PREA AUDIT REPORT ☐ INTERIM ■ FINAL

COMMUNITY CONFINEMENT FACILITIES

NATIONAL PREA RESOURCE CENTER

BJA Bureau of Justice Assistance U.S. Department of Justice

Auditor Information			
Auditor name: Maggie Capel			
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Telephone number: 479-521-5142			
Date of facility visit: March 25 – 27, 2015			
Facility Information			
Facility name: Hazel D. Plant Women's Treatment Facility			
Facility physical address: 620 Baylor Blvd., New Castle, DE 19720			
Facility mailing address: *(if different from above)*			
Facility telephone number: 302-777-6800			
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: Carole Evans			
Number of staff assigned to the facility in the last 12 months: 91			
Designed facility capacity: 96			
Current population of facility: 92			
Facility security levels/resident custody levels:			
Age range of the population: 19-59			
Name of PREA Compliance Manager: Roberta Wright		**Title:** Correctional Staff Lieutenant	
Email address: Roberta.Wright@state.de.us		**Telephone number:** 302-995-6120	
Agency Information			
Name of agency: Delaware Department of Corrections			
Governing authority or parent agency: *(if applicable)*			
Physical address: 245 McKee Road, Dover, DE			
Mailing address: *(if different from above)*			
Telephone number: 302-739-5601			
Agency Chief Executive Officer			
Name: Robert Coupe		**Title:** Commissioner	
Email address: Robert.Coupe@state.de.us		**Telephone number:** 302-739-5601	
Agency-Wide PREA Coordinator			
Name: Michael Records		**Title:** Planner V	
Email address: Michael.records@state.de.us		**Telephone number:** 302-739-5601	

AUDITFINDINGS

NARRATIVE

This auditor was assigned to conduct two PREA audits for facilities within the Delaware Department of Correction. The agency sent a jump drive to this auditor approximately one week before the audit. The jump drive contained policies and supporting documentation for each standard. Prior to the audit, this auditor sent a tentative schedule and a list of additional documentation that would be needed during the site audit and. The agency had several audits scheduled for this same week: PREA audit of three facilities, and ACA audit of the Central Office.

All auditors dined with Michael Records, PREA Coordinator, Robert Coupe, Commissioner, and several members of the executive management team.

The first day of the Plant audit was spent touring the facility and interviewing staff and residents. The second day of the audit, the interviews were concluded. This auditor met with the warden, PREA managers, and Rachel Bolden (a certified PREA auditor who was available to assist throughout the audit). This team began reviewing each standard for compliance. Robert May, Deputy Warden for the Baylor facility, joined the group on the last day of the audit for further review of the Baylor standards.

This auditor discussed some changes that were needed in several agency policies with Michael Records. Changes to the wording on resident PREA posters and visitor PREA posters were changed immediately. The policy revisions were completed within the 30-day period following the audit.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Plant facility houses level 4 and 5 residents. The first floor contains offices for administration, medical and mental health services, and the kitchen. There are group rooms on the first floor and a visitation area that is used for a classroom throughout the week. There are ten housing areas located on the second floor. One dormitory is reserved for inmate trustees who perform housekeeping duties around the facility. Two dorms house work release residents. All of the remaining dorms house residents involved in the substance abuse program.

SUMMARY OF AUDIT FINDINGS

This auditor noted that the resident posters did not address confidentiality for the hotline calls. The posters for visitors did not provide clear contact information for 3rd parties to report sexual abuse or harassment. Both of these posters were changed immediately and sent to all facilities. The agency policies were changed to include:

- Assignment of staff to monitor retaliation
- Clear directions for staff in the event an offender is at substantial risk of imminent of sexual abuse
- Modifications to the policy as related to offenders with disabilities.
- Changes to the screening process for employees, volunteers, and contractors. These changes include development of a new form for documenting the contacts made with previous employers and criminal background checks.
- Several modifications were made to the grievance process as it relates to PREA.

Overall, this auditor found the staff to be well trained, the residents were well informed about their rights and generally felt safe from sexual assault or harassment. Residents indicated they felt comfortable reporting any situation involving sexual abuse, harassment, or retaliation.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 1

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)

Delaware Department of Correction policy 8.60 mandates zero tolerance towards all forms of offender sexual abuse or harassment and provides definitions of prohibited behaviors. This policy also outlines the facility approach to preventing, detecting, and responding to such behaviors. The agency PREA Coordinator is Michael Records. Mr. Records reports to the Planning and Research Director, who reports to the Commissioner. The agency has designated PREA Compliance Managers at each facility. All PREA managers coordinate efforts through the agency PREA Coordinator. The agency PREA Coordinator has sufficient time and authority to oversee the agency efforts to comply with these standards.

Compliance was determined by a review of the agency PREA policy, agency organizational chart, interviews with the Commissioner, and PREA Coordinator.

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)

☒ Not applicable

The agency does not contract for the confinement of offenders. If the agency should decide to contract for confinement of offenders, Mr. Records would be charged with monitoring the contracts for compliance.

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)

The average population for the facility is 96. The facility has identified specific critical posts. The facility fills critical posts at all times. The number of posts may vary depending upon institutional emergencies, facility activities, or unscheduled transports. The facility warden supervises three facilities. Staff is cross-trained to work at any of the facilities. In the event there are not adequate staff to cover a shift, staff may be assigned from one of the other facilities. If there are not adequate staff from the other facilities, overtime is offered to provide the needed coverage. If overtime staff cannot be assigned, staff from the previous shift will "freeze" (be required to work mandatory overtime) to cover the shift. An incident report is completed when staffing requires overtime or "freezing."

This auditor reviewed the staffing plan that shows the number of staff assigned to each post. This auditor recommended a revision to the staffing plan that considers leave, training, and other factors when determining the number of staff required for the facility. Mr. Records indicated the agency would conduct a formal staffing analysis and develop formal staffing plans for each facility within the agency.

There are no judicial findings of inadequacy, or findings of inadequacy from federal investigative agencies or internal or external oversight bodies.

When determining staffing, the facility administration considers the composition of the resident population, bind spots within the facility, number, and placement of supervisory staff, program activities, and substantiated and unsubstantiated incidents of sexual abuse.

Supervisors from the rank of sergeant and above conduct unannounced rounds regularly. These rounds are logged in the logbooks and documented on shift reports. Staff is prohibited from alerting other staff of these rounds.

Compliance was determined by review of agency and facility policies, review of shift rosters, and observations during the facility tour and interviews with the Warden, PREA Manager, and PREA Coordinator.

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)

DDOC policy 8.60, 8.32 and facility SOP 3.43 prohibit cross gender pat or strip searches, except in exigent circumstances. Program access or out of cell activities are not restricted, if female officers are not available to conduct searches. Any cross-gender searches are documented on an incident report form. The PREA Compliance Manager maintains a log and copies of these incidents. During this audit period, there has been no cross gender pat or strip searches. All staff was aware of the agency and facility policy regarding cross gender searches and confirmed there have been no cross gender searches during this audit period. This was also confirmed through interviews with residents. Video cameras are strategically placed to protect residents' right to privacy. Facility policy prohibits searching or examining a trans-gender or inter-sex resident for the sole purpose to determine genital status.

Opposite gender staff is required to announce their presence when entering a housing unit. Facility SOP also requires at least two staff members' presence before entering an offender's cell. Offenders are afforded privacy when toileting, showering and changing clothes.

The auditor reviewed the power point training for conducting cross gender searches. The training meets the requirements of this standard. This training educates staff about the prevalence of past sexual trauma for female offenders and the importance of remaining professional to minimize re-traumatizing the offender.

Compliance with this standard was determined by observations on the facility tour, interviews with officers and residents, review of agency and facility policies.

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)

The agency contracts with Para-Plus Translations Inc. to provide interpretive services for non-English speaking residents. The medical department has a contract with Deafinitions and Interpreting, LLC to provide services for hearing impaired residents. The facility does not rely on resident interpreters, readers, or assistants except where a delay in accessing an interpreter would compromise first responders, the investigation, or safety of the resident. There have been no occasions in which resident interpreters or readers have assisted in PREA related complaints. The resident PREA video provides closed captioning for hearing impaired and a Spanish version for non-English speaking residents. The resident PREA handout is available in braille. There were no disabled or non-English speaking residents at the facility, at the time of the audit.

Compliance was determined by a review of the agency and facility policy, MOU for interpreter services, and interviews with staff.

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)

The agency policy and Delaware Code Title 11, 6506, B. prohibits the hiring or promotion of employees or contractors who have engaged in sexual abuse in an institutional setting or been convicted of or civilly/administratively adjudicated for sexual activity in the community as outlined in this standard. Criminal background checks were completed for all employees and contract employees hired during the audit period. Criminal background checks are conducted annually.

The human resource department provides information of substantiated allegations of sexual abuse or harassment involving a former employee to institutional employers.

The internal affairs department conducts the criminal background check and contacts previous employers. There is no written procedure for the background checks and no mechanism to confirm to the auditor that previous employers were contacted. This was corrected by the agency. Procedures were developed and a form created which documents the background checks for applicants.

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)

There has been no expansion or renovations to the facility during this audit period. In 2013, the video monitoring system throughout the facility was upgraded and expanded. The system clearly enhances the sexual safety of residents.

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)

Administrative investigations are conducted by trained investigators within the facility or by internal affairs depending on the seriousness of the allegations. Any investigation that may involve criminal charges is forwarded to the Delaware State Police. If the evidence warrants criminal charges, the case is referred to the Attorney General.

Both facility and agency investigators have been trained in conducting sexual abuse investigations and the preservation of evidence. Interviews with investigators and review of training records reflected that investigators are well equipped to conduct these investigations.

SAFE/SANE trained nurses at Christina Hospital provide victims of sexual abuse forensic examinations. There is no cost to the victim for these services. At the request of the victim, rape crisis advocates are available to victims through Contact Lifeline. Advocates provide support services during the forensic exam and investigation and short-term services following the incident. Support services are also available within the facility through the mental health department.

A review of the agency MOU with Contact Lifeline and agency policies, as well as interviews with facility and internal affairs investigators, determined compliance with this 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)

The facility has had one allegation of sexual abuse or harassment during the audit period. Two of these allegations were referred to the Delaware State Police for criminal investigation. One is still pending. All of these allegations were investigated in accordance with agency policy 8.35. DDOC policy 8.35 is available for

review by the public on the agency website. After review of investigations and interviews with facility and internal affairs investigators, this auditor determined the agency was in full compliance with this 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)

The agency has provided PREA training to all employees who have contact with residents. This training is comprehensive and covers all of the requirements for this standard. Gender specific training is also provided for staff. A review of employee training records confirmed 100% of the available facility employees were provided training (excludes employees on extended leave, FMLA and the like). Employees receive annual refresher training through ILEARN. ILEARN is available through the agency share drive and provides on-line training for employees. At the completion of the training, each employee must pass a test, indicating understanding of the training. Changes to current policies related to PREA are also available to employees through the agency's share drive. New employees are provided pre-service PREA training at the training academy.

Interviews with employees and review of agency policy and training records determined compliance with this 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)

In the past twelve months, there were fifty-nine volunteers and contract employees who had contact with residents. All of these individuals received PREA training. The level of training provided was determined by the service provided. Compliance with this standard was determined by a review of the agency policy, training curriculum, training records, and interviews with volunteers and contractors.

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)

There were 411 residents received at the facility during the twelve months prior to the audit. There were 100 residents transferred from a different community confinement facility. All of these residents received PREA information within 1 to 2 hours of their arrival. This included an explanation by the intake staff and a PREA handout. This information is available in Spanish, braille, and closed captioning.

Treatment staff is available to assist with limited reading or comprehension skills. Residents sign acknowledging receipt of this training. Information regarding the agency's zero tolerance policy and reporting mechanisms are posted in each housing area and throughout the facility.

Interviews with offenders and staff and review of training records determined compliance with this 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)

The agency and facility investigators complete administrative investigations. When the evidence suggests the matter may rise to the level of a criminal matter, the investigation is referred to the Delaware State Police. The agency and facility investigators have received training in conducting sexual abuse investigations in a correctional setting. This training includes interviewing techniques, Miranda and Garrity warnings, evidence collection, and the amount of evidence required for administrative or prosecution referral. The agency was able to provide documentation of this training. Interviews with investigators revealed they understand the training and apply the training to their handling of sexual abuse/harassment allegations.

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)

Twenty-three (23) medical and mental health staff works regularly at the facility. All of these staff has received PREA training. In addition, these staff has received specialized training to assist in the detection and assessment of signs of sexual abuse and harassment, evidence preservation, response, and referral. This was supported by a review of the training records, interviews with mental health and medical staff and review of the training curriculum.

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)

There were 386 residents received at the facility whose stay was 72 hours or longer. Of these residents, all received the required training. All residents received are screened during the intake process for risk of sexual victimization or abusiveness. Residents are screened within one to two hours of arrival. This was supported by a review of agency and facility policies, intake documentation, and interviews with staff and residents.

There are two screening instruments utilized by the agency. The Quick Screen is used upon admission to make an initial assessment of victim or abuser potential. The agency has developed a Quick Screen for

assessing potential victimization and another for potential abusiveness. The 21-Day/Periodic Sexual Victimization Assessment and/or the 21-Day/Periodic Sexual Aggressor Assessment is completed within 30 days of admission. Residents assessed to be at risk are referred to the mental health department for assessment and services if indicated. If additional information is received, the resident is reassessed.

Residents are not disciplined for failure to disclose information requested as part of the assessment. This information is stored in the institutional record and is accessible to the facility's administration, PREA Manager, and treatment staff only.

Compliance with this standard was determined by review of the intake risk assessment screening tools and agency policy, interviews with staff, residents, PREA Coordinator and PREA Manager.

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)

The information from the risk screening is considered when making individualized housing, work and program assignments. The electronic resident data system referred to as DACS, prevents potential victims and abusers from housing in the same cell.

The agency has not dedicated a housing area for transgender, homosexual, lesbian, bisexual or intersex residents. These offenders are assigned housing, program, and work assignments according to their individual needs. The facility considers the opinion of the transgender resident when making these placements. Transgender residents are given the opportunity to shower and undress separately and are reassessed every six months.

A review of agency and facility policies, interviews with the staff who complete risk screening, residents, and the PREA Compliance Manager, as well as, observations during the site visit, determined compliance for this 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)

The agency provides several avenues for residents to report sexual abuse, sexual harassment, or retaliation. Residents may also report any neglect of staff duties that led to an incident of sexual abuse or harassment. Residents may report to any staff member, write the agency PREA Coordinator, or internal affairs, may file a grievance, or may report through a third party. Resident interviews indicated residents are aware of these options. The agency has also established an MOU with Contact Lifeline to provide a means to report outside of the agency. Residents may dial the Contact Lifeline phone number, which is conspicuously posted

throughout the facility. The auditor tested the contact number during the audit and found residents did not have to provide identifying information to make the call. Contact Lifeline staff will relay information for the resident to the PREA Coordinator. During the audit, the auditor observed Contact Lifeline contact the PREA Coordinator and observed an immediate response on their part.

Interviews with staff and residents revealed all are well aware of the resident reporting procedures. Staff is provided a confidential reporting mechanism through the DACS system. A staff member may write an incident report and mark the report confidential. The recipient may only read this report.

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)

Residents may utilize the established grievance procedure for reporting sexual abuse or sexual harassment. These reports do not require informal resolution. All PREA related grievance are marked as such and handled in the same manner as emergency grievances. PREA related grievances require an immediate investigation. There are no time limits imposed for these complaints. Residents are not required to submit these grievances to the subject of the complaint and those named in the complaint will not be involved in the investigation or resolution of the grievance. A third party complaint filed on behalf of the resident will be accepted and processed if the alleged victim agrees to the filing of the complaint. These grievances are typically resolved well within the 90-day time limit. Agency policy does state a final determination of these grievances will be completed within 90 days. The policy allows for a one-time 70-day extension and the resident is notified in writing of the extension. During the audit period, there have been no PREA related grievances filed at this facility.

Any grievance filed which alleges imminent risk of sexual assault is immediately forwarded to the shift commander or facility administration for immediate action to ensure the safety of the resident. All staff interviewed was aware of the need to take immediate action.

A review of agency policies, interviews with staff and residents, a review of the grievance process, and observations on the site visit determined compliance with this 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)

The agency has established an MOU with Contact Lifeline to provide a toll free hotline and support services for residents. The auditor reviewed this MOU and called the hot line number through a phone in the housing area. The call was answered promptly and the caller was not required to give any identifying information to place the call. This auditor noted the PREA posters did not notify the residents of the confidentiality of the hotline calls. This was corrected immediately and the PREA poster, posted throughout the facility, notifies residents of the limits of confidentiality pertaining to hot line calls. Interviews with residents indicated they were aware of this service and aware of the support services available to them within the facility and upon release.

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)

Third party reports are accepted by the agency and all reports are investigated. This auditor noted that the PREA posting in the lobby and visitation area did not provide clear contact information for reporting sexual abuse or harassment. This was corrected immediately. Reporting information is available through posters in the lobby, visitation area, throughout the facility and on the website. Compliance with this standard was determined by a review of agency policy, observations on the facility tour, and review of the agency's public website.

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)

The agency policy requires all staff to report immediately any information regarding sexual abuse or sexual harassment. Staff is also required to report incidents of retaliation for reporting or staff neglect of duties that may have contributed to the incident. A random sampling of staff revealed staff are aware of their responsibilities in this regard and are aware of the importance of maintaining confidentiality of sexual abuse/harassment reports. Medical and mental health staff interviewed was also aware of their reporting duties. All reports of sexual abuse or sexual harassment are reported to the facility investigators and/or internal affairs investigators. A review of agency policy, and interviews with investigators, and staff determined compliance with this 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)

The agency policy requires immediate action if it is determined that a resident is at imminent risk of sexual abuse. All staff interviewed was aware of this requirement and understood the importance of this action. Compliance was determined by review of agency policy and interviews with staff, the Agency Head, and warden.

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)

If a resident alleges they, were the victim of sexual abuse at another institution, agency policies requires the facility head to notify the facility head of the institution in which the alleged abuse occurred and to document these reports. Facility policy requires this notification to be made within 72 hours. There were no allegations of this type received at this facility during this audit period. Agency policies address this requirement and interviews with staff reveal they are aware of this requirement.

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)

The agency PREA policy thoroughly addresses first responder duties. All staff interviewed was aware of these duties and were able to cite the steps to be taken in the event they received an allegation of sexual abuse.

Compliance was determined by review of agency policies and interviews with first responders (security and non-security) and residents.

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)

The facility has a SART (Sexual Abuse Response Team) policy that outlines the facility's plan to coordinate actions with first responders, medical and mental health staff, facility administrators and investigators, in the event of an incident of sexual abuse. A review of this policy as well as staff interviews determined compliance with this 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)

The agency has three collective bargaining agreements: F.O.P. for probation and parole officers, C.O.A.D. for

Correctional Officers through the rank of Sergeant, Local 247 for Lieutenants and Captains. None of these agreements limits the agency from removing alleged staff sexual abusers from contact with residents pending the outcome of the investigation or of a determination of whether and to what extent disciplinary sanctions are warranted. Copies of these agreements were provided to this auditor for review.

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)

The agency policy states that action will be taken to protect residents or staff from retaliation for reporting sexual abuse or cooperating with an investigation. The Bureau of Prisons policy outlines multiple measures for protecting resident victims from retaliation. These options include housing changes, transfer of the victim or the abuser, removal of alleged staff or resident abusers from contact with victims and emotional support services for staff or residents. The SART policy designates the facility's PREA compliance manager as the staff member responsible for monitoring retaliation. The PREA manager will monitor the resident or staff for a minimum of 90 days but will continue to monitor beyond the 90-day period if necessary.

Compliance with this standard was determined by review of agency policies, SART policy, and staff interviews.

115.268	**Post-allegation protective custody**

- ☐ 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)

The agency policy prohibits the placement of residents who have suffered sexual abuse, in involuntary segregation unless all other alternatives have been explored. Staff is aware of these requirements as evidenced through staff interviews. This facility has not had a case that required protective custody. If that situation should occur, the resident would be transferred to the Baylor facility.

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)

The agency PREA policy requires that allegations of sexual abuse or harassment be promptly forwarded to the investigator. Investigators initiate investigations for all allegations to include anonymous and third party. There are five trained investigators at the facility and all have received specialized training in conducting sexual abuse investigations in a correctional setting. This training included interviewing techniques and evidence collection.

If the evidence suggests criminal activity, the matter is referred to internal affairs. Internal affairs will refer the

case to the Delaware State Police. Facility investigators generally are not involved in DNA collection at the crime scene. Facility investigators assist by reviewing and gathering electronic evidence, logs, reports, and the like. Facility investigators conduct most resident-on-resident allegations. Staff-on-resident allegations are usually referred to internal affairs. Residents are not required to take a polygraph to determine truthfulness. Staff conduct is considered during investigations to determine if staff action or inaction contributed to the incident. The Delaware State Police conduct criminal investigation. If the case has enough evidence to warrant prosecution, it is referred to the Attorney General office for review and handling. The Delaware State Police provide a copy of their completed investigations to the facility. The PREA manager is charged with monitoring the status of all cases referred to the Delaware State Police.

The facility policies require written reports for administrative and criminal investigations will be retained for five additional years after an abuser is no longer incarcerated or no longer employed by the agency. Interviews with investigators, review of agency and facility policies and completed investigations determined compliance with this standard.

115.272 Evidentiary standard for administrative hearings

☐ 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)

All investigators interviewed had received training in the standard of evidence required for administrative investigations. Investigators understood that administrative investigations required only a preponderance of the evidence to determine the allegations are substantiated.

A review of agency and facility policies and interviews with investigators determined compliance with this 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)

There was one administrative investigation in the past 12 months. For each investigation, in which an alleged victim was identified, the resident received a notification of the outcome of the investigation.

Compliance was determined by review of facility and agency policies and staff interviews.

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)

The agency PREA policy outlines disciplinary sanctions for staff violations of policies related to sexual abuse or harassment that includes termination. During the 12-month period, there have been no instances of staff disciplinary actions for these types of violations.

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)

The agency PREA policy requires that any volunteer or contractor who engages in sexual abuse with a resident will be prohibited from contact with residents and will be reported to the Delaware State Police. There was one such incident during the past twelve months. This incident was reported as required and appropriate remedial measures were taken.

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)

The agency prohibits all sexual contact between residents. The activity is considered sexual abuse if it is forced or coerced.

Residents are subject to disciplinary sanctions if it is determined through administrative investigations and the formal disciplinary process that the resident engaged in resident on resident sexual abuse. Sanctions are determined after consideration for the circumstances and nature of the abuse, disciplinary history, and contributing factors such as mental illness or disability. Residents are not disciplined for sexual contact with staff unless the staff member did not consent to the contact. If an administrative investigation does not substantiate an allegation of sexual abuse, the resident who made the report is not disciplined, if the resident had a reasonable belief that the abuse occurred. During the past 12 months, there were of incidents of substantiated resident on resident sexual abuse.

The facility offers treatment for abusers through a program entitled Transitions. The Transitions program is provided by Connections, a contracted mental health counseling service. The facility does consider making completion of the Transitions program a requirement for sexual abusers.

Compliance was determined by review of agency policies, disciplinary procedures, and interviews with staff.

115.281	Medical and mental health screenings; history of sexual abuse

☐ 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)

The mental health staff provides follow-up services for all residents who disclose prior victimization during the screening process. Documentation to support follow-up services is maintained in IChart, the electronic medical record that is part of the DACS electronic database. Staff also provided follow-up services for residents who perpetrated sexual abuse. Residents are seen within the 14-day window required by this standard. Access to this information is restricted to medical and mental health staff, and the facility warden, deputy warden and PREA manager. Mental health staff obtains informed consent from the resident before reporting prior victimization that did not occur in an institutional setting. A review of medical and mental health records, interviews with staff determined compliance with this 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)

Residents who are victims of sexual abuse receive prompt, access to medical treatment and crisis intervention services. The medical and mental health staff determines the type of services and nature of the services, according to their professional judgment. Staff interviewed during the site visit is aware of their responsibility to separate and protect the victim. Medical and mental health staff is on-call after hours to respond to these emergencies. Where appropriate, emergency contraception and sexually transmitted infection prophylaxis are provided to residents. The victim is provided services at no cost even if the abuser is not named or the victim chooses not to participate with the investigation. The auditor reviewed the agency's health policy B-05, interviewed residents who reported a sexual abuse, mental health and medical staff, and first responders in determining compliance with this 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)

The facility provides medical and mental health evaluations for victims of sexual abuse in an institution. Treatment is also provided and includes treatment plans, follow-up services, and referrals upon release. The facility provides a specialized group for victims of sexual abuse at the facility, through the mental health contract. The level of care meets or exceeds the services available to the community. Medical staff stated pregnancy related medical services are offered should a victim become pregnant. Victims of sexual abuse are tested for sexually transmitted infections. All of the above services are provided to victims at no cost and are

not dependent on the victim's willingness to disclose names or to participate with the investigation.

Compliance was determined by review of the agency medical policies, interviews with residents, and medical and mental health staff.

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)

The facility conducts sexual abuse incident reviews within 30 days of the conclusion of the investigation. The review considers all of the requirements of this standard. The review team consists of the agency PREA Coordinator, deputy warden, a representative from the mental health and medical departments, and the facility PREA manager. Reviews are documented on the critical incident review forms as well as corrective action taken because of the review. A review of the agency policy and interviews with members of the incident review team determined compliance with this 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)

The agency collects data for every allegations of sexual abuse. This information was used to complete the Department of Justice Survey of Sexual Violence in August 2012. The agency began aggregating this information annually in 2012. This information is available on the website. The 2014 data will soon be made public on the website but was not available for this audit. This information is stored in the DACS system and is stored in investigation files.

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)

The agency policy DDOC 8.6 specifies that data is collected and aggregated annually to assist in improving the effectiveness of the agency's ability to assess, detect, and respond to sexual abuse in agency facilities. This auditor reviewed the 2012 and 2013 reports available on the website. The 2014 report was not available at the time of this audit.

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)

The data is collected through information securely and permanently stored in the DACS system. The annual report is available to the public through the agency website. Identifying information is not included in the report.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

_____ _____

Auditor Signature Date

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)

The data is collected through information securely and permanently stored in the DACS system. The annual report is available to the public through the agency website. Identifying information is not included in the report.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

Maggie Cycel _____ 4/27/15 _____

Auditor Signature Date