DOC PREA Policy #8.60 considers screenings to be confidential, only to be used by staff to assist in the placement and protection of residents from abuse. The policy requires the facility to 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.

Observation:
During the intake/booking process, the auditor observed screening information being collected as data on an assessment form. The information in the assessment was used to determine the placement of the resident's housing assignment.

The auditor reviewed files provided by SWR of residents who were screened for housing placements based on the screening results.

Interview:
Interviews with one (1) intake security staff, two (2) medical and (1) mental health staff revealed that information is being collected to consider for placement at the facility. Medical staff reported after the resident is screen a physical assessment is completed with 24-72 hours. Medical staff further confirmed that if there is any history or fears indicating a resident has been sexual abuse or sexually assaulted a referral is then generated to mental health.

The intake security staff informed the auditor that based on the screening information potential victims and perpetrators are separated by housing units. The mental health staff further acknowledged to the auditor that both victims, as well as perpetrators of sexual abuse are offered an assessment and treatment.

Summary:
Interviews with one (1) intake security staff, two (2) medical and (1) mental health staff supports interviews with residents. Observation and review of documentation also supports the use of the screening information as being used with appropriate custody and security. The facility is in compliance with standard 115.242.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware DOC PREA Plan Policy #8.60 demonstrate 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. PREA posters provide a telephone number to an outside advocate and third party reporting mechanism for residents to report sexual abuse.

Observation:
The auditor observed several posters displayed throughout the facility and by the telephones. Additionally, SWR residents receive resident orientation training and a handbook for residents that address sexual assault awareness, rape avoidance and information for residents who are sexually assaulted. This finding was evidenced by interviews with residents.

Information provided to residents on emergency grievances alleging substantial risk of imminent sexual abuse may be filed. This was evidenced by information provided in resident handbooks, posters displayed in the housing units and intake areas, postings on bulletin boards, informational handouts and through staff.

Interview:
Eleven (11) out of the eleven (11) residents interviewed were able to articulate different methods of reporting sexual assault and sexual harassment including: reporting to PREA hotline; writing or verbally reporting to PREA Manager, shift commander, security staff, and supervisors of security staff. Collectively, residents interviewed informed the auditor they felt comfortable reporting sexual abuse and sexual harassment incidents without fear of retaliation; each resident interviewed was also able to identify and articulate the process for third party reporting sexual abuse on behalf of the resident.

Interviews with several security staff members revealed them to be knowledgeable on reporting sexual abuse and sexual assault without fear of retaliation. Security staff informed the auditor that they felt comfortable reporting sexual abuse and sexual harassment incidents without fear of retaliation. Security staff was able to articulate with specifics the process of reporting sexual abuse and sexual harassment.

Summary:
Review of policies, procedures, interviews with residents and staff and the auditors' observations revealed that both residents and staff are knowledgeable on reporting procedures on sexual abuse and sexual harassment demonstrating they are well informed of their rights under PREA. The facility is in compliance with standard 115.251.

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.

Policy:
Review of cross-reference of agency/department/policy/procedure of Delaware Department Policy #8.60 addresses residents grievances regarding sexual abuse along with policy and procedures for filing emergency grievances alleging that a resident is subject to substantial risk of imminent sexual abuse. Emergency grievances including third party alleging substantial risk of imminent sexual abuse may be filed on behalf of a resident. After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance to a level of review at which immediate corrective action may be taken, shall provide an initial response with 48 hours and shall issue a final decision within five (5) calendar days.

Observation:
Review of the PREA Pre-Audit Questionnaire revealed there were zero (0) number of emergency grievances alleging substantial risk of imminent sexual abuse filed in the past twelve (12) months. Subsequently, zero (0) number of alleged sexual abuse incidents resulted in disciplinary actions for bad faith filing or any final decisions made by the facility as evidenced by a review of the PREA Pre-Audit.

Interview:
Several residents interviewed were able to communicate ways of reporting sexual abuse and sexual harassment through third party reporting including fellow residents reporting, staff members, family members, attorneys, and advocates.

Summary:

Third party reporting information is attainable in resident handbooks, posters, bulletin boards, information handouts, libraries and, of course, through staff. Review of policies, procedures, interviews with residents, staff and the auditors' interviews revealed that both staff and residents are knowledgeable in reporting procedures of sexual abuse and sexual harassment. Based on information provided during the interviews both staff and residents are well informed of their rights under PREA. In the past 12 months, zero (0) grievances were filed alleging sexual abuse as evidenced by the auditor's review of PREA Pre-Audit questionnaire. PREA standard 115.253 is met.

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.

Policy:
Review of cross-reference of agency/department/policies/procedures of Delaware PREA Policy #8.60 require the facility to provide 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. The policy requires SWR staff to inform a 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.

Observation:
Residents are given access to outside confidential support services information when they arrive at the facility and also are shown a PREA training video, and through posters shown in the facility; in addition, residents are provided a PREA handout when entering the facility.

The auditor observed PREA posters displayed visible throughout the facility. The PREA posters provided information on outside advocate and third party reporting mechanism for residents who are a victim of abuse. The posters displayed information that informed residents that numbers listed were not monitored and all interactions communicated were confidential.

The auditor reviewed a Memorandum of Understanding (MOU) or agreement, drafted between Delaware Department of Corrections and Connections Community Support Programs (CSP) to satisfy the 115.253 requirement of SWR's ability 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.

Review of MOU draft documentation confirms that residents have access to outside confidential support services.

Interview:
The auditors' interview with PREA Coordinator revealed the agency has an agreement with ContactLifeline. The PREA Coordinator reported that staff from ContactLifeline will be available by telephone to provide advocacy when requested by a resident-victim. The PREA Coordinator stated that ContactLifeline serves as a third-party agency for residents to report allegations of sexual abuse. The PREA Coordinator confirmed that any communications or concerns are reported directly to him from the victim or a third-party. During the interview, the PREA Coordinator further confirmed that another MOU was drafted to ensure that contractors would be present in the emergency room to assist victims of sexual assault.

Interviews with several residents showed they were knowledgeable about access to outside victim advocates for emotional support services. The residents were able to provide specific details when identifying the process to access services. Residents further advised that reminders regarding access to services are reinforced daily via informational posters displayed throughout the facility.

Summary:
The auditor's review of MOU draft documentation and current agreement with ContactLifeline confirmed that residents have access to outside confidential support services. The MOU draft document provided information identifying avenues to access outside confidential support services. Based on information from the PREA Coordinator a corrective action was established that resulted in MOU draft documentation with Connections Community Support Programs to ensure supported services if a resident-victim is transported to BDE Health Care for SANE/SAFE.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware PREA Policy #8.60 mandate that the facility provides a method to receive third-party reports of a resident's sexual abuse or sexual harassment made verbally, in writing, or anonymously and publicly distributes information on how to report resident sexual abuse/harassment on behalf of residents.

Observation:
The auditor reviewed posted advertisement with the Third-Party reporting information in the facility, reviewed developed curriculum used in mandatory PREA training, brochures, pamphlets, handouts and displays of PREA information on the agency's website.

Posters are displayed and visible throughout the facility promoting an outside advocate and third party mechanism for residents who are victims of abuse.

The facility provides posters that have the rape crisis organization toll-free hotline numbers for reporting sexual abuse and sexual harassment. The posters provided detailed information which informs residents that the number referenced is not monitored and all interactions communicated are confidential.

Interview:
Interviews with several residents revealed they were aware of how to facilitate third-partying reporting. The residents interviewed by the auditor were able to convey that third party reporting is confidential and were able to

advise the auditor of the toll-free number listed on the posters throughout the facilities.

Summary:
Based on the display of information posted throughout the facility, residents' interviewed and a thorough review of training curriculum for staff and residents it was found that SWR provides avenues to confidential access to third–party reporting of sexual abuse and sexual harassment incidents. Interviews of residents found that each resident interviewed was well informed and the facility is adhering to PREA standard 115.254.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware DOC PREA Policy #8.60 require all staff 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 residents or staff who reports incidents, and any staff neglect or violation of responsibilities that may contribute to an incident of retaliation. The policy prohibits staff from revealing any information related to sexual abuse reported to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Observation:
Review of the PREA Pre-Audit Questionnaire disclosed zero (0) reporting of sexual abuse or sexual harassment from staff and residents over the past twelve (12) months.

Delaware Internal Affairs (IA) maintained a log of all calls to the PREA hotline. A copy of this log is provided to the facility PREA Compliance Manager each month. The Call Log to the PREA hotline was presented by the facility and a review of the log sheet was completed by the auditor. The log showed zero (0) reporting of sexual abuse or sexual harassment from staff and residents over the past twelve (12) months.

The auditor reviewed the orientation process for new residents and signed forms of health care staff that confirmed the both staff and residents are aware of the reporting procedures. The review of documentation further revealed that staff is aware of the policy for staff reporting duties as required by the PREA and professional healthcare standards as evidenced by staff ability to illustrate the reporting process.

Interview:
The auditor's interview with the PREA State-wide Coordinator revealed that he is the identified person to receive third-party confidential reporting of sexual abuse and sexual harassment allegations. The PREA-State-wide Coordinator was able to clearly identify and state the mechanisms in place for confidential third-party reporting procedures for both residents and staff. The PREA State-wide Coordinator reported zero (0) reporting of sexual

abuse or sexual harassment from staff and residents over the past twelve (12) months.

Interviews with three (3) staff from medical and mental health revealed their knowledge in reporting sexual abuse and sexual harassment incidents; reporting any suspicious behaviors, and were also aware of their responsibilities for reporting and the no retaliation policy. Health care staff members (medical and mental health) were aware that they were mandatory reporters of sexual abuse and sexual harassment. Each staff member interviewed was able to recite their duty to inform residents of their professional obligation to report any type of sexual abuse or sexual harassment.

Summary:
Review of documents and interviews, specifically health care staff, confirmed the facility is following PREA 115.261 standard.

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.

Policy:
Reviews of cross-reference agency/department/policy/procedures of Delaware DOC PREA Policy #8.60 require staff to take immediate action to protect the resident immediately when knowledge, suspicion, or information is received regarding an incident of sexual abuse/harassment.

Observation:
The PREA Pre-Audit Questionnaire reported zero (0) reporting of sexual abuse or sexual harassment allegations over the past twelve (12) months.

Interview:
Interviews with several security staff and three (3) health care staff (medical and mental health) revealed that staff members were very knowledgeable and well trained in their protection duties if a resident was subject to imminent sexual abuse or sexual harassment as evidenced by signed training logs and each staff member interviewed ability to provide specific detail regarding their protection duties. Staff interviewed were able to discuss reporting methods, no retaliation policy, and their obligations for reporting sexual abuse and sexual harassment.

The interview with the PREA Manager showed him to be aware of his responsibilities to taking immediate action to ensure the safety of residents from sexual abuse or sexual harassment. Immediate action can occur when a resident is immediately at risk of being sexually abused or have been sexually abused. The PREA State-wide Coordinator revealed zero (0) reporting of imminent sexual abuse or sexual harassment from staff and residents over the past twelve (12) months.

Summary:
Based on the auditor's interviews with staff, observation, and review of training logs and policy documentation the facility is meeting PREA standard 115.262.

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.

Policy:
Review of cross-reference agency/department/policy/procedures of Delaware DOC PREA Policy #8.60 states that upon receiving an allegation that a resident was sexually abused while confined at another facility, it is required by Delaware DOC that 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.

Observation:
Observation of the intake/booking process showed the intake staff inquiring about previous abuse to be documented on the screening form.

Review of PREA Pre-Audit questionnaire showed in the past 12 months the facility received six (6) sexual allegations which reported the abuse of a resident while confined to another facility.

Review of PREA Pre-Audit questionnaire showed in the past 12 months there was zero (0) sexual abuse allegations the facility (SWR) received from another facility. Documentation reviewed showed correspondence from the administrator at SWR to an administrator at another facility about a resident's alleged sexual abuse.

Interview:
The auditor's interview with intake staff and the Warden revealed that when a resident answers yes to question one (1) during intake; if she was a past victim of abuse while incarcerated, SWR will followed up with the alleged victim. Intake staff was able to report that a more comprehensive evaluation is completed by medical staff and a referral is generated to mental health. The intake staff was able to report that if the alleged abuse occurred in another facility, the Deputy Warden will then contact the other facility and report the alleged sexual abuse for possible investigation. Deputy Warden confirmed this process during his interview with the auditor.

Summary:
Based on the auditor's interviews, observation and review of policy and email documents the facility meet PREA standard 115.263.

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.

Policy:
Review of the cross-reference agency/department policy/procedures of Delaware DOC PREA Policy #8.60 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; separate alleged victim and abuser; preserve and protect crime scene; collect any evidence; if the timeframe allows collect and protect evidence and advise resident to not take any action that could destroy evidence.

Observation:
The auditor reviewed the guidelines for Delaware Department of Correction (DDOC) Sexual Assault Response Team (SART) which was established to ensure the coordination of a consistent, respectful, victim-centered response to sexual abuse.

Review of PREA Pre-Audit Questionnaire revealed in the past twelve (12) months showed zero (0) allegations that a resident was sexually abused; zero (0) allegations where staff were notified within a time period that still allowed for the collection of physical evidence; and zero (0) times a first responder staff had to preserve and protect any crime scene, showed no request that alleged victim took any actions to destroy any physical evidence, and ensure the alleged abuser did not take any action to destroy any physical evidence.

The auditor reviewed a list of critical incidents including PREA incidents which confirmed zero (0) alleged sexual abuse incidents were reported.

A review of signed specialized training logs for healthcare staff and investigators confirmed the identified staff training participation.

Interview:
The auditor's interview with three (3) health care staff, two (2) medical and one (1) mental health staff demonstrated staff's ability to specifically recite their first responder duties. Each medical staff interviewed was able to articulate guidelines such as separating the victim from the abuser; preserving evidence; providing medical and crisis care. The healthcare staff is part of the multi-disciplinary SART. Healthcare staff talked about their special training as first responders to sexual abuse.

One (1) investigator disclosed being a member of the SART. The investigator discussed his training for first responder and special training to investigate sexual abuse allegations. The investigative staff was able to articulate guidelines for interviewing the victim and abuser. The investigator was able to identify the chain of command for reporting findings.

Summary:
Review of policies, documentation/forms, observations and interviews with staff confirmed that all staff members were informed of first responder duties and are prepared to respond according to the PREA Policy. The facility is following PREA standard 115.264.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of Delaware DOC PREA Policy # 8.60 and Sussex Community Corrections Center policy #8.6 address responding to an allegation of sexual abuse which requires a coordinated effort between unit first responders, security staff, investigators, medical and mental health services and facility administrators.

Observation:
Observation of responding procedures showed a systematic notification in the response process following a reported sexual abuse incident. A review of the Delaware Department of Correction Sexual Assault Response Team (SART) guidelines demonstrated a standardized structure and implementation of a Sexual Assault Response Team.

To confirm the establishment of the SART team the facility provided the auditor with a written list of SART team members that consisted of security staff, first responder representative, institutional investigator, PREA Compliance Manager, treatment/classification unit, medical and mental health staff.

Documentation showed that SART meetings are held in conjunction with each Critical Incident Review.

Interview:
The interviews with SART team members which medical and mental health staff, an investigator and the PREA Manager disclosed that the team was established to meet the needs of the sexually abused victims through crisis intervention and support services. SART team members discussed their roles, responsibilities, special training and understanding of SART guideline to respond to sexual abuse incidents. Medical staff was able to provide detail insight into the protocols for sexual assault, and support services provided such as medical exams for sexual assault victims. The PREA Manager, investigator, mental and mental staff each were able to detail how the team provides support, treatment to victims of sexual assault, conducts an investigation of the reported sexual assault, document and preserve forensic evidence for a potential prosecution, and communicate progress to the victim. The SART Plan detailed coordinated actions to be taken in response to an incident of sexual abuse. The interview with the Warden and Deputy Warden confirmed the coordinated effort between unit first responders, security staff, investigators, medical and mental health services and facility administrators in responding to an allegation of sexual abuse.

Summary:
Review of the SART Plan and interviews with the Warden, Deputy Warden, PREA Coordinator, PREA Manager, security, medical and mental health staff demonstrated a commitment by the facility leadership for handling a coordinated response to sexual abuse and sexual harassment as evidenced by the facility following (SART) guidelines demonstrated by a standardized structure and implementation of a Sexual Assault Response Team.

The facility is adhering to the PREA standard 115.265.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of Delaware DOC PREA Policy # 9.12 ensures that all employees are held accountable and that disciplinary action is taken and consistent department-wide. The auditor reviewed the employee Code of Conduct hand book. Delaware DOC renewed a collective bargaining agreement effective July 1, 2016-June 30, 2018 states when employees continued presence on the job poses a threat to the safety or security of staff, residents, the public operations; they may be suspended immediately with or without pay pending completion of an investigation.

Observation:
The auditor reviewed Union agreements between Delaware DOC and State Merit Employee Compensation Unit 11 Bargaining Coalition and Delaware DOC and State Merit bargaining Unit 10. The contract agreements confirmed that when an employee continued presence on the job poses a threat to the safety of security staff, residents or public operations they may be suspended immediately with or without pay pending completion of an investigation.

Interview:
The interview with the Warden affirmed that personnel are dismissed from the workplace during any criminal investigation or serious administrative investigation and can be placed on paid or unpaid suspension. This was confirmed by the auditor upon review of the agreement.

Summary:
Based on the collecting bargaining agreements and interview with the warden the facility is meeting PREA standard 115.266.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of the Delaware DOC PREA Policy #8.60 and SCCC OP #8.60 ensures the protection of all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigation 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, also protect against retaliation. There is a 90 day monitoring time period for a retaliation review.

Observation:
Review of the PREA Pre-Audit Questionnaire identified zero (0) as the number of incidents of retaliation that occurred in the past twelve (12) months.

Observation of training modules to staff and residents included zero retaliation as the policy of the Department of Corrections and facility.

There is a 90 day monitoring time period for a retaliation review. There is resident ninety (90) day monitoring form, and a staff ninety (90) day monitoring form to monitor for any retaliation on reporting sexual abuse and sexual harassment.

Interview:
Interviews with several residents revealed a complete understanding of zero tolerance against retaliation for reporting sexual abuse and sexual harassment. Interviewed residents were able to communicate with authority the facility's responsibility to protect them against any retaliation for reporting sexual abuse and sexual harassment. Residents conveyed to the auditor that they had no fears of retaliation if they were to report sexual abuse and sexual harassment.

The auditor interviewed the PREA Manager who conveyed that his primary job responsibly is to ensure that the facility is meeting all the PREA standards. The PREA Manager was able to articulate and outline steps on following-up on allegations of sexual abuse and sexual harassment, particularly monitoring for retaliation and communicating with the victim as the case moves forward. PREA Manager was also able to provide specific details regarding the process of investigations and monitoring for any retaliation against reporting of sexual abuse and sexual harassment.

Summary:
The SWR PCM is designated to be the monitor for retaliation at SWR. There were no reports of retaliation or reports of sexual abuse or sexual harassment during the previous twelve months. The facility is meeting PREA standard 115.267.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of Delaware DOC Policy # 8.60 outlines 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 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 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 Office of the Internal Affairs addresses and ensures retention of all written reports for as long as the alleged abuser is incarcerated or employed by the agency +5 years.

Observation:
Review of PREA Pre-Audit Questionnaire disclosed one (1) substantiated an allegation of misconduct that appeared to be criminal and this allegation was referred for prosecution on August 20, 2012.

The auditor reviewed the facility's 8-hour lesson plan; Specialized Investigations/PREA manual; and specialized training attendance. Attendance showed eight (8) out of eight (8) investigators received this training.

Interview:
The auditor interviewed Delaware's State Police Supervisor and one (1) SWR Investigators who each stated their investigation responsibilities to SWR and the attainment of specialized training to complete criminal investigations on sexual assaults. The Delaware's State Police Supervisor reported that his seven state investigators were all specially trained to collect evidence and interview alleged abusers, alleged victims, and witnesses. This was evidenced by signed training logs provided by the facility. Delaware's State Police Supervisor further communicated that once investigations are completed investigators are to present their findings to the prosecutor who would decide on whether to proceed with charges.

The auditor's interview with the facility investigator revealed the investigator to be highly trained to collect evidence and interview alleged abusers, alleged victims, and witnesses. This was evidenced by signed training logs and feedback from the Delaware State Police Supervisor. The facility's investigator was able to communicate his knowledge on the process of completing administrative investigations. In addition, the facility investigator reported that should there be enough evidence to warrant a criminal investigation he would submit his finding to Warden and then the Warden would decide whether to pursue criminal charges by contacting the DSP and initiating a criminal investigation.

Summary:
Review of SWR policies and interviews with investigative staff confirms this standard is considered a priority.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of Delaware PREA Policy #8.60 outlines and imposes a standard of preponderance of the evidence for determining whether or not allegations of sexual abuse or sexual harassment are substantiated.

Observation:
Specialized PREA training for investigators manual and lesson plans were reviewed. The lesson plans included how to interview witnesses, victims, abusers, collecting evidence, and first responder reactions to sexual assault.

Interview:
The facility investigator informed the auditor that he follows the standard of preponderance of the evidence for determining whether or not allegations of sexual abuse or sexual harassment are substantiated. The warden also confirmed this process on substantiating sexual abuse. The facility investigator has received special training to investigate sexual abuse allegations and sexual harassment allegations. This was evidenced by reviewed signed training logs.

Summary:
Interviews with facility investigator and review of specialized training documentation confirm the facility is adhering to PREA standard 115.272.

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.

Policy:

Review of the cross-reference agency/department/policy/procedures of the Delaware PREA Policy #8.60 state requirements 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.

Observation:

Review of the PREA Pre-Audit Questionnaire revealed zero (0) criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the facility in the past twelve (12) months. The PREA Pre-Audit Questionnaire revealed zero (0) residents notified, verbally or in writing of the results of the investigation. Zero (0) investigations was the number of resident sexual abuse in the facility that was completed by an outside agency in the past twelve (12) months and there was zero (0) residents notified, verbally or in writing of the results of the investigation by an outside agency in the past twelve (12) months.

In the past twelve (12) months there was one victim resident notified that charges were being filed against the alleged abuser that occurred in another facility. Review of the Notification of Investigation Status signed by the resident confirmed the notification required by policy.

Interview:

Interview with one (1) investigator confirmed that a resident who makes an allegation that she/he suffered 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. This was evidenced by a review of the Notification of Investigation Status signed by the resident. The investigator states that he investigates sexual abuse and sexual harassment allegations on residents and staff. Additionally, the investigator informed the auditor that anytime an allegation was made by resident on staff the facility ensures no retaliation occurs, no contact between alleged victim and abuser; and the PREA Manager is responsible for communicating the progress of the allegations to the victim. This was evidenced by the facility organizational chart.

The PREA Manager informed the auditor that he is responsible for communicating to residents following an alleged sexual abuse and sexual harassment on the progress of the investigation and whether the abuser has been indicted on charges or convicted of sexual abuse.

Summary:

Based on interviews with staff, review of policy and PREA Pre-Audit questionnaire document the facility is adhering to PREA standard 115.273.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of the Delaware DOC PREA Policy #8.60 confirms disciplinary sanctions for violations of the agency's policy relating to sexual abuse or sexual harassment are commensurate with the nature and circumstances of acts committed. In the personnel policies of the Delaware Department of Corrections disciplinary sanctions are listed up to and including termination for violation of agency sexual abuse and sexual harassment policies.

Observation:
Review of the PREA Pre-Audit Questionnaire disclosed that in the past 12 months, there were zero (0) staff from the SWR that violated the agency sexual abuse or sexual harassment policies; or have been disciplined, short of terminated or been terminated

The PREA Pre-Audit Questionnaire showed zero (0) staff was terminated, zero (0) staff resigned or zero (0) staff was reported to law enforcement for violation of agency sexual abuse or sexual harassment policies.

Interview:
Interview with the facility's investigator revealed staff members were specially trained in investigating sexual abuse allegations as evidenced by signed training logs. The investigator informed the auditor on the processes of investigating an allegation of staff on resident sexual abuse or sexual harassment. The investigator verbally communicated that termination or resignation for alleged sexual abuse and sexual harassment may not prevent criminal charges. The investigator further advised that the ultimate decision to proceed with charges would be up to the Warden and Deputy Warden. The investigator confirmed that zero (0) staff from the SWR violated agency sexual abuse or sexual harassment policies; or have been disciplined, short of terminated or been terminated, zero (0) staff have been terminated, resigned, or were reported to law enforcement for violation of agency sexual abuse or sexual harassment policies.

Summary:
Interviews with staff, review of policy and PREA Pre Audit questionnaire documents confirmed adherence to PREA standard 115.276. This policy is considered a priority by SWR.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of Delaware DOC PREA Policy #8.60 and Sexual Harassment and Complaint Procedures #9.18 confirms that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with inmates and shall be reported to Delaware State Police for possible prosecution, unless the activity was clearly not criminal, and to relevant licensing bodies and the facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Observation:
Review of the PREA Pre Audit Questionnaire shows in the past 12 months, there were no contractor or volunteer terminated for personal contact with a resident.

Review of contractors and volunteers records revealed background check for past sexual abuse allegations and zero (0) allegation of sexual misconduct at SWR.

Review of contractors and volunteers signatures on documentation training material acknowledging "A guide to the prevention and reporting of sexual abuse and misconduct with residents' is included as part of security clearance application.

Auditor reviewed a memorandum specifying that during this PREA cycle there was no substantiated PREA investigation against volunteers or contractor and as a result, no corrective actions were imposed.

Interview:
Interviews with two (2) contractors, two (2) medical staff, one (1) mental health staff, two (2) teachers and one (1) volunteer revealed them to be knowledgeable about PREA's Zero Tolerance Policy. Each interviewed staff member was able to provide specific insight regarding training on maintaining appropriate boundaries when interacting with residents. Each staff member interviewed was able to recite their duty to report abuse, and identify red flags on staff possibly engaging in sexual misconduct with a resident. Additionally, each resident interviewed was able to identify the facility's Sexual Harassment and Compliant Procedures.

Contractors and volunteers stated they receive an annual PREA training to maintain their knowledge and focus on their responsibilities and this was evidenced by signed training logs.

Summary:
Review of documentations, interviews with investigative and health care staff demonstrate PREA standard 115.277 is performed by SWR.

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.

Policy:
Review of the cross-reference agency/departments/policy/procedures of Delaware DOC PREA Policy 8.60, Grievance #4.4, and Exceptional Incident Reporting #8.8 address and require residents to be subject to disciplinary sanctions following an administrative finding that the resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse. For the purpose of a 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.

Observation:
Review of the PREA Pre-Audit Questionnaire disclosed there were zero (0) resident-on-resident administrative or criminal sexual abuses during the past twelve (12) months.

A review of a list of program sanctions provided by the facility showed zero (0) resident-on-resident administrative or criminal sexual abuses during the past twelve (12) months.

Review of Incident reports provided by the facility showed zero (0) resident-on-resident administrative or criminal sexual abuses during the past twelve (12) months.

PREA standard 115.67 Monitoring log showed zero (0) resident-on-resident administrative or criminal sexual abuses during the past twelve (12) months.

Interview:
Interviews with several residents revealed they are well informed on PREA Zero Tolerance Policy. Residents interviewed were able to detail the process for reporting sexual abuse and sexual harassment and third party reporting. Each resident interviewed stated their awareness of the no retaliation policy for reporting and possible sanctions for sexual assault. Interviewed residents informed the auditor that they did not experience any sexual abuse or sexual harassment incidents. The residents interviewed were fully aware of the consequences of sexual misconduct or sexual abuse. Residents interviewed informed the auditor that they considered SWR to be a safe environment from sexual abuse and sexual harassment.

Interviews with the PREA Manager and facility investigator confirmed zero (0) resident-on-resident administrative or criminal sexual abuses during the past twelve (12) months. The PREA Manager and investigative staff were knowledgeable in the disciplinary sanctions following an administrative finding that the resident engaged in

resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse. The facility investigator was able to provide clear insight into the reporting processes.

Summary:
Review of documents, interviews with staff, residents confirmed disciplinary sanctions for residents are according to the PREA standard 115.278.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of Agency PREA Policy #8.60 and Correctional Healthcare Services Policy and Procedures #11-A-05, Patient Safety #11-B-02, Federal Sexual Assault Reporting #11-B-04 and Procedure in event of Sexual Abuse #11-B-05 mandates resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, at no cost to the inmate, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment and consistent with BCHS Policy #11-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.

Observation:
Review of Policy E-01.1 excludes residents involved in any PREA incidents from copying medical fees.

Review of Agency PREA Policy #8.60 and Correctional Healthcare Services Policy and Procedures #11-A-05, Patient Safety #11-B-02, Federal Sexual Assault Reporting #11-B-04 and Procedure in event of Sexual Abuse #11-B-05 mandates resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, at no cost to the resident, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment and consistent with BCHS Policy #11-B- 05. The victim will be offered pregnancy testing and crisis counseling.

Interview:
Interviews with two (2) medical staff revealed staff is highly trained staff in treating and first responding to sexual

abuse incidents. Each medical staff was able to describe the evaluation and treatment process of residents identified as victims. Medical staff was able to speak fluently on what treatment includes as well the referral process, if necessary, for continued care following their transfers to, or placement in, other facilities or their release from custody. Additionally, medical staff interviewed informed the auditor that they were a team member of the SART. Medical staff reported they were specifically trained to provide sexual abuse victims and abuser medical and mental health treatment. This was evidenced by signed training logs.

Interview with mental health staff disclosed that PREA incidents (abusers and victims) are always referred to mental health. Interviewee communicated that mental health practitioner routinely performs mental health evaluations including risk assessment for suicidal ideology. The interviewee further reported that Crisis Counseling is available immediately upon notification of a sexual abuse incident.

Summary:
Interviews with medical and mental health staff as well as the review of policies confirmed that when disclosure or identification of victimization of a resident is identified the victim is immediately referred and has access to medical and mental health services.

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.

Policy:
Review of the cross-reference agency/department/policy/procedures of Delaware DOC PREA Policy #8.60 states if the intake or 30 days security screening, or medical intake or subsequent mental health screening indicates that a resident has experienced prior victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered follow-up meeting with a medical or mental health practitioners within fourteen (14) days of that screening.

Delaware DOC PREA Policy #8.60 states if the intake or 30 days security screening, or medical intake or subsequent mental health screening indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered follow-up meeting with a medical or mental health practitioners within fourteen (14) days of that screening.

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.

Medical/mental health treatment is outlined in the Delaware DOC PREA Policy #8.6, Correctional Healthcare Services Policy #11-A-05 and Procedure in event of Sexual Abuse #11- B-05, which further addresses ongoing care and follow-up. 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.

Observation:
Review of Agency PREA Policy #8.60 and Correctional Healthcare Services Policy and Procedures #11-A-05, Patient Safety #11-B-02, Federal Sexual Assault Reporting #11-B-04 and Procedure in event of Sexual Abuse #11-B-05 mandates resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, at no cost to the resident, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment and consistent with BCHS Policy #11-B- 05. The resident will be offered pregnancy testing and crisis counseling

Review of sexual assault awareness brochures and handout materials received at intake and other information in the resident orientation document advises the resident population of the offerings by the medical and mental health departments involving evaluation, treatment and ongoing medical and mental health care as appropriate for the sexual abuse treatment of residents, victims, and abusers.

Interview:
Interview with two (2) medical staff revealed highly trained staff in treating and first responding to sexual abuse incidents. Medical staff informed the auditor that they are a team member of the SART and are specifically trained to provide sexual abuse victims and abuser medical and mental health treatment as evidenced by signed training logs presented by the facility.

Interview with mental health staff disclosed that PREA incidents (abusers and victims) are always referred to mental health. Mental staff reported that the mental health practitioner routinely performs mental health evaluation, including risk assessment for suicidal ideology. Mental staff was able to describe the immediate availability of Crisis Counseling upon notification of a sexual abuse incident.

Interviews medical and mental health staff at the SWR confirmed their commitment and dedication to facilitating appropriate healthcare to residents as evidenced by their significant knowledge of the policy and procedures.

Interviews with several residents revealed they were well informed about the health care available to victims of sexual abuse or assault.

Summary:
Review of brochures and handout materials received at intake and other information in the resident orientation documentation advise resident population of the offerings by the medical and mental health; review of policies on victims receiving timely, unimpeded access to emergency medical treatment and crisis intervention services; and interview with medical and mental health practitioners confirmed SWR is adhering to PREA standard 115.283

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.

Policy:

Review of cross-reference agency/department/policy/procedures 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 done for substantiated, unsubstantiated, and unfounded cases and is initiated within 30 days of completion of the investigation, absent exigent circumstances. The policy indicates that a comparison previous years incident data will be compared to provide for an assessment of the facility's progress in addressing sexual abuse. The team review shall consist of upper-level management with input from medical, mental health, investigators, and supervisors.

Observation:

The auditor reviewed the sexual assault/critical incident minutes presented by the facility. The review team included the Warden or Deputy Warden, State-wide PREA Compliance Coordinator, facility PCM, investigator, and medical/mental health this was evidenced by documentation presented by the facility.

Documentation of sexual assault/abuse incident reviews and logs confirmed that PREA incidents are being reviewed. The auditor reviewed a detailed questionnaire that analyzed PREA incidents and reviewed methods of preventing re-occurrences. Critical incidents reports indicated the team reviews any PREA incident to determine a need for policy change or practices to prevent detect and eliminate sexual abuse.

Interview:

Medical, Mental Health, and PREA Manager were each able to articulate the review team's purpose and how it functions. All staff interviewed identified as team members of the Critical Incident Review Team. The PREA Manager informed the auditor that any PREA incident is reviewed to determine ways to prevent detect and eliminate sexual abuse. Staff interviewed expressed the importance of technology. Each staff interviewed cited the use of cameras/video monitoring as a necessary asset. The PREA Manager reported cameras are useful in assessing and helping to determine whether incidents could be prevented with increased technology.

Interviews with Deputy Warden, State-wide PREA Compliance Coordinator, facility PREA Manager, also confirmed the Review Team meets to review critical incidents and examine ways to prevent reoccurrences. This was confirmed by the auditor review of the critical incident minutes.

Summary:

Review of notification of Review Team meeting, documentation of sexual assault/abuse incident review reveals the team is completing sexual abuse incidents; reviewing them, and looking at methods 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.

Policy:
Review of cross reference agency/department/policy/procedures of Delaware PREA Policy #8.60 and Management Information System #6.5 requires the Department 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.

Observation:
Review documentation of sexual assault/abuse incident review, logs confirms that PREA incidents are being reviewed. The auditor reviewed a detailed questionnaire that analyzes PREA incidents and reviews methods of preventing re-occurrences. Critical incidents reports indicated the team reviews any PREA incident to determine a need for policy change or practices to prevent detect and eliminate sexual abuse.

The auditor reviewed annual aggregate critical incidents reports, annual aggregate critical incidents and comparisons of data for all DOC facilities. The auditor also reviewed the Survey of Sexual Violence questions and answers that is completed after each sexual abuse incident.

Interview:
Interviews with the State-wide PREA Compliance Coordinator and facility PREA Manager 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. This was evidenced by a review of critical incident reports, aggregate data collection, and critical review team minutes.

Interview with Deputy Warden revealed the critical incident review team reviews all PREA incidents to determine a need for policy change or practices to prevent detect and eliminate sexual abuse. Deputy Warden disclosed the critical incidents review team assesses technology and staffing to determine whether PREA incidents can be eliminated. This was evident through review of team minutes.

Summary:
Interviews with critical incident review team members, reviews of critical incident reports, aggregate data collection, and critical review team minutes confirm adherence to PREA standard 115.287.

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.

Policy:
The agency PREA Policy #8.60 requires the Department 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.

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.

Observation:
The report is approved by the Commissioner of Corrections; Annual Report contains comparisons from the previous year and included the assessment as per the standard. The auditor reviewed the Annual Reports, visited the Report on the Department's website and found the documentation met the requirements for the Department to be compliant with this standard.

Review of Delaware Department of Correction Annual PREA report shows aggregated data collected from all Delaware facilities.

Review of team Critical Incident minutes indicates the team reviews any PREA incident to determine a need for policy change or practices to prevent detect and eliminate sexual abuse.

The auditor reviewed memorandum stating zero (0) incident-based data from the private facility with which it contracts.

The auditor reviewed aggregated data report collected monthly (January) on all facilities under Delaware DOC and confirmed that data is being collected, analyzed and compared by facilities.

Interview:
Interview with PREA Manager and PREA coordinator revealed the team help to identify problems that facilitated PREA incident and corrective actions to prevent detect and eliminate reoccurrences.

Summary:
Review of data collected reports, the department website, incident reports, and interviews confirmed the facility is following PREA standard 115.288.
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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.

Policy:
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.

Observation:
The Department makes available to the public its annual report on PREA on the agency's website and the latest annual report on the website, September 2016, was reviewed by the auditor.

The policy on records retention schedule and the report on records management were reviewed and confirm storage, publication, and destruction is per PREA standards. The Agency Prea Policy #8.6, states the agency shall maintain sexual abuse data collected pursuant to 115.87 for at least 10 years after the date of the initial collection unless Federal, State, or Local Law requires otherwise. The policy also states the agency shall retain all written reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five (5) years.

The auditor reviewed of memorandum presented by the facility which stating zero (0) incident-based data from the private facility with which it contracts.

The auditor's review of data collection on the agency's website did not reveal any personal identification information.

Interview:
Interviews with PREA State-wide Coordinator and PREA Facility Manager confirmed the agency will maintain sexual abuse data collected pursuant for at least 10 years after the date of the initial collection. The interviews revealed that data collected is secured by the Delaware DOC and that critical incidents at contracting facilities are being monitored annually.

Summary:
Interviews with PREA State-wide Coordinator and PREA Facility Manager; policies reviews; observation of reports confirmed the facility is meeting PREA standard 115.289.

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 17, 2017______________

Auditor Signature Date