

**PREA AUDIT REPORT     Interim     Final  
COMMUNITY CONFINEMENT FACILITIES**

**Date of report:** January 16, 2016

Auditor Information			
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<b>Telephone number:</b> 479-521-5142			
<b>Date of facility visit:</b> July 20-24, 2015			
Facility Information			
<b>Facility name:</b> Morris Community Correction Center			
<b>Facility physical address:</b> 300 Water Street, Dover, DE			
<b>Facility mailing address:</b> <i>(if different from above)</i> N/A			
<b>Facility telephone number:</b> (302) 739-4758			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input checked="" type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
<b>Name of facility's Chief Executive Officer:</b> James B. Hutchins, Warden			
<b>Number of staff assigned to the facility in the last 12 months:</b> 35			
<b>Designed facility capacity:</b> 150			
<b>Current population of facility:</b> 145			
<b>Facility security levels/inmate custody levels:</b> Level 4 – Community Corrections (Minimum)			
<b>Age range of the population:</b> 18+			
<b>Name of PREA Compliance Manager:</b> David Benson		<b>Title:</b> Captain	
<b>Email address:</b> <a href="mailto:david.benson@state.de.us">david.benson@state.de.us</a>		<b>Telephone number:</b> (302)657-6100	
Agency Information			
<b>Name of agency:</b> Delaware Department of Correction			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> State of Delaware			
<b>Physical address:</b> 245 McKee Road, Dover, DE 19901			
<b>Mailing address:</b> <i>(if different from above)</i> N/A			
<b>Telephone number:</b> (302) 739-5601			
Agency Chief Executive Officer			
<b>Name:</b> Robert Coupe		<b>Title:</b> Commissioner	
<b>Email address:</b> <a href="mailto:rob.coupe@state.de.us">rob.coupe@state.de.us</a>		<b>Telephone number:</b> (302)857-5389	
Agency-Wide PREA Coordinator			
<b>Name:</b> Michael Records		<b>Title:</b> Planner V and PREA Coordinator	
<b>Email address:</b> <a href="mailto:Michael.records@state.de.us">Michael.records@state.de.us</a>		<b>Telephone number:</b> (302) 857-5389	

## AUDIT FINDINGS

### NARRATIVE

This auditor was hired by the American Correctional Association to conduct the audit of two minimum security community facilities in Delaware. The two facilities share a common warden, deputy warden and captain. The facility procedures (BCCC) in this report apply to both facilities. The facilities captain serves as the compliance manager.

The auditor coordinated pre-audit details with Michael Records, agency PREA Coordinator. Approximately two weeks prior to the audit, this auditor received a flash drive containing the pre-audit questionnaires and copies of electronic files with supporting documentation for each standard. This material was reviewed and a request for additional documents was submitted the week prior to the audit.

On Sunday evening, July 19, 2015, this auditor dined with Christopher Klein, Bureau Chief of Prisons and Alan Grinstead, Bureau Chief of Community Corrections, Michael Records, Agency PREA Compliance Coordinator and Barbara King, a second auditor contracted to audit two separate minimum security facilities, during this same time period. The audit process was discussed over dinner as well as discussions about the agency. The names of random staff and offenders to be interviewed was provided. The two auditors agreed to discuss with each other, any policy modifications or other corrective actions effecting the agency as a whole, to ensure continuity in corrective actions, if any.

The audit began on Monday, July 20, 2015. This auditor initially was welcomed by the Warden, Deputy Warden and Security Captain (also serves as investigator and facility PREA Manager). This auditor explained that a tour, interviews, and video monitoring and review would be conducted at the Morris Community Correctional Center until mid afternoon on Tuesday, July 21, 2015. At this time the auditor would travel to the Central Violation of Probation Center to complete a tour, interviews and video review. This auditor explained that interviews would be conducted for officers on all shifts. To achieve this, the auditor would be reporting early to the facility and would likely be working 8-12 hours each day. Thursday, July 23, 2015 this auditor would meet with designated staff to review standards for both facilities and discuss any corrective actions needed. Friday, this auditor would meet with the Warden, Deputy Warden and PREA Manager to discuss the audit, auditor impressions of the facility's PREA program and corrective actions, if any.

This auditor completed the tour of the facility early afternoon on Monday and began interviewing staff and offenders. The interviews were concluded on Tuesday morning and the auditor exited the facility. On Thursday, the auditor reviewed standards with the PREA Manager, Deputy Warden and intermittently with the PREA Coordinator. This review was concluded around 9:00 p.m. that evening. This auditor met with the Warden, Deputy Warden and Captain/PREA Manager on Friday morning to complete interviews of the executive staff and to summarize the auditor's impression of each facility and to discuss any needed corrective actions.

Following the site visit, this auditor worked in conjunction with Barbara King, Auditor and Michael Records, PREA Coordinator regarding revisions to agency policies. This auditor worked with Michael Records and Deputy Warden Kent Raymond regarding corrective action at the facility. All corrections were made within 30 days of the site visit with the exception of installation of several cameras. An interim report was submitted.

During the corrective action period, this auditor maintained regular contact with Mr. Records and Mr. Raymond. There was some delay in the purchasing and installation of the cameras for the basement and kitchen areas. Mr. Raymond notified this auditor when the cameras were installed and operational. Mr. Raymond also provide photographs of the camera views of each newly installed camera. The concerns noted in the interim report were adequately addressed and facility is in full compliance with the PREA standards.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The Morris Community Correction Center is a level 4 (minimum security) facility. The facility only houses male offenders. The facility has a design capacity of 150 but the average number of offenders is 129. On the day of the audit the population was 145. Morris Community Corrections Center is one of two facilities in the Kent County Community Corrections (KCCC) division. There is one Warden, Deputy Warden, and Captain for the two facilities.

This facility is designed as a work release facility providing a gradual release of offenders into the community. As part of this program, offenders seek employment, re-establish ties with family and friends through weekend phase passes (furloughs), attend medical appointments, address personal business, and participate in mandated treatment programs. Offenders can be court ordered to participate in work release directly from the community, others are transferred to the facility from a prison setting, 180 days prior to release.

Normally offenders participate less than one year with the average stay of 4 to 6 months. Offenders on work release usually work for private employers and participate in treatment and educational programs. While employed, offenders pay \$25 per week toward room and board and \$25 per week toward court costs or fines.

Also participating in the work release program are offenders participating as part of treatment in the CREST program. The CREST program is a substance abuse treatment program using the therapeutic community model. These offenders complete Phase Two and Three of the CREST program at the Morris facility. The facility also employs one sex offender group facilitator.

The facility houses a small population (12 to 14 offenders) who are level 5 offenders classified by the Department of Corrections to Community Corrections to work in the kitchen and laundry areas of the facility.

## SUMMARY OF AUDIT FINDINGS

The corrective action for the Morris Community Correction Center is summarized below:

1. The shower curtains hung from the ceiling to the floor, preventing supervision in the shower area. The facility corrected this by removing 18 inches from the bottom of each shower curtain.
2. Staff interviews revealed many officers were not familiar with the policies regarding inmate interpreters or contacting the interpreter services. This auditor required the use of an interpreter and encountered problems. The facility addressed this by retraining staff in both the policy regarding use of offender interpreter and how to access the interpreter service. A copy of this training was forwarded to this auditor.
3. The maintenance area is located in the basement of the facility. An elevator is used to access the basement. In the basement entry area there is a security camera and one security door to enter the maintenance area. Once inside the maintenance area there are numerous blind spots and the layout is such that supervision of offenders would be very difficult. The facility addressed this concern by restricting offenders from the maintenance area entirely and requesting a wide angle camera to improve visibility of the entrance area.
4. Offenders work in the kitchen area but supervision is impeded due to blind spots and limited visibility. There are no cameras in the kitchen. The kitchen office, back hallways behind the kitchen or the storage area have poor visibility and many blind spots. The facility decided to address this issue by purchasing five additional cameras for this area. During the corrective action period seven (7) cameras were purchased and installed. Screenshots of each camera coverage was provided to this auditor. The addition of these cameras has greatly reduce blindspots and improved supervision of offenders.
5. The form utilized by the counselors after the offender PREA education classes was generic. This auditor suggested using the same form as CVOP. The facility designed a new form that summarizes and highlights the education provided and requires the offender's signature as acknowledgment.
6. The criminal background check process of current employees could not be confirmed. The agency policy was changed to require the Internal Affairs Department to retain a copy of the first page of the most recent criminal background check of current employees.
7. Standard 115.217 (f) was verified for all applicants but not for current employees. The agency explained that revisions are in process for employee performance evaluation but at this time it is inconsistent. The agency suggested and this auditor agreed that the same acknowledgment form used by new applicants will be signed by current employees during the annual PREA refresher training. The agency has an effective system for tracking this training.
8. The agency amended the current contract with New Expectations to include all requirements in standard 115.212.
9. Although all applicants are asked about previous misconduct, this is not done for current employees as part of the promotion process or as part of the reviews of current employees. The form used for new applicants was revised for use the current employees. The employee reviews are not completed regularly for all employees. It was decided that employees would sign this form as part of the PREA refresher training which is tracked and completed annually.
10. The form used for volunteers to sign after their PREA briefing did not include an acknowledgement that the PREA education was received and understood. The form was revised to address these concerns and a signature line was added.
11. This auditor and Barbara King, auditing two other facilities in this same period, worked cooperatively in recommending revisions to Delaware DOC policy 8.60 to include:
  - a. The agency will conduct compelled interviews only after consulting prosecutors.
  - b. Grievances alleging sexual abuse or sexual harassment will be assigned to a PREA investigator and not returned to the Grievance Officer for processing as a typical grievance. Note: Part of the grievance process involves a review by a committee. Other offenders serve on this committee.
  - c. Standard wording was replaced in the policy as it relates to presumptive disciplinary sanctions, for sexual abuse involving staff or contractors.
  - d. Medical and Mental Health practitioners duty to report and limitations of confidentiality was changed to standard wording.
  - e. DOC policy 8.60 did not adequately address the requirements of standard 115.271 (i). The policy was revised to standard wording.
  - f. The contract with New Expectations was revised to include standard wording.

The agency has corrected all areas of concern except for concerns noted for standard 115.213, the areas that prevent adequate supervision, which they are addressing with the installation of new cameras. The cameras have been requested by the facility but they are awaiting approval and installation.

Number of standards exceeded: 3

Number of standards met: 36

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.**

Delaware DOC policy 8.6 entitled Prison Rape Elimination Act (PREA) clearly states the agency position of zero tolerance toward all forms of sexual abuse and harassment. This policy outlines the agency approach to prevent, detect, and respond to conduct of this nature. The Kent County Community Corrections (KCCC) Procedure Manual procedure 8.6 also mandates the agency policy of zero tolerance. These policies provide clear definitions of prohibited behaviors and sanctions for staff, volunteers and/or inmates involved in sexual abuse or harassment.

The agency PREA Coordinator is responsible for and has the authority to develop, oversee and implement the agency’s compliance with the PREA standards. The agency organizational chart indicates the PREA Coordinator reports to the Planning and Research Chief, who reports to the Commissioner.

Compliance was determined through review of the agency and facility policies, discussions with the Commissioner, executive staff, facility staff, offenders, contract personnel, and volunteers. In addition, this mandate is evident in the excellent training provided to staff, PREA information throughout the facility and available on the agency website.

The agency is in compliance with this standard.

**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)

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The agency has recently contracted with the private sector to house selected pregnant mothers in a minimum security setting. The New Expectations Program allows eligible offenders to remain with their infants for the first six months of life. The agency contract does require the facility to adhere to all PREA standards and monitoring by the agency. The PREA Coordinator acts as the agency contract monitor and ensures the program adheres to the PREA standards. This program has only been opened for a few months but the PREA Coordinator will document monitoring visits which will be helpful in future reviews of this standard.

The agency amended the contract to include the requirements for this standard.

The facility is in compliance with this standard.

**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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The facility was designed for 150 residents. Since August 2012, the average daily population is 129. The staffing plan was predicated on a population of 150. During this audit period, there have been no deviations from the staffing plan. KCCC policy 1.4, Security Staffing, outlines the minimum security staffing for the facility. This policy is reviewed annually by the Warden. In February 2015, a more formal detailed staffing plan was completed. This format will be used in future annual staffing plans.

Additional cameras and some upgrades were installed in 2013. Cameras were added to the second floor to include hallways, two treatment staff offices, computer lab and video courtroom. The facility management have determined that additional and upgraded cameras are needed and are anticipated as funds become available. The resident population are minimum security or eligible for community correction placement.

During the tour, there were several areas of concern related to supervision and monitoring of offenders:

Shower curtains hung from the ceiling to the floor preventing officers from monitoring the number of offenders in a single shower. The facility corrected this concern by removing 18 inches from the bottom of the shower curtains thereby allowing the officer to see how many offenders were in the individual showers while still affording the offenders privacy.

The west basement wing which is primarily used for storage of maintenance supplies and equipment presented many blind spots. Offenders often utilized this area under the supervision of correctional officers. The entrance is monitored by one video camera. This camera can view those exiting the elevator and the security entrance door but there was no monitoring mechanism once the offender and/or officer passed the security doors. Initially the facility addressed this concern by restricting offenders from this area. During the corrective action period, the facility purchased a new camera with a wide angled lens which allows for good visibility of the common area. Supplies were relocated to shelving in the common area. Offenders retrieve supplies from this area under supervision of a correctional officer. Correctional officer and offenders are not allowed outside the common area. This is monitored at the control room. The facility provided the auditor with pictures of the camera view of this area. With the restrictions to this area and the installation of the new camera, this area of concern is resolved.

The kitchen area presented concerns. Offenders are utilized in meal preparation and serving. There are no cameras in this area or security staff assigned to this area. The food service area consists of a food preparation area, food storage areas, a back hallway behind the kitchen and an office. There were numerous blind spots and monitoring is very difficult. The facility addressed this concern by requesting the purchase of five cameras for this area. During the corrective action period, cameras were installed in the back of the kitchen, the east back kitchen hallway, the front of the kitchen, the kitchen store room, the kitchen office hallway, and the west back kitchen hallway. The installation of these cameras significantly reduced blindspots, improved visibility into each area and allows for improved monitoring of this area. The facility provided the auditor photographs of the camera view of each of these areas.

The number of serious incidents and sexual abuse allegations were reviewed and the current staffing was considered adequate if the above requests are approved to improve supervision of the offenders. In the event staffing is below minimum level, posts are filled through voluntary overtime or "freezing". Freezing is involuntary overtime, until additional staff can be assigned to relieve staff.

With the reduction in blind spots and improved supervision, the changes to staff and inmate access to the basement area and the installation of cameras in the basement and kitchen, the facility has addressed each area of concern noted in the interim report.

The facility is compliant with this standard.

#### **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)

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DOC and KCCC policy 8.60 prohibits cross gender strip or body cavity searches except in exigent circumstances. In exigent circumstances, the search must be documented on an incident report form and reviewed by the PREA Manager. There have been no such searches during this audit period. This facility is for male residents only, so parts of this standard referring to female residents do not apply.

The above policy also addresses privacy from cross gender viewing for offenders while showering, performing bodily functions and changing clothing. An announcement is made at the beginning of each shift alerting offenders that opposite gender officers are working. Announcements are made when female staff enter a housing area where residents may be toileting, showering or changing clothes. Observations on the tour of the housing areas as well as interviews with staff and inmates confirmed offenders were provided adequate privacy and female staff were announcing their presence when entering the housing area.

The above policy also prohibits searching or physically examining a transgender or intersex resident solely to determine their genital status. There have been no incidents of this occurring during this audit period. All staff interviewed were aware of the policy and procedures for cross-gender and transgender searches. When asked to describe proper search techniques, staff responded appropriately.

The auditor reviewed agency policies and lesson plans for Cross Gender Supervision, Contraband and Searches, and LGBTI and Cross Gender Issues as well as training logs for staff. Training is provided during the pre-service training at the agency training academy and refresher training required annually. This auditor also conducted interviews with randomly selected correctional officers and offenders in determining compliance with this standard.

This facility complies with this standard.

#### **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.**

The agency has taken steps to ensure residents with disabilities and non-English speaking residents are able to participate in and benefit from the agency's efforts to prevent, detect, and respond to sexual abuse or sexual harassment. DOC 8.6 and KCCC 8.6 outline these steps. The state has contracted with LTC Language Solutions, Linguista International, and ACES, LLC to provide interpretive services for non-English speaking residents. Services are available telephonically or in person. The state contracted with All World Language Consultants, Inc. and American Sign Language Inc. (Contract No. GSS15602-LINGUIST) to provide interpreters for deaf and hard of hearing residents. PREA education is available in braille. The facility has developed a form for documenting when these services are accessed.

Delaware policy 8.60 page 5 forbids the use of inmate interpreters, readers or assistants except in circumstances in which a delay could impact the resident's safety. Of the staff interviewed, many did not understand that inmate interpreters should not be used for disabled offenders or offenders who were not English proficient. While conducting offender interviews, this auditor required the use of a Spanish

speaking interpreter. The first interpreter contacted did not have a current contract with the agency. Staff were able to contact an interpreter within 40 minutes of the request. The interpreter was skilled in interpreting for both the offender and the auditor. The facility has addressed this concern by retraining staff at both facilities in the user of offender interpreters.

Within 30 days of completion of the audit, the facility provided additional training for staff in the use of offender interpreters and access to the contracted interpreter services. Staff signed acknowledging they received and understood the training. Verification of this training was provided.

This auditor reviewed agency and facility policies and procedures, contracts, and relied on information received from interviews with the Commissioner, non-English speaking offenders, and random sample of correctional officers to determine compliance with this standard. With the corrective action taken, this facility is in compliance with this standard.

### **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)

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Policies DOC and KCCC 8.60 prohibit the hiring or promotion of anyone who will have contact with offenders, to include volunteers and contract employees, who have engaged in any of the noted acts in this standard. Any incidents of sexual harassment are also considered when making hiring or promotion decisions.

To meet this requirement, the agency requires a criminal background check as part of the pre-employment process. This process also includes contact with prior institutional employers to determine if the applicant had any substantiated allegations of sexual abuse or if the applicant resigned in lieu of termination for such allegations. The internal affairs department completes employment background checks of all employment applicants and began documenting this process in April 2015 following a separate PREA audit. The facility was able to provide verification of these background checks for employees hired after April 2015.

The Internal Affairs Department (IAD) is also charged with completion of criminal background checks to be completed every five years for current employees. The Internal Affairs Department was unable to provide verification of the number of background checks completed for the facility. But they did provide a total number completed for the agency for fiscal year 2014 and for six months in 2015. To check compliance with this standard, this auditor requested the Internal Affairs Department provide confirmation of criminal background checks within the past five years for a random sample of facility staff. Internal Affairs was able to provide a date of the last criminal history check for 72% of the selected employees. It is noted that the internal affairs department began recording the dates of the last criminal background check in response to a PREA audit earlier this year. For 28% of the employees selected there was no date for the last criminal history check.

The PREA Coordinator contacted the Delaware State Police for verification that criminal background checks were completed for the 30% of employees without dates for the last criminal background check. Of these 28% of employees, the Delaware State Police were able to verify that some but not all of these employees received criminal background checks in the past five years.

After much discussion with the agency, it was determined the Internal Affairs Department will maintain the first page of all criminal background checks to allow verification of this process for internal and external audits. The Internal Affairs Department will continue to track dates of the last background check. Delaware DOC policy 8.60 was revised to include these changes and the agency also added that an employee's failure to affirm or material omissions to the questions may result in termination. Further the Deputy Warden conducted criminal background checks for all facility employees during the thirty days following the audit.

Contracted employees are provided identification badges which are valid for a two year period. A criminal background check must be completed for contract employees before identification badges are renewed. The agency is current with background checks for contracted employees.

Applicants are required to complete the PREA Disclosure Agreement form. This form meets the requirements of this standard. Material omissions or false information are grounds for termination. This information is not collected in promotions or during employee reviews. This auditor discussed options to ensure current employees are asked if they committed any of the target offenses detailed in this standard. The policies governing hiring, promotions and performance reviews is issued by the State Office of Management and Budget and would likely require longer than the six month window allowed for PREA compliance following an audit. Additionally, the performance review process is being reviewed and does not occur annually. The agency offered and this auditor agreed that the current PREA Disclosure Form could be modified for use with current employees. This form will be signed by employees during the annual PREA refresher training. The agency has an effective system in place that allows for tracking of annual PREA refresher training.

The agency provides information to other institutional employers regarding substantiated allegations of sexual abuse or harassment.

The employee handbook is provided to each employee and clearly states that all employees have a continuing obligation to report any violation of conduct standards, which includes any PREA related violations.

This auditor reviewed agency and facility policies and procedures, reviewed documentation of criminal background checks and conducted interviews with human resource staff, and other actions as noted above in determining compliance with this standard.

Given the corrections noted above, this standard is in compliance.

### **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)

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There has not been any substantial expansions or modifications to the facility since August 20, 2012. In 2013, a security camera upgrade was performed for safety and security enhancement to the second floor areas consisting of the two treatment staff satellite offices, computer lab, video court room, and adjacent hallways. Prior to this time, these areas were not typically accessible by offenders without staff escort.

Interviews with the Commissioner and Warden, observations noted on the facility tour and noted in 115.213, determined this facility is compliant with this standard.

### **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)

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The agency is responsible for conducting administrative investigations. If an investigation appears to be criminal in nature, it is referred to the Delaware State Police. The Internal Affairs Department is notified of all allegations of sexual abuse or harassment and conducts all investigations involving staff members. Trained investigators are on staff at the facility to conduct administrative investigations. Interviews with investigators confirmed they are trained in the proper interviewing of sexual abuse victims and the collection of evidence.

Victims of sexual abuse are afforded forensic examinations at Bayhealth Medical Center in Dover, DE. The hospital provides SANE/SAFE certified staff to conduct the examination. This auditor contacted the hospital and was able to speak with the Emergency Room Administrator who confirmed this service and stated certified staff are always available to conduct forensic evaluations. There is no charge to the offender for these services.

The facility has an active MOU with ContactLifeLine to provide a 24-hour hotline service for offenders and crisis support for victims of sexual abuse. ContactLifeline staff will accompany the victim through the exam and investigation process if requested by the victim. This agency also provides emotional support, crisis intervention and referral services, as needed.

Compliance for this standard was determined through a review of the MOU with ContactLifeLine, review of agency and facility policies, telephone interview with the hospital emergency room administrator, PREA Coordinator interview and interviews with randomly selected security staff.

### **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.**

KCCC policy #8.60 states, "An administrative and/or criminal investigation will be completed for all allegations of sexual abuse and sexual harassment. If an allegation indicates criminal behavior, it shall be referred to the Delaware State Police for investigation." DOC policy 8.35 entitled, Investigative Responsibilities and Assistance from the Delaware State Police also requires all criminal investigations to be referred to the Delaware State Police. Agency policies are available for review by the public on the agency website: doc.delaware.gov.

During this audit period, the facility received three allegations of sexual abuse/harassment. None of the allegations indicated criminal behavior and investigations were conducted at the facility level. This auditor reviewed the investigation reports and the completed Incident Review of each allegation. Two allegations were determined to be unfounded and one allegation was determined to be unsubstantiated.

Review of investigative reports, and agency policies, as well as, interview with the Commissioner and review of the agency website support full compliance with this standard.

### **Standard 115.231 Employee training**

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion**

**must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The training requirements noted in this standard are addressed in Delaware policy 8.60 pages 6 and 7. This policy requires that all employees with inmate contact receive this training at the academy and refresher training annually. A review of the lesson plan entitled, PREA Basic covers each training topic adequately. Gender specific training is provided at the academy and annually during refresher training. This ensures all employees with offender contact are trained and able to work with offenders of either gender. Upon completion of training employees are required to pass an exam covering course material, verifying the employee understands the training provided.

This auditor determined compliance with this standard through review of course curriculum, agency policies and employee training records to include exam scores and interviews with randomly selected staff.

### **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.**

Delaware policy 8.60 and Kent County Community Correction policy 8.60 require, "for vendors, volunteers and others who are not sworn personnel, the level and type of training will be consistent with the amount of interaction and contact there will be with offenders."

There are ninety-eight (98) volunteers and contract staff with offender contact, at the facility. Of these staff, 100% were provided training required by this standard and agency and facility policies.

The facility provided this auditor with the curriculum for specialized staff training i.e. medical and pharmacy staff, vendor training materials, security briefing pamphlet provided to and covered with volunteers. Exams are required at the conclusion of training for contract staff to include medical, substance abuse treatment, mental health and pharmacy employees. In addition to a policy and document review, several contract employees and volunteers were interviewed. All confirmed receiving and understanding their responsibility to prevent, detect and respond to sexual abuse or sexual harassment. The form used for volunteers to acknowledge the PREA briefing, did not include an acknowledgement that the PREA education was received and understood. The form was revised to address these concerns and a signature line added.

The facility is in compliance with this standard.

### **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.**

Delaware policy 8.60 page 7 and Kent County Community Correction procedure 8.60 page 7, require each offender to be provided PREA education upon intake. This education includes the offender's right to be free from sexual abuse, sexual harassment and retaliation for making reports, instructions for reporting such incidents and the facility's response. Offenders are also provided a PREA Handbook, PREA brochure and the Morris Community Corrections Center Orientation Manual.

Offenders are also provided refresher information upon their arrival at Morris Community Corrections Center. Within 30 days of their arrival offenders participate in an indepth PREA orientation class. The facility provided PREA orientation to 100% of the 566 offenders admitted in the past 12 months. The facility also provided PREA refresher education to 100% of the 294 offenders who were transferred from other community confinement facilities.

The agency maintains an electronic record of all PREA education, and assessments provided to individual offenders at all of the agency's facilities. These records clearly verify the agency and facility commitment to providing timely PREA education and assessments.

This information is also readily available to disabled offenders. All PREA handouts, orientation manuals, posters, signs, and the like are available in Spanish. The offender handbook is also available in braille. There are interpreter services available for deaf offenders who require sign language interpretation.

This auditor reviewed intake records of transferred offenders, interviewed intake staff and randomly selected offenders and reviewed of education material and related agency and facility policies as well as materials provided for disabled offenders in determining compliance with this standard.

### **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.**

Delaware policy 8.60 page 7 and KCCC procedure 8.60 page 7 require all investigators responsible for conducting administrative investigations are to receive specialized training related to PREA. The Employee Development Center is charged with ensuring specialized training for investigators is available and maintaining records that allow tracking of this training.

This auditor reviewed the training curriculum provided for agency investigators. This review included: Sex Crime Investigations and Specialized PREA Training: Investigations. Both curriculum provided excellent training material which sensitized the investigator to the dynamics of sexual abuse in the correctional setting and provided clear and relevant information about crime scene preservation, interviewing techniques, determining credibility, and evidence collection in a correctional setting.

This auditor also reviewed training records for the facility investigators and conducted interviews with investigators. The facility is in compliance with this standard.

### **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.**

The Bureau of Correctional Healthcare Services policy B-05, pages 1 and 2 as well as Delaware Policy 8.60 page 7 and KCCC procedure page 7 outline the requirements for medical and mental health staff to receive specialized PREA training. Medical and mental health staff are provided initial and annual PREA training which includes detection and assessment of sexual abuse and/or sexual harassment, evidence preservation, professional and effective response to victims, and reporting procedures for reporting sexual abuse or sexual harassment.

The training and training materials are approved by the Employee Development Center. The Employee Development Center also retains training records for these contract employees. Employees must pass an exam following the training to ensure they understood the training they received.

This auditor reviewed the initial PREA training curriculum and the specialized training curriculum and employee training records. This auditor also interviewed medical and mental health staff to determine compliance with this standard.

#### **Standard 115.241 Screening for risk of victimization and abusiveness**

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Delaware policy 8.60 page 8 and KCCC procedure 8.60 page 7 mandate that an initial assessment will be completed within 72 hours of intake to determine risk to be sexually abused or sexually abusive. The agency utilizes an initial screening using the Sexual Victimization Quickscreen and Sexual Aggressor Quickscreen for all offenders. This risk assessment tool considers 13 factors when making an initial assessment for potential risk of victimization. This screening tool considers separately whether the offender has been victimized in the community and/or victimized while incarcerated and also if the offender is detained on a sex offense against a child. This tool also considers whether the offender appears weak or fearful. There are seven (7) factors considered when making an assessment for risk of sexual aggression. In addition to the three (3) required criteria, this risk assessment assesses physical build, gang affiliations, aggressive disciplinary histories, aggression toward staff, and prior victim of sexual abuse. A second assessment, the 21 Day Periodic Sexual Victimization Assessment and the 21 Day Periodic Sexual Aggressor Assessment, is typically completed within 21 days of intake.

The results of the risk assessment is entered into the DACS system. The responses to these questions is placed in the inmate record which is accessible only to those staff with a need to know. All 566 offenders who were received at the facility during the 12 month audit period were assessed and reassessed using these assessment tools.

Interviews with staff who conduct the risk assessments as well as a random sampling of residents confirmed that the screening is being completed as required by this standard. In fact, all risk assessment are completed within hours of intake into the facility and within 21 days of admission, which exceeds the requirement of this standard.

#### **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.**

How the screening tool is to be used, is defined in Delaware policy 8.60 page 8 and KCCC procedures 8.60 page 8. The screening tool is to be used to make individualized decisions regarding housing, bed, work, education, and program assignments. The DACS system does not allow confirmed victims and aggressors to be housed in the same housing area. The DACS system sends an alert if a staff member attempts to house potential aggressors and potential victims in the same housing area.

This facility provides a treatment program for sexual offenders. This population tends to score higher on the victim and aggressor assessments. This auditor looked closely at the housing of these offenders. Staff makes every attempt to separate these offenders. If they are placed in the same housing area, bed placement is assigned to allow maximum visibility by officers assigned to this area.

Although there are no transgender or intersex offenders housed at this facility at this time, agency policy requires that the offenders own view of their safety is taken into consideration. This auditor questioned the PREA Manager and administration as to how accommodations would be made in the event a transgender or intersex offender was placed at the facility. Staff has made provisions for the offender to shower separately and housing and bed assignment would ensure the offender is in easy sight of security staff.

Interviews with the PREA Coordinator, PREA Manager, facility administration and staff responsible for conducting risk screening was used to determine compliance with this standard. This auditor also reviewed agency and facility policies as well as the DACS alert system.

The facility is in full compliance with this standard.

### **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.**

Delaware policy 8.60 page 8 to 9 and KCCC procedure 8.60 page 8 define multiple ways for offenders to report sexual abuse, sexual harassment or retaliation. KCCC 8.60 defines nine (9) separate options for offenders. These options include: reporting to a staff member, submitting a sick call request or grievance, a phone call to someone outside of the facility who can make the report, contacting the facility investigator, internal affairs or the PREA Coordinator, writing a sealed, confidential letter to the warden, a call to the PREA hotline, or contacting outside resources.

The facility has an MOU with ContactLifeline to provide a confidential hotline for offenders to make such reports. Contact information for ContactLifeline is posted in each housing area and throughout the facility. The ContactLifeline staff make immediate contact with the PREA Coordinator. The PREA Coordinator immediately notifies the facility to take appropriate action to protect the offender and to investigate the complaint. This auditor observed this process on several occasions during the audit week.

Staff accept verbal, written or third party reports of abuse or harassment and immediately document such reports. During the interviews, staff understood this standard and reported they would immediately document any verbal reports. Offenders also responded affirmatively to this question.

Staff are afforded several options for privately reporting sexual abuse, sexual harassment or retaliation to include, contacting the PREA Coordinator, Internal Affairs, Warden Deputy Warden, PREA Manager, PREA hotline and filing a grievance or sick call. When interviewed, staff were able to cite two or more options for reporting privately.

The PREA Informational flier is written specifically for employees. This flier includes instructions for privately reporting and also clearly states that employees are mandatory reporters. This standard is addressed in Delaware policy 8.60 pages 8 – 9, and KCCC procedure 8.60 page 8.

This facility is in compliance with this standard.

### **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.**

The agency has a grievance procedure for offenders, so it is not exempt from this standard. Delaware policy 8.60 page 11, KCCC procedure 8.60 pages 13 to 14 and Bureau of Community Corrections procedure 4.4 address the grievance process as it relates to PREA complaints.

There are no time limits imposed as to when an offender may submit a grievance of an allegation of sexual abuse or sexual harassment. Offenders are not required to submit an informal grievance prior to filing a formal grievance for allegations of sexual abuse. The offender is not required to submit the grievance to a staff member who is the subject of the complaint nor will the complaint be referred to a staff member who is the subject of the complaint. An offender may be disciplined for filing a grievance related to sexual abuse only where the agency can demonstrate that the offender filed the grievance in bad faith.

Third parties are allowed to file and/or assist the offender in filing a grievance related to sexual abuse. The Warden or designee may require that the alleged victim agree to the filing of the grievance prior to processing the complaint. Staff will document if the offender declines to have the complaint filed on their behalf.

The agency grievance procedures allow for grievances to be reviewed by a committee that includes offenders. This auditor had concerns about another offender being privy to grievances filed related to an allegation of sexual abuse or harassment against another offender or staff. To address these concerns, Delaware policy 8.60 was revised to read:

“Any allegation of sexual abuse or sexual harassment made via the Department’s offender grievance system, shall immediately be investigated as a report of sexual abuse. A copy of the grievance report will be provided to the shift commander, who will ensure the complaint is assigned to a PREA investigator. At no time will this complaint be returned to the grievance officer for processing as a typical grievance complaint.”

During this audit period, there were no grievances filed related to sexual abuse or grievances filed alleging substantial risk of imminent sexual abuse during this audit period.

A review of the agency and facility PREA policy and procedure to include revisions and the agency grievance policy were reviewed in determining compliance with this standard.

The agency is in compliance with this standard.

### **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.**

Delaware policy 8.60 page 9 states that the agency will provide offenders with access to outside advocates. The services provided are to include emotional support services in the event of sexual abuse. Contact information which includes mailing addresses and phone numbers for these services will be provided to offenders. In addition, a toll free hotline will be available to allow reasonable and confidential communications between the offender and the advocate.

ContactLifeline entered into a MOU with the agency to provide confidential emotional support services to include a crisis line, accompany the victim to the hospital, and/or in-person crisis counseling. The unmonitored crisis line is provided by the agency. If requested by the victim, follow-up and on-going contact with the offender will be allowed by the agency. The advocate is allowed to provide support to the victim during the forensic medical examination and investigatory interviews. The advocate may refer the victim to the facility's medical and/or mental health staff.

The contact number for the rape crisis center is provided on posters posted throughout the facility to include each housing area, visitation, hallways etc. The posters includes information for the offenders regarding the confidentiality of the calls. The posters state,

“Please be aware we are attempting to provide you with as confidential a communication source as is possible. However, we can't guarantee that staff or other offenders may not overhear your conversation. This number is not monitored by DOC. Matters you discuss with the hotline will only be reported to DOC if you request, or if there is an immediate threat to your safety or others.”

This auditor determined the facility was in compliance with this standard by reviewing agency and facility policies, viewing hotline information posted throughout the facility and in handbooks and brochures, interviewing a random sample of offenders and reviewing the MOU established between ContactLifeline and the agency.

#### **Standard 115.254 Third-party reporting**

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Delaware policy 8.60 page 9 states that the agency will accept third party reports of sexual abuse and harassment either verbally, in writing, or anonymously. The agency makes these reporting methods known to the public through the agency website (doc.delaware.gov), posters posted in the visitation area, lobby, and offender living areas, brochures which include the PREA Coordinator brochure, pamphlets and handouts. Third party reporting methods are also outlined in offender orientation and in staff training.

Interviews with offenders and review of agency policies, PREA posters, website information available to the public, and review of PREA education for offenders confirmed that the agency was in compliance with this standard.

### Standard 115.261 Staff and agency reporting duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Delaware DOC policy 8.60 page 9 and KCCC procedure page 9 require all staff to report immediately any knowledge, suspicion, or information regarding sexual abuse or harassment of an offender. The agency also requires all staff to report any retaliation toward offenders or staff for making such reports or cooperating with investigations. Staff are also required to report any staff violation or neglect of duties that may have contributed to an incident of sexual abuse or harassment.

Agency policy prohibits staff from revealing any information related to a sexual abuse or harassment incident, except for reporting to supervisors and as necessary to investigate the incident, treat the victim, or safely house the victim and aggressor. The agency will report any allegation of sexual abuse of an offender under the age of 18 to the Department of Services for Youth, Children and Families. If an allegation of sexual abuse is made by an offender who is considered a vulnerable adult, Adult Protective Services is notified. There are no vulnerable adults or offenders under the age of eighteen at this facility. Of the random staff interviewed, all were aware of their duty to report any knowledge, information or suspicions regarding sexual abuse, sexual harassment, retaliation, or staff neglect or violation of duty that may have contributed to an incident or retaliation. All random staff interviewed were also aware of the procedure for reporting this information.

All Mental Health and Medical staff interviewed confirmed that they disclose the limitations of confidentiality and duty to report at the initiation of services. All staff interviewed understood that they are required to report any knowledge, suspicions, or information regarding sexual abuse or harassment to a supervisor immediately upon learning of it. Several staff shared they had become aware of such incidents and reported them as required. It was clear that staff practiced their duty to report and informed consent. The policy was somewhat vague in this regard. The agency addressed this concern by clarifying these responsibilities in the agency policy.

KCCC procedure 8.60 page 9 requires all complaints or suspicions of sexual abuse or harassment to be submitted to the facility investigator and PREA Manager (in this case, one person fulfills both roles). This is accomplished through the DACS system or through email if the staff member does not have DACS access.

A review of agency policies and revisions to the policies, interviews with the Commissioner, PREA Coordinator, Medical and Mental Health staff, and a random selection of correctional officers determined compliance with this standard.

The facility is in compliance with this 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.**

Delaware DOC policy 8.60 page 4 and KCCC procedure 8.60 pages 9-10 require that immediate action is taken to protect the offender if the agency learns the offender is at substantial risk of imminent sexual abuse. This is also clearly stated in the DOC Sexual Abuse Response Plan.

The facility is in compliance with this standard as evidenced by a review of the relevant policies and procedures and interviews with the Commissioner, Warden, Deputy Warden, and randomly selected correctional officers.

**Standard 115.263 Reporting to other confinement facilities**

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Delaware DOC policy 8.60 page 9 – 10 and KCCC procedure 8.60 page 11 define the steps staff must take when an allegation of sexual abuse at another facility is received. The head of the facility that received the allegation will report to the head of the facility for which the abuse allegedly occurred within 72 hours. The reporting facility will document that the notification was made. The facility in which the alleged incident occurred will refer the incident to appropriate investigators for investigation.

There was one incident of an offender reporting an alleged threat of sexual assault by another offender while at the Morris Community Corrections Center. The report was investigated immediately and documented. There were no incidents received by Morris CCC staff of sexual abuse or harassment at another facility.

This auditor determined compliance with this standard by reviewing agency policy, facility procedures, the investigative report, and tracking forms, as well as, interviews with the Commissioner, Warden, Deputy Warden, and PREA Manager. The facility is in compliance with this standard.

**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.**

The Delaware Sexual Abuse Response Plan outlines how employees are to respond to a sexual abuse incident. The first security responder on the scene is to ensure the victim is safe and to accompany the victim to the medical unit for immediate attention. The response plan outlines the notification steps and the importance of securing the crime scene and protecting evidence. If the assault occurred within 72 hours the Sexual Abuse Response Plan requires that the victim be asked and the abuser be required not to brush teeth, wash, change clothing, urinate, defecate, drink or eat. The abuser will be placed in a dry cell to preserve evidence. If the first staff responder on the scene is not a

security staff member, the responder will be required to request that the victim not take any action that could destroy physical evidence and to notify the supervisor.

In the past twelve months, there were three allegations that a resident was sexually abused. Of these incidents, there were two occasions in which the victim was separated from the abuser. Only one incident was reported within a time period that allowed for collection of physical evidence. The incident reports and completed investigations for each of these incidents were reviewed by this auditor with no problems noted.

The security and non-security staff interviewed were well aware of their duties if they receive an allegation of sexual abuse.

Compliance was determined by a review of the Delaware Sexual Abuse Response Plan and interviews with security and non-security staff and a review of the incidents.

### **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.**

The agency and facility have developed a plan to coordinate actions in the event of a report of sexual abuse. This plan coordinates the actions of first responders, medical and mental health staff, investigators, the shift commander, the PREA Manager and the Warden. The agency and facility plan was reviewed by this auditor to determine compliance with this standard, as well as, responses from the agency Commissioner.

This facility is in compliance with this standard.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The agency has entered into or renewed four union contracts since August 2012. The contracts are with: Fraternal Order of Police, Probation and Parole Lodge #10, Local 247, State Merit Bargaining Unit 10, and Merit Employee Compensation Unit 11 Bargaining Coalition. The auditor reviewed each contract and found the agreements do not limit the agency's ability to remove alleged staff sexual abusers from contact with any offenders, pending the outcome of an investigation. The contract also will not interfere with a determination of whether and to what extent discipline is warranted.

The facility is in compliance with this standard.

### 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.**

Delaware DOC policy 8.60 page 4 states that a staff member will be assigned to protect and monitor for evidence of retaliation any offenders and staff who report the sexual abuse or participate in the investigation. The policy directs the facilities to assign a staff member to monitor retaliation. KCCC procedure 8.60 page 11 states that the PREA Manager will be responsible for monitoring retaliation for a minimum of 90 days. The PREA Manager is responsible for in-person status checks, monitoring offender disciplinaries, program or housing changes and negative performance reviews or reassignment of staff.

To determine compliance with this standard, this auditor reviewed agency and facility policy and procedures and considered information obtained from interviews with the Commissioner, Warden, and PREA Manager. This auditor also considered information received from interviews with offenders who had experienced sexual abuse while incarcerated (not necessarily at this facility). All of these offenders felt protected at this facility.

The facility is in compliance with this standard.

### Standard 115.271 Criminal and administrative agency investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Delaware DOC policy 8.60 page 10 addresses PREA investigations within the agency. This policy requires all investigations of allegations of sexual abuse and harassment, to include third party and anonymous reports, to be conducted promptly, thoroughly and objectively. The agency is responsible for conducting administrative investigations. If it is determined the incident is of a criminal nature, it is referred to the Delaware State Police and compelled interviews are not conducted. If the Delaware State Police determine a crime has been committed, the DSP will refer the case to the Attorney General Office for prosecution.

The agency investigators have been trained to conduct sexual abuse investigations in a confinement setting. Investigators are provided three courses that address the special conditions which affect sexual assault in a confinement setting. The training includes evidence collection to include DNA, obtaining video evidence, interviewing techniques of victims and abusers, and the importance of reviewing prior sexual abuse/harassment complaints involving the perpetrator. Two of the courses are provided by staff from the Delaware State Police, the third course is provided by the agency PREA Coordinator.

The credibility of the victim, witnesses or abuser is decided on an individual basis. Credibility is not based on the person's status as offender or staff. The alleged victim is not required to submit to a polygraph or other truth-telling device as a condition for proceeding with an

investigation.

Administrative investigations include efforts to determine if staff actions or failure to act contributed to the abuse. The investigations are documented in the DACS system. The reports include all of the requirements of this standard: description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. These reports are retained permanently in the DACS system. When the Delaware State Police conduct the investigation, facility staff cooperate with the investigation, and the PREA Manager checks the status of the investigation regularly.

The PREA Manager and one staff lieutenant are trained to investigate all PREA related reports within the facility. The designated staff lieutenant is currently on leave due to illness. If needed, the Center for Violation of Probation facility would provide an additional investigator. Both facilities are administered by the same Warden, Deputy Warden and Captain (PREA Manager).

This auditor reviewed the training curriculum for investigator training, reviewed agency and facility policies and procedures, and used information obtained from interviews with the Commissioner, PREA Coordinator and investigative staff in determining compliance with this standard.

The facility is in full compliance with this standard.

### **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.**

Delaware DOC policy 8.60 page 11 and KCCC procedure 8.60 page 12 require that administrative investigation will not require a standard higher than a preponderance of the evidence when determining whether an allegation of sexual abuse or sexual harassment is substantiated. Investigators interviewed were aware of this requirement.

The facility is in compliance with this standard.

### **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.**

Delaware DOC policy 8.60 page 10 requires that a victim and any third party reporter will be notified in writing that a case has been closed as substantiated, unsubstantiated, or unfounded. Further, the policy states that where cases are referred for criminal prosecution, the

designated staff member (PREA Manager at this facility) will follow the case until it has been determined to be substantiated, unsubstantiated or unfounded and will notify the victim or any third party reporter in writing of this determination. When an arrest is made or prosecution is pending, the PREA Manager is required to notify the victim. The PREA Manager will also notify the victim in writing each time the case moves from one step of the adjudication process to the next. If a staff member allegedly committed the sexual abuse and the case is substantiated or unsubstantiated, the offender will be informed when the staff member is no longer assigned to the unit or employed by the facility, or if the staff member is indicted or convicted related to the sexual abuse.

In the event the allegation is against another offender, the victim is informed if the alleged abuser is indicted or convicted related to the sexual abuse. All of these notifications are documented.

There were three allegations of sexual abuse within the audit period. In each case, the resident was notified in writing of the results of the investigations. All of these incidents were handled administratively. There were no incidents, substantiated or unsubstantiated, against staff members during this period.

This auditor determined compliance with this standard by reviewing each investigation file and notification documentation, reviewing agency and facility policies, and through interviews with the Commissioner, investigative staff, PREA Manager, Deputy Warden, and offenders who had reported a sexual abuse.

### **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.**

DOC policy 8.60 page 11 addresses disciplinary sanctions for staff. The policy read, "Staff shall be subject to disciplinary sanctions up to and including termination for substantiated cases of sexual abuse." At the request of the auditor, the agency policy was revised and now states, "...substantiated cases of sexual abuse or sexual harassment."

The policy requires that termination will be the presumptive sanction for employees who have engaged in sexual abuse of an offender. Other than actually engaging in sexual abuse, the agency considers the employee's disciplinary history and the nature and circumstances of the offense. The sanctions imposed are also consistent with sanctions imposed for comparable offenses with other employees with similar histories.

When employees are terminated or resign in lieu of termination for violations of sexual abuse or sexual harassment are referred to the Delaware State Police if the offense is of a criminal nature. Relevant licensing bodies are also notified of the abuse/harassment.

There were no staff at this facility who violated agency sexual abuse or sexual harassment policies.

This facility is in compliance with this standard.

### **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.**

Delaware policy 8.60 page 12 addresses the agency policy for handling substantiated cases of sexual assault against a vendor or volunteer. The policy requires that all contact with offenders will be barred and the case will be referred to the Delaware State Police. There have been no instances of these offenses during this audit period.

The facility is in compliance with this standard.

#### **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.**

Delaware policy 8.60 page 13 addresses discipline for offender-on-offender sexual abuse. The discipline process is defined in KCCC procedure 4.6 and the Bureau of Community Correction procedure 4.3.

Offenders are subject to disciplinary sanctions following a formal disciplinary process, and administrative finding of guilt for engaging in offender-on-offender sexual abuse or sexual harassment or criminal finding of guilt for offender-on-offender sexual abuse. These sanctions are commensurate with the resident's disciplinary history, and sanctions imposed for similar offenses and histories. The disciplinary process considers the offender's mental disability or mental illness when determining sanctions and does not sanction offenders for reports made in good faith. Offenders are not sanctioned for sexual activity with staff unless the staff member did not consent to the contact. The agency prohibits sexual activity between offenders. Uncoerced incidents of sexual activity is not considered sexual abuse.

The disciplinary team consists of a multi-discipline team of security and treatment staff appointed by the Warden. Sanctions are considered final when reviewed and approved by the Warden. The Mental Health staff offers counseling or other interventions to address the underlying reasons for the abuse.

This auditor determined compliance through a review of agency and facility policies, investigative and disciplinary reports, interviews with the Commissioner and Mental Health staff.

#### **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.**

Delaware policy 8.60 page 13, KCCC 8.60 page 14, and Bureau of Correction Health Services (BCHS) B-05 page 2 mandates the emergency medical and mental health services that will be provided to victims of sexual abuse. Offenders are provided timely, unimpeded access to emergency medical treatment and crisis intervention services at no cost to the offender. Victims are not required to name the abuser or cooperate with the investigation to receive access to treatment services. Medical and mental health staff determine the nature and scope of the services provided, according to their professional judgment. In the event no qualified medical or mental health practitioner was available at the time a report of recent sexual abuse was made, security first responders are required to take preliminary steps to protect the victim and will immediately notify the medical and mental health practitioners.

BCHS policy B-05 page 3, states, "the victim will receive an immediate referral to the site mental health department, upon return from the outside emergency care facility, for off hour returns the mental health on-call system will be utilized. Mental health (staff) will conduct a mental health evaluation to include suicide risk assessment of the victim and assess the need for crisis intervention counseling and long term follow-up within two hours of notification."

While incarcerated, victims of sexual abuse are offered information and timely access to sexually transmitted infection prophylaxis where medically appropriate and in accordance with professionally accepted standards.

This auditor reviewed relevant policies, procedures and interviewed medical and mental health staff in determining the facility is in compliance with this standard.

**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.**

Delaware policy 8.60 page 13 mandates if the intake screening, 30 day security screening, medical intake or subsequent mental health screenings indicate the offender has experienced prior sexual victimization, whether it occurred in an institutional setting, or in the community, staff will ensure the offender is offered a follow-up meeting with a medical or mental health within 14 days of that screening.

BCHS B-05 page 3, provides for the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans and referrals for continued care following a transfer or placement in other facilities or release from custody. This procedure also requires that mental health staff shall attempt to conduct a mental health evaluation and suicide risk assessment of the alleged perpetrator within 72 hours of the incident to assess the need for sexual violence counseling.

As noted in the previous standard, victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted diseases as medically appropriate and treatment services are provided at no cost to the victim.

Interviews with medical and mental health staff revealed the staff was well trained in these policies and understood their responsibilities in these incidents.

Compliance was determined through a review of medical case notes, relevant policies and procedures, and interviews with medical and mental health staff. The facility was in compliance with this standard.

**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.**

Delaware policy 8.60 page 14 mandates that a sexual abuse Critical Incident Review (CIR) will be conducted at the conclusion of every sexual abuse investigation. The agency exceeds the standard which requires sexual abuse incident reviews for all substantiated and unsubstantiated cases. The CIR is initiated within 30 days of the conclusion of the investigation and will be completed within 90 days, except in exigent circumstances.

The CIR team includes the Warden or Deputy Warden, the facility PREA Manager, a facility or internal affairs investigator, medical/mental health administrators, the agency PREA Coordinator and other staff deemed appropriate by the facility. The team considers whether a policy or practice change is indicated to improve detection, prevention or response to sexual abuse. The team considers whether the incident was motivated by race, ethnicity, gender identity, gay, transgender or intersex identification status or perceived status, gang affiliation, or other group dynamics at the facility. The area where the incident allegedly occurred is examined to assess whether the physical barriers in the area may enable abuse. Staffing and monitoring technology is assessed. The final review of the CIR report is completed by the Bureau Chief. All substantiated and unsubstantiated cases are reviewed on-site where the incident occurred. Unfounded cases may be reviewed remotely by electronic means.

The questionnaire asks for the number of reviews conducted in the past 12 months, excluding unfounded. There was one case that was reviewed according to this criteria.

This auditor reviewed each CIR report and discussed each case with the Deputy Warden and PREA Manager. The reports met the requirements of this standard. This auditor also reviewed relevant policies and procedures and interviewed members of the incident review team, PREA Coordinator and Commissioner in determining compliance. The agency's requirement to review all allegations of sexual abuse exceeds the requirement of this standard.

#### **Standard 115.287 Data collection**

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Delaware policy 8.60 page 14 outlines the requirement for data collection. The policy requires accurate, uniform data will be collected for every allegation of sexual abuse, using a standardized instrument and set of definitions. This is achieved by entering all incidents into the Delaware Automated Correctional System (DACS) upon completion of the incident reports. This system of data collections allows the agency to aggregate data as needed. The agency provides this information annually to the United States Department of Justice.

The agency also reviews this data to assess and improve the effectiveness of the sexual abuse response plans and related policies. Compliance was determined through review of the agency policies and review of the information provided on the website.

The facility is in compliance with this standard.

### 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.**

Delaware policy 8.60 page 14 states that the agency will review the data in order to assess and improve the effectiveness of its sexual abuse response plans and policy. This information is provided in an annual report which compares the current year to previous years to include corrective actions. This report provides an assessment of the agency's progress in addressing sexual abuse. This report is approved by the Commissioner and available on the agency's website for viewing by the general public. The agency removes personal identifiers in the report as well as material that presents a clear threat to security or safety.

This auditor reviewed the agency policies and the 2013 annual report, as well as a 2013 addendum.. The 2013 report compares data from the calendar year 2012 and 2013. The report was also viewed on the agency website. Interviews with the Commissioner and PREA Coordinator was also considered in determining compliance with this standard.

### 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.**

Delaware policy 8.60 page 14 mandates that the agency will maintain sexual abuse data collected for at least 10 years after the date of the initial collections unless Federal, State, or local laws requires otherwise. The policy also mandates that all written reports will be retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

This information is stored securely in the agency DACS system indefinitely, which exceeds the requirements of this standard. Compliance with this standard was determined by review of applicable agency standards, public reports provided on the agency website, and interview with the agency PREA Coordinator.

### 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.

Maggie Capel

January 16, 2016

Auditor Signature

Date