

Staff Report

May 2026

Focused Review:

**Monitoring of Health Care
Grievances and
Vendor Contracts
within Delaware's
Correctional System**

- **Adult Correction Healthcare
Review Committee**

153rd General Assembly, 2nd Session

*Respectfully submitted to the
Joint Legislative Oversight and Sunset Committee*

Authored by: Division of Legislative Services



**JOINT LEGISLATIVE OVERSIGHT
& SUNSET COMMITTEE**

Adult Correction Healthcare Review Committee

Focused Review: Monitoring of Health Care Grievances and Vendor Contracts within Delaware's Correctional System.

This focused review examined how well the Adult Correctional Health Care Review Committee fulfills its statutory duties, as they relate to the monitoring of health care grievances and vendor contracts within Delaware's correctional system.

This review found that although the Committee was created to provide correctional health care system oversight, it is not operating in alignment with its statutory duties or national best practices. Its work remains focused on individual case reviews, with no structured process for analyzing data, identifying trends, or tracking recurring issues. The Committee plays only a minimal role in vendor contract oversight and relies heavily on information from the Department of Correction, with limited independent analysis or engagement with external stakeholders. Its advisory impact is further weakened by outdated public reporting and unclear expectations around information sharing. As a result, Delaware lacks a correctional health care oversight system with the independence, structure, and data-driven processes needed to identify systemic issues and support meaningful improvement.

“Delaware lacks a correctional health care oversight system with the independence, structure, and data-driven processes needed to identify systemic issues and support meaningful improvement.”

Key issues identified during this Adult Correctional Health Care Review Committee review include:

- Broad statutory duties without the processes or data systems needed to carry them out.
- No structured process to analyze grievance data and identify recurring system-level issues.
- No tracking or identifying recurring issues from grievances or case reviews.
- No involvement in health care vendor contract development.
- No systematic processes to evaluate or monitor contractor performance.
- Oversight that relies primarily on information provided by the Department of Correction, with limited independent analysis or stakeholder input.
- Outdated public reporting that lacks system-level analysis or follow-up.
- Unclear and inconsistent information-sharing and advisory responsibilities.
- A structure that does not align with national correctional oversight best practices.
- No fully independent review of grievance processes or health care vendor contracts.

This report identifies structural and information gaps that limit the Committee's ability to fulfill its statutory duties, along with opportunities to address them.

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I. About This Report

This staff report, prepared by the Division of Legislative Services (“DLS”), provides a focused review of the role and activities of the Adult Correction Healthcare Review Committee (“ACHRC” or “Committee”) as they relate to the monitoring of health care grievances and vendor contracts within Delaware’s correctional system. The Joint Legislative Oversight and Sunset Committee (“JLOSC”) selected this topic and assigned it to the Division of Legislative Services staff on June 26, 2025.

JLOSC is a bipartisan 10-member legislative body which performs periodic legislative review of the performance and activities of state entities designed to increase accountability and improvement. The primary purpose of any JLOSC review is to assess genuine public need and performance of the entity under review. JLOSC performs its duties with support provided by the dedicated and objective staff of DLS. DLS serves as an independent and confidential reference bureau for the General Assembly and supplies many services, including staff support for JLOSC.

JLOSC staff completes focused reviews as assigned by majority vote of JLOSC members. A focused review contrasts with the broader evaluation of a full review and evaluates a component within an entity, such as a specific statute, policy, rule, regulation, or program related to the entity. JLOSC and its staff define the scope of a focused review, guiding the research process. Once the research is completed, a staff report is prepared for JLOSC members, summarizing the research, findings, conclusions, and recommendations.

JLOSC staff prepared this report following research conducted in line with an agreed-upon project scope. The focused review adhered to national evaluation standards, requiring thorough planning and execution to gather sufficient evidence supporting the findings and conclusions based on the review’s objectives and scope. Staff believe the evidence obtained provides a reasonable basis for their findings and conclusions. Additionally, the Objectives, Scope, Methodology section discusses the fieldwork procedures used while conducting the research and developing this report.

This staff report contains staff recommendations for JLOSC to review and discuss. JLOSC members are not obligated to adopt the staff’s recommendations and may modify or reject them, or propose new ones. Final recommendations are determined during public meetings and adopted with an affirmative vote from 7 members. Once JLOSC adopts recommendations, the review progresses to the implementation phase, which may involve drafting legislation.

Next Steps

JLOSC will hold a public meeting to receive an overview of the staff report and accept public comment on the scope of the review.¹ Following this, JLOSC will determine the appropriate next steps, which may include adopting recommendations or scheduling additional meetings for further discussion.²

¹ Public meeting notices found on JLOSC’s website and the State of Delaware’s Public Meeting Calendar.

² [29 Del. C. § 10214](#).

II. Objective, Scope, Methodology

Objective

The objective of this review is to examine the role and activities of ACHRC as they relate to the monitoring of health care grievances and vendor contracts within Delaware's correctional system.

Scope

This focused review examines the role and activities of the ACHRC as they relate to the statutory duties of monitoring of health care grievances and vendor contracts within Delaware's adult correctional system. The goal is to assess how effectively the ACHRC advises the Governor, General Assembly, and Department of Correction ("DOC") in these areas, and how the ACHRC's work contributes to identifying and addressing recurring issues and shaping contractual frameworks that govern health care delivery for incarcerated individuals.

This review covers the period of January 2022 through January 2026 and includes the following 5 review objectives:³

- Review Objective #1: How the Committee performs its role in reviewing monthly summaries of health care related grievances and resolutions.
- Review Objective #2: What the Committee's process is to analyze, identify, and address recurring issues from reviewed health care grievance summaries.
- Review Objective #3: How the Committee performs its role in health care vendor contract construction.
- Review Objective #4: How the Committee carries out its role in monitoring the quality and appropriateness of health care services delivered by a contractor in Delaware's adult correctional facilities.
- Review Objective #5: How the Committee carries out its advisory role to the Governor, General Assembly, and DOC Commissioner relating to the communication of findings, concerns, and recommendations related to health care delivery for incarcerated individuals.

Methodology

This review relied on publicly available information, as well as materials provided by Criminal Justice Council ("CJC") staff, such as ACHRC meeting minutes, agendas, and responses to JLOSC staff questions.⁴ Additional sources included relevant legislation, DOC policies on health care and grievance processes, vendor contracts, published reports, and news coverage related to correctional health care in Delaware. Audio of debates in the Delaware House of Representatives and Senate was reviewed to better understand the legislative intent behind ACHRC's creation. Contracted reviews and Committee annual reports published before the review period were also examined to provide context on prior recommendations and

³ These 5 review objectives are addressed in sections IV through VIII of this report.

⁴ CJC staff also serve as staff support for ACHRC.

assessments of correctional health care in Delaware, as contracted reviews completed during the review period were not accessible.

To supplement the document review and provide additional context on Committee operations, JLOSC staff conducted interviews with members of the General Assembly, members of the public, CJC staff, and the ACHRC chair.

This review focuses on ACHRC's structure, statutory responsibilities, and operational practices, with emphasis on processes, information flow, and alignment between statutory duties and Committee activities. This review does not assess the appropriateness of decisions, evaluate individual grievances, or vendor performance. Fieldwork consists of document analysis, review of CJC-provided materials, and stakeholder interviews.

Fieldwork Completed

- Reviewed relevant websites, public documents, and news articles.
- Reviewed related ACHRC legislation and audio from enabling legislation:
 - House of Representatives chamber, June 24, 2008, House Bill No. 446.
 - Senate chamber, July 1, 2008, House Bill No. 446.
- Reviewed ACHRC annual reports, 2018–2025.⁵
- Reviewed Council on Correction annual reports, 2022–2024.
- Reviewed CJC staff structure, website, and budget documents.
- Reviewed DOC websites and published policies governing health care services, grievance processes, and internal oversight structures.
- Reviewed DOC Insider Series webinar, *Prison Healthcare*, June 2022.⁶
- Reviewed published DOC health care vendor contracts.
- Reviewed national standards and information related to the National Commission on Correctional Health Care Resources and American Correctional Association.
- Reviewed national best practices for correctional oversight systems from the National Resource Center for Correctional Oversight.
- Reviewed correctional health care vendor and grievance oversight systems used nationally.
- Reviewed information related to the Federal Bureau of Prisons contract with the American Correctional Association, including an audit of the contract by the U.S. Department of Justice, Office of the Inspector General.

⁵ Reports retrieved from DLS research analysts, Secretary of the Delaware State Senate, and Chief Clerk of the Delaware House of Representatives.

⁶ Video found at: https://youtu.be/pch5iEjt_Uw?si=X8YLC_ad7_VYcZ_y and June 24, 2022 DOC press release found at: https://doc.delaware.gov/assets/documents/newsroom/2022/22press0624_1.pdf.

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- Reviewed published contracted review reports:
 - *Final Report: Independent Review of Security Issues at the James T. Vaughn Correctional Center*. Led by the Honorable William L. Chapman, Jr. and the Honorable Charles M. Oberly, III, with support from the Police Foundation. August 2017.⁷
 - *Technical Assistance Report: Focused Assessment of Health Services, James T. Vaughn Correctional Center*, National Commission on Correctional Health Care Resources, Inc. May 2018.⁸
 - *Healthcare Quality and Safety, Delaware Department of Correction, Christiana Care Quality and Safety Review Team*. November 2019.⁹
 - Conducted interviews of individuals experienced with ACHRC or correctional health care in Delaware, including:
 - Members of the General Assembly.
 - CJC staff.
 - ACHRC chair.¹⁰
 - Council on Correction vice chair.
 - Public advocates.
 - Reviewed information supplied by CJC staff, including:
 - ACHRC meeting agendas.
 - ACHRC meeting minutes.
 - Responses to review questions submitted by JLOSC staff.

⁷ Report found at: <https://www.policinginstitute.org/publication/final-report-independent-review-of-security-issues-at-the-james-t-vaughn-correctional-center/>.

⁸ Report found at: <https://bloximages.newyork1.vip.townnews.com/wdel.com/content/tncms/assets/v3/editorial/c/8a/c8ae64a8-591a-11e8-a271-67fe51312b10/5afc492fac1ea.pdf.pdf>

⁹ Report found at: https://doc.delaware.gov/assets/documents/DOC_Healthcare_Quality_and_Safety_Review_Report.pdf.

¹⁰ Outreach to the ACHRC vice chair did not result in a response.

III. Review Background and Committee Structure

The obligation to provide health care in correctional settings is based in constitutional law.¹¹ In Delaware, the current correctional health care oversight structure was developed through federal intervention, administrative changes within DOC, and legislative action.



In 2006, the Civil Rights Division of the United States Department of Justice (“DOJ”) identified significant deficiencies in medical and mental health services within Delaware correctional facilities. As a result, the State entered into a Memorandum of Agreement requiring corrective action. Reforms implemented between 2006 and 2012 included expanded clinical oversight, quality assurance processes, and increased monitoring of health care providers. Delaware was released from the agreement in 2012 after demonstrating substantial compliance.¹²

One year before the 2006 agreement, DOC created an internal medical unit in 2005, which was formalized in 2009 as the Bureau of Correctional Healthcare Services. The Bureau was established to oversee health care delivery, monitor contracted providers, and ensure compliance with clinical standards.

In 2019, the Bureau expanded and was renamed the Bureau of Healthcare, Substance Use Disorder and Mental Health Services (“BHSAMH” or “Bureau”). The Bureau now oversees and manages medical care, substance-use treatment, and mental health services for individuals in custody. BHSAMH contracts for these services in all Level V and Level IV facilities.¹³ In addition, the Bureau provides behavioral health services to people on supervised probation.¹⁴ DOC posts a daily population summary on its website, like the graphic shown on this page.¹⁵

¹¹ Failing to provide adequate care for an incarcerated person’s serious medical needs can amount to deliberate indifference, which constitutes a violation of the Eighth Amendment’s prohibition on cruel and unusual punishment. (*Estelle v. Gamble*, 429 U.S. 97 (1976)). This was included in the December 29, 2006 DOJ findings letter, which concluded that certain conditions in Delaware’s correctional facilities were deficient and fell below the constitutionally required standard of care. DOJ findings letter found at <https://clearinghouse.net/doc/19382>.

¹² DOJ press release December 31, 2012, found at: <https://www.justice.gov/archives/opa/pr/justice-department-announces-successful-resolution-case-regarding-delaware-state-prisons>.

¹³ DOC defines Level V facilities as 24-hour incarceration (currently operates 4 such facilities) and Level IV facilities as work release centers, home confinement with electronic monitoring, residential drug treatment, and violation of probation centers. Level V and IV facilities include individuals on pre-trial detention. Delaware has a unified correctional system, meaning that all facilities fall under the authority of the state.

¹⁴ DOC Bureau information found at: https://doc.delaware.gov/views/bureaus_divisions.blade.shtml.

¹⁵ The graphic reflects data as of May 15, 2026, and is provided to give readers a general overview of the population affected by these programs. Information found on the DOC website at <https://doc.delaware.gov>.

The ACHRC was established by law in 2008 to perform advisory and oversight-related functions concerning health care services within Delaware’s adult correctional system.¹⁶ ACHRC was created in response to concerns raised by families and formerly incarcerated individuals about the quality of health care provided in Delaware’s correctional system. The primary sponsor of the bill creating the ACHRC noted that most incarcerated people eventually return to the community and emphasized the importance of ensuring proper treatment of chronic and communicable conditions before release¹⁷. ACHRC was established to help ensure that incarcerated individuals receive appropriate quality care and to reduce the risk that untreated illnesses could affect both the prison population and the broader community.

Under statute, “the Committee serves in an advisory capacity to the Governor, the General Assembly, and the Commissioner of the Department of Correction on all matters in Delaware’s adult correction system relating to the provision of inmate health-care services, the review of all inmate deaths and autopsies relating to those deaths, the construction of health-care contracts that provide inmate health-care services, and the review of all statistics relating to inmate health care.”¹⁸ ACHRC is exempt from the Freedom of Information Act (“FOIA”) as it relates to open meetings and public records, but statute requires the Committee issue an annual report to the Governor, the General Assembly, and the DOC Commissioner by December 31 of each year.¹⁹

In 2019, a legislative amendment modified the Committee’s administrative support, by transferring administrative and budgetary responsibilities from DOC to the CJC.²⁰ The fiscal note attached to the bill included support for one full-time Criminal Justice Planning Coordinator. Although the 2019 legislation contemplated full-time support, information obtained during this review indicated that staff support is not dedicated exclusively to ACHRC.

Today the Committee consists of 9 voting members and 3 nonvoting members, who receive no salary for their service but may be reimbursed for reasonable expenses.²¹

The 3 nonvoting members are:²²

- Chief of the Bureau of Healthcare, Substance Abuse, and Mental Health Services.
- Chairperson of the House Corrections Committee.
- Chairperson of the Senate Corrections and Public Safety Committee

¹⁶ House Bill No. 446, 144th Delaware General Assembly, enacted July 2008.

¹⁷ Remarks on House Bill No. 446, House chamber, June 24, 2008.

¹⁸ [11 Del. C. § 6518\(f\).](#)

¹⁹ [11 Del. C. § 6518\(v\).](#)

²⁰ House Bill No. 173 as amended by House Amendment No. 1, 150th Delaware General Assembly, enacted June 2019.

²¹ [11 Del. C. § 6518\(h\).](#)

²² [11 Del. C. § 6518\(d\).](#)

The 9 voting members are:²³

- Delaware licensed physician.
- Delaware licensed forensic psychologist.
- Delaware licensed psychologist.
- Delaware licensed registered nurse.
- Member of the Delaware Bar.
- Expert in the field of substance abuse treatment.
- An additional healthcare professional who by virtue of training, education, and specialization holds expertise in correctional healthcare.
- An individual representing a nonprofit that is serving the families of inmates or the inmates themselves, or a local civil rights organization.
- Delaware licensed psychiatrist.

Voting members are appointed by the Governor and confirmed by the Delaware Senate for a term of 3 years, with no term limits.²⁴ Statute provides that outside professional organizations may submit recommendations to the Governor for appointment consideration, however in practice the Committee has played a primary role in identifying and vetting potential members.²⁵ Participation by some members has been inconsistent, including those intended to represent incarcerated individuals or their families, and legislative attendance has declined.

²³ [11 Del. C. § 6518\(c\).](#)

²⁴ [11 Del. C. § 6518\(c\).](#) [11 Del. C. § 6518\(e\).](#)

²⁵ [11 Del. C. § 6518\(j\).](#)

IV. Health Care Grievance Review

Statute directs the Committee to “receive and review monthly summaries of inmate, staff, public, and other health-care related grievances and the resolutions of these grievances in order to be fully apprised of the state of health-care services in Delaware’s adult correction facilities.”²⁶

This review found that the Committee is not carrying out this responsibility at the level contemplated by statute. Meeting records indicate that, in practice, the Committee receives only high-level verbal summaries—typically aggregate counts of grievances that reached Step 3—without accompanying detail or facility-level breakdowns.²⁷ Step 3 grievance data is reported only in aggregate, with meeting minutes often reflecting statements such as, “there are 20–30 grievances on average filed monthly that make it to Step 3,” or, with slightly more detail, “DOC receives about 25–30 grievances monthly. Most grievances are resolved between steps 1–2, but many individuals appeal them.” In a single instance, meeting minutes identified 3 primary medical care concern categories within grievances—insufficient care, delays in consultations, and unmet equipment needs—but this information was not accompanied by quantitative data or follow-up analysis. The Committee does not routinely receive information on grievance concern categories, facility-specific trends, timeliness, resolution outcomes, root-cause analysis, or whether recurring issues resulted in corrective action. As a result, the information reviewed does not support meaningful assessment of system-wide performance or identification of underlying issues.

A disconnect exists between the Committee’s documented activities and how its work is described publicly. Monthly meeting records reflect limited and summary-level review, while annual reports describe grievance oversight in broad, generalized terms without demonstrating how that oversight is carried out in practice.

As illustrated in the following figures, the grievance sections of ACHRC annual reports largely repeat the same language and categories year after year, with minimal variation, expansion, or annual updates. ACHRC annual reports do not include detailed data, longitudinal analysis, or evidence of sustained monitoring.

²⁶ [11 Del. C. § 6518\(n\)\(4\)](#).

²⁷ There are 3 steps outlined in DOC policy 11-A-10 (“Grievance Process for Healthcare Complaints”). Found in Appendix A and at https://doc.delaware.gov/views/policy_and_regulations.blade.shtml.

Verbatim Grievance-Section Text from ACHRC Annual Reports (2022–2025)

Annual Report 2022	Annual Report 2023	Annual Report 2024	Annual Report 2025
The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances.	The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances.	The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances.	The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances.
DOC has outlined the process for medical and behavioral health grievances with the group.	DOC has outlined the process for medical and behavioral health grievances with the group.	DOC has outlined the process for medical and behavioral health grievances with the group.	DOC has outlined the process for medical and behavioral health grievances with the group.
Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff/contractors and/or within a specific facility.	Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff/contractors and/or within a specific facility.	Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff/contractors and/or within a specific facility.	Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff/contractors and/or within a specific facility.
It was recognized that there is an attempt to resolve the grievance in each stage of the process and the individual has an opportunity to communicate understanding and degree of satisfaction. Some grievances get resolved, however, the incarcerated individual still pushes the item, so leadership learns about the issue.	It was recognized that there is an attempt to resolve the grievance in each stage of the process and the individual has an opportunity to communicate understanding and degree of satisfaction. Some grievances get resolved, however, the incarcerated individual still pushes the item, so leadership learns about the issue.	It was recognized that there is an attempt to resolve the grievance in each stage of the process and the individual has an opportunity to communicate understanding and degree of satisfaction. Some grievances get resolved, however, the incarcerated individual still pushes the item, so leadership learns about the issue.	It was recognized that there is an attempt to resolve the grievance in each stage of the process and the individual has an opportunity to communicate understanding and degree of satisfaction. Some grievances get resolved, however, the incarcerated individual still pushes the item, so leadership learns about the issue.
DOC examines all grievances. Medical and other grievances are all submitted through the same process.	DOC examines all grievances. Medical and other grievances are all submitted through the same process.	DOC examines all grievances. Medical and other grievances are all submitted through the same process.	DOC examines all grievances. Medical and other grievances are all submitted through the same process.

Figure IV-1: This figure displays information taken verbatim from the grievance sections of ACHRC annual reports for 2022–2025. The text from these sections was organized into a chart to make patterns and recurring language easier to identify. Figure IV-2 on the following page presents the same type of information for report years 2018–2021.

Verbatim Grievance-Section Text from ACHRC Annual Reports (2018–2021)

Annual Report 2018	Annual Report 2019	Annual Report 2020	Annual Report 2021
April 20, 2018 meeting: Discussed two articles <i>Council on Connection's</i> [Correction's] <i>Future Remains in Limbo</i> and <i>Terminal Cancer Spreads as Prison Neglected Delaware Inmates Pleas</i> .	The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances.	The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances.	The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances.
July 18, 2018 meeting: Discussed the Inmate's Grievance Process and ways it could be improved.	DOC has outlined the process for medical and behavioral health grievances with the group.	DOC has outlined the process for medical and behavioral health grievances with the group.	DOC has outlined the process for medical and behavioral health grievances with the group.
	Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff and/or within a specific facility.	Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff and/or within a specific facility.	Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff and/or within a specific facility.
	The Committee determined that the Bureau of Healthcare, Substance Abuse and Mental Health Services would present data on the number and type of grievances that are appealed to the Bureau and the outcome after Bureau review.	The Committee determined that the Bureau of Healthcare, Substance Abuse and Mental Health Services would present data on the number and type of grievances that are appealed to the Bureau and the outcome after Bureau review.	The Committee determined that the Bureau of Healthcare, Substance Abuse and Mental Health Services would present data on the number and type of grievances that are appealed to the Bureau and the outcome after Bureau review.
		Members noticed two trends – 1. There were lots of equipment requests and 2. Many individuals requested to be seen by an outside specialist.	Members noticed two trends – 1. There were lots of equipment requests and 2. Many individuals requested to be seen by an outside specialist.
		DOC did also start self-care medical lessons so more individuals will be better equipped to self-manage his/her own health situation when possible.	DOC did also start self-care medical lessons so more individuals will be better equipped to self-manage his/her own health situation when possible.
		It should be highlighted that DOC is being innovative and offering alternative pain and health management programs such as Tai Chi.	

Figure IV-2: This figure displays information taken verbatim from the grievance sections of ACHRC annual reports for 2018–2021.²⁸ The text from these sections was organized into a chart to make patterns and recurring language easier to identify. Figure IV-1 on the previous page presents the same type of information for report years 2022–2025.

²⁸ The 2018 annual report did not contain a distinct grievance section; instead, it provided meeting-by-meeting summaries, a reporting method not used in subsequent years. A dedicated grievance section was first introduced in 2019. The 2018 column reflects the 2 meetings in which grievances were associated with an article or discussion. Notably, the April 20, 2018 meeting discussion of *Terminal Cancer Spreads as Prison Neglected Delaware Inmate's Pleas* article which addressed allegations by a formerly incarcerated individual that his grievances were ignored and included a photograph depicting a stack of more than 20 grievance filings requesting care with little action taken. Article published by the News Journal on February 23, 2018, and found online at: <https://www.delawareonline.com/story/news/local/2018/02/23/suit-terminal-cancer-spread-prison-neglected-delaware-inmates-pleas/346489002>.

This lack of variation in the grievance sections is illustrated by the verbatim text presented in Figures IV-1 and IV-2. For example, the 2019, 2020, and 2021 annual reports each state that the Committee determined the Bureau would report the number and types of grievances appealed, along with outcomes.²⁹ From these Bureau reports, the 2020 and 2021 annual reports identified the same 2 trends—a high number of equipment requests and frequent requests to see outside specialists—and the 2020 report also noted the introduction of self-care medical lessons.

The 2020 annual report further highlights alternative pain and health management programs, such as Tai Chi. However, these observations were not developed further in subsequent reports, and there was no indication of follow-up analysis, tracking, or resulting recommendations. Notably, the Committee’s discussion of these alternative pain management programs did not include context regarding their origin. These programs were allegedly introduced by DOC and health care vendor Connections Community Support Programs as part of their response to misuse concerns outlined in their 2019 pain management initiative policy, which restricted the use of medications such as tramadol, Lyrica, and gabapentin.³⁰ The policy was later allegedly continued when Centurion Health assumed the health care contract in April 2020. Subsequent public reporting in 2022 indicated that this policy change led to litigation alleging that effective treatment options were limited, that inadequate alternatives were provided—such as psychiatric medications or non-clinical methods like “distraction” and yoga—and that these practices constituted deliberate indifference to incarcerated individuals’ medical needs in violation of constitutional rights, with plaintiffs seeking class-action certification.³¹ This coverage also highlighted a potential conflict with National Commission on Correctional Health Care guidance, which allows for monitored use of such medications in correctional settings.

The absence of this context—and the lack of follow-up on identified trends—further limits the usefulness of the Committee’s grievance review. Overall, the Committee’s current approach does not provide a sufficient basis to identify systemic issues, assess the effectiveness of grievance resolution, or develop informed recommendations related to health care delivery.

Separately, DOC maintains established internal processes for monitoring health care grievances and service quality, which have the potential to generate data relevant to the Committee’s work but are not incorporated into the Committee’s standard processes. Policies such as Policy 11-A-10 (“Grievance Process for Healthcare Complaints”) and Policy 11-A-04 (“Administrative Meetings and Reports”) require regular evaluation of grievance volume, type, timeliness, and effectiveness through facility-level and statewide Continuous Quality Improvement (“CQI”) structures. These processes include audits, trend analyses, and

²⁹ This reporting practice is not reflected in the 2022 annual report or in subsequent years, and it is unclear whether the practice was discontinued or simply no longer documented.

³⁰ Policy was named and described in litigation *Brown v. Centurion of Delaware, LLC*, 22-CV-0923 (D. Del. 2022), at 2. Found at <https://www.ded.uscourts.gov/sites/ded/files/opinions/22-923.pdf>.

³¹ Delaware News Journal. (Aug. 24, 2022). *Prison policy change makes sick prisoners needlessly suffer, says lawsuit*. Found at: <https://www.delawareonline.com/story/news/local/2022/08/24/lawsuit-ill-prisoners-suffering-because-of-ban-on-certain-medicines/65410148007>.

reporting mechanisms designed to identify issues and support performance improvement, as well as routine health care meetings and quality assurance activities.

Policy 11-A-10, paragraphs H. and J. state that:

- BHSAMH may audit grievances and the grievance process for timeliness of grievance referrals, effectiveness of proposed resolutions, and completion, or follow through, on upheld grievances.
- The grievance system must be evaluated annually by the facility's Continuous Quality Improvement (CQI) Committee (in accordance with BHSAMH Policy [11-A-06] A-06 Continuous Quality Improvement Program) to determine its efficiency and effectiveness. This will include an analysis of both the quantity and nature of individual grievances for the previous year. The results of these evaluations shall be reported to the Statewide CQI Committee annually.

However, these internal oversight activities are not integrated with the Committee's work. The Committee does not participate in these processes and does not routinely receive the resulting analyses, reports, or audit findings.³² Policy updates and changes related to grievance processes are also not formally presented on a consistent basis.³³ As a result, the Committee operates largely separate from DOC's established health care monitoring framework and lacks direct access to the data and analysis necessary to fulfill its statutory grievance oversight responsibilities. It is unclear whether current Committee members are aware of these policies, the optional BHSAMH audits, or the required annual CQI evaluations, or whether BHSAMH and health vendors are carrying out these activities as described in DOC policies.

³² The Committee's annual reports consistently list "quality improvement reports from each facility" and "internal quality monitoring reports" in the appendix under the work plan as reports expected prior to the January and July meetings; however, the reviewed meeting minutes and annual reports provide no evidence that these reports were submitted, reviewed, or discussed.

³³ The Committee's 2019 annual report stated that DOC finalized its "quality assurance plan" outlining strategies for overseeing health care service delivery, and that the Committee received a copy of the plan. Related information or updates do not appear in annual reports released in 2020 through 2025.

V. Identification and Resolution of Recurring Issues

As previously explained, the Committee does not review grievance summaries and receives only high-level information on grievances that reach Step 3, without details on how they were resolved. As a result, the Committee lacks a defined or consistent process for analyzing trends or identifying recurring issues. Although statute assigns broad oversight responsibilities, including advising on the identification of strengths, weaknesses, and opportunities for improvement; ensuring the resolution of identified problems; and helping to assure that all individuals who are incarcerated receive appropriate and timely services in a safe environment, the Committee's work in practice focuses primarily on monthly mortality and critical incident reviews.³⁴

During these reviews, it is unclear whether the Committee routinely receives—or is aware of—other key internal DOC policies and materials relevant to mortality and critical incident oversight. This includes documentation produced under DOC Policy 11-A-09, such as Clinical Morbidity and Mortality Committee reviews or facility-level reports prepared by medical and mental health leadership.³⁵ It is also unknown whether the Committee examines precursor information—such as sick-call requests or prior health care grievances—that could provide important context for identifying patterns or recurring issues. These materials are not explicitly incorporated into DOC policy or attachments, and Committee documentation does not indicate that Committee members routinely request or analyze the materials.

Even within this narrow focus, this review could not identify a consistent method for synthesizing information across case reviews to detect patterns or recurring concerns. Current Committee practices do not reflect a structured approach for translating individual case reviews into system-level findings, trends, or recommendations. Case discussions appear to occur primarily on an individual high-level basis, without clear mechanisms to document, track, or aggregate findings over time.

Annual reports that the Committee produced likewise do not indicate the use of a structured analytic approach. As a result, opportunities to identify systemic issues—such as delays in care, gaps in grievance resolution, or recurring clinical concerns—may not be fully recognized or addressed.

Beyond individual case review, the Committee does not appear to use its statutory authority to access protected health information to conduct broader, system-level assessments. Other oversight tools—such as facility site visits, direct observation of care, routine contractor engagement, or review of accreditation surveys—are not regularly used to identify trends or validate findings from grievance or case reviews. This limits the Committee's ability to independently assess whether recurring issues are present across facilities or over periods of time.

³⁴ [11 Del. C. § 6518\(n\)\(7\)](#).

³⁵ DOC policy 11-A-09 (Procedure in the Event of an Offender Death or Incident of Self-Directed Violence") identifies these documents as policy attachments A and B. Appendix A includes DOC policies and attachments relevant to this report, found online at: https://doc.delaware.gov/views/policy_and_regulations.blade.shtml.

The Committee also does not systematically track or follow up on its own information requests or identified areas of concern. For example, after discussing sick-call response times in November 2022, the Committee unanimously voted and requested quarterly sick-call timeliness reports from DOC. The Committee added this to its work plan starting with its 2022 annual report; however, neither subsequent annual reports nor quarterly meeting minutes show evidence that these reviews are occurring despite the reviews remaining in the Committee’s work plan. Only the April 2023 meeting minutes indicate that the Committee reviewed a quarterly report which covered July–September 2022. The 2022 annual report included information noting that DOC began providing the Committee with quarterly data on sick-call response times, based on routine audits, which showed approximately 90% compliance with policy. After the 2022 annual report and the April 2023 minutes, sick-call response-time reviews were not mentioned again. Analysis of results, identified trends, or follow-up actions related to the information presented at meetings are not included. Without a formal tracking mechanism, the Committee cannot ensure that requested data is consistently received, reviewed, or used to inform oversight activities.

Overall, the absence of structured processes for data collection, analysis, trend identification, and follow-up limits the Committee’s ability to identify and address recurring issues in health care delivery. While individual cases are reviewed, there is no clear framework to translate those reviews into actionable, system-level insights. As a result, current practices are not aligned with the Committee’s statutory responsibility to monitor health care quality and identify patterns or systemic concerns within correctional health services.

These limitations are also reflected in the Committee’s more recent work. At an August 2025 meeting, the Committee reviewed a news article regarding hostile working environments at a hospital and discussed concerns about potential impacts on incarcerated patients’ care.³⁶ Members proposed patient care surveys and follow-up reviews, while DOC reported no related complaints and noted that allegations in the article were unsubstantiated. DOC did agree to implement a re-entry hospital survey. According to the Committee’s 2025 annual report, DOC now administers these surveys, provides aggregate scores and narrative responses to ACHRC at each meeting, and the Committee plans to review negative feedback and assess potential patterns, noting that initial results show positive experiences with community-based healthcare. Meeting minutes and the 2025 annual report do not provide detailed information regarding those reviews. Additionally, neither the meeting minutes nor the 2025 annual report provide detailed data, charts, or other information to corroborate the follow-up reviews described, and it is unclear whether the Committee or its staff are systematically logging or tracking this information or developing procedures for reviewing it on any regular basis. The 2025 annual report also does not add these monthly reviews to its work plan in the appendix, unlike the inclusion of sick-call response-time monitoring that began with the annual report issued in 2022.

³⁶ Delaware News Journal. (July 9, 2025). *Nurses at Beebe Healthcare claim hostile work environment, discrimination in state filings*. Found at: <https://www.delawareonline.com/story/money/industries/healthcare/2025/07/09/ex-nurses-at-beebe-healthcare-claim-discrimination-in-state-filings/77831346007>.

VI. Role in Health Care Vendor Contract Development

Statute assigns the Committee broad advisory roles, including involvement in the construction of health-care contracts, as reflected in the following language (bold added for emphasis):

The Committee serves in an advisory capacity to the Governor, the General Assembly, and the Commissioner of the Department of Correction on all matters in Delaware’s adult correction system relating to the provision of inmate health-care services, the review of all inmate deaths and autopsies relating to those deaths, **the construction of health-care contracts that provide inmate health-care services**, and the review of all statistics relating to inmate health care.³⁷

In practice, the Committee focuses exclusively on reviewing deaths, but in the last 9 annual reports it has repeatedly noted difficulties obtaining autopsy reports. The DOC has long struggled to obtain timely autopsies, often waiting more than 6 months, which prevents the Committee from reviewing deaths effectively and fulfilling its oversight responsibilities.

The Committee’s statute does not define specific duties or clarify how it should participate in the construction of health-care contracts. The Committee’s meetings do not address health-care contracts or their construction, and this review did not identify a formal process through which the Committee participates in contract development or provides structured feedback during procurement or negotiation.

The Committee is not involved in drafting, reviewing, or shaping contract terms, nor does it provide input on performance metrics, reporting requirements, staff expectations, service delivery standards, or grievance-related provisions. The Committee is not engaged in formal processes within DOC for evaluating contractor performance or determining whether contracts should be extended, renegotiated, or rebid through a competitive request for proposal (“RFP”) process. DOC was not observed soliciting the Committee’s advice regarding contracts, despite annual reports stating that the Committee “provides input regarding the DOC medical provider contract.”³⁸

This review found that the Committee does not perform a meaningful role in the construction, monitoring, or evaluation of health care vendor contracts, and its statutory responsibilities in this area are not reflected in current operations.

³⁷ [11 Del. C. § 6518\(f\) \(emphasis added\)](#).

³⁸ ACHRC annual reports for 2023–2025 are provided in Appendix B. This statement appears in all 3 annual reports on pages 76, 94, and 112.

VII. Monitoring Quality and Appropriateness of Contracted Health Care Services

Statute directs the Committee to provide advice and assurance to the Governor, General Assembly, and DOC Commissioner across a broad range of responsibilities related to vendor oversight, including safety, quality, risk management, resource efficiency, credentialing, education, system coordination, and issue resolution.³⁹ In practice, however, this review found that the Committee does not perform a meaningful role in monitoring, evaluating, or overseeing contracted health care services, and its statutory responsibilities in this area are not reflected in its current operations.

The Committee does not receive the information necessary to support meaningful contract oversight. While general staffing updates may be shared, they are not accompanied by performance data needed to assess contractor effectiveness, such as service demand, timeliness of care, vacancy rates by function, quality outcomes, patient satisfaction, or grievance resolution trends. DOC also does not provide information on its internal continuous quality improvement processes conducted under agency policies. Without access to this data, the Committee is not positioned to determine whether contract requirements are being met or to provide informed advisory input regarding vendor performance.

Oversight tools that could supplement contract monitoring are also underutilized. Statute and DOC policy allow accreditation surveys, reports, and evaluations from the National Commission on Correctional Health Care (“NCCHC”) and the American Correctional Association (“ACA”) to be shared with the Committee but only upon the Committee’s request. In practice, the Committee typically receives only high-level updates indicating when evaluations are scheduled or completed, which are reflected as dates in annual report charts.⁴⁰ These updates and charts do not include substantive findings, conclusions, or corrective-action requirements, and the Committee has not developed a practice of requesting or reviewing full reports.

This “upon request” structure, combined with current information sharing practices, limits the Committee’s ability to incorporate independent assessments into its oversight activities. The Committee has also not engaged in accreditation processes, despite statutory provisions allowing accrediting bodies to contact members during evaluations, and the Committee has not discussed its potential role in these processes. Further, the Committee has not evaluated the purpose, value, or effectiveness of accreditation, nor reviewed DOC’s accreditation arrangements, despite associated costs and evolving national perspectives on their utility.⁴¹

³⁹ [11 Del. C. § 6518\(n\)\(7\)](#).

⁴⁰ The Committee’s annual reports consistently list “NCCHC and ACA yearly reports” in the appendix under the work plan as reports expected prior to the January and July meetings; however, the reviewed meeting minutes and annual reports provide no evidence that these reports were received, reviewed, or discussed.

⁴¹ The Federal Bureau of Prisons (“BOP”) ended its \$2.75M annual accreditation contract with ACA in March 2024 amid criticism that ACA audits lacked independence, relied on advance notice and checklists, and failed to detect serious facility issues. Additional concerns included potential conflicts of interest and reports of accredited facilities with unsafe or unsanitary conditions. BOP March 29, 2024 press release found at: <https://www.bop.gov/news/20240329-fbop-contract-with-aca-expires.jsp>. A November 2023 U.S. DOJ Office of Inspector General audit similarly found that ACA audits often mirrored the

As a result, accreditation is not meaningfully incorporated into the Committee’s assessment of contractor performance or contract effectiveness.

The Committee relies primarily on information that the DOC provides and does not maintain formal mechanisms to obtain input from contractors, vendors, incarcerated individuals, family members, staff, or the public. Although statute permits the Committee to request contractor participation in meetings, such engagement is limited, reducing opportunities for direct oversight.⁴²

The Committee also does not maintain processes for receiving information confidentially or anonymously. This limits its ability to identify issues that may not be raised through DOC channels or in public settings, including sensitive concerns related to care delivery, access, or staff conduct. National oversight models emphasize the importance of diversified information sources and confidential reporting mechanisms to identify systemic risks. Structured mechanisms—such as public submission portals or testimony processes—to collect stakeholder input, are not currently in place for ACHRC.

Internal practices further limit the Committee’s ability to monitor contractor performance. Meeting time is primarily dedicated to reviewing individual deaths and emergency room utilization. While these reviews provide case-level insight, they have not consistently resulted in documented recommendations, identification of recurring issues, or system-level analysis of contractor performance. The Committee does not maintain formal processes to track trends over time or to translate case findings into measurable indicators of quality, access, or appropriateness of care.

Coordination with other entities is also limited. Within Delaware, the Council on Correction addresses overlapping subject matter, including grievances and facility conditions; however, this review did not identify regular communication or shared reporting between the 2 bodies. Similarly, although DOC maintains a public liaison function, the Committee does not routinely receive reports or trend data from this role or other outreach efforts.

Information continuity and institutional knowledge are not supported by formal structures. It is unclear whether new members receive standardized orientation materials, whether a system of record is maintained, or whether staff support includes monitoring external developments such as litigation or policy changes. Historically, DOC has provided such information, with only limited supplementation from individual Committee members.

Committee composition and engagement practices further limit the incorporation of stakeholder perspectives. Although the Committee’s membership includes representation from a nonprofit serving incarcerated individuals or their families, this has not resulted in consistent or structured input. The Committee does not include individuals with lived experience of incarceration and does not maintain formal mechanisms to systematically gather such perspectives.

Bureau’s own internal evaluations, providing little independent oversight or meaningful corrective action. Report found at: <https://oig.justice.gov/reports/audit-federal-bureau-prisons-contract-awarded-american-correctional-association>.

⁴² [11 Del. C. § 6518\(o\)](#).

Historical Context of Health Care Contracting and Oversight

ACHRC was created in 2008, 2 years after Delaware was put under a Memorandum of Agreement with the U.S. DOJ regarding deficiencies in correctional health care. At the release of that agreement in 2012, DOJ identified the creation of ACHRC as “an independent entity to conduct oversight of the Bureau of Correctional Healthcare Services and its vendors” as part of the state’s commitment to improving oversight of correctional health services.⁴³ Even so, Delaware’s correctional health care system has continued to face operational challenges, external scrutiny, and litigation.

Since ACHRC’s creation, DOC has relied on multiple private contractors to provide health care and behavioral health services, with several transitions occurring over time:

Health Care and Behavioral Health Contractors Timeline:

- 2005–2010: Correctional Medical Service, health care and behavioral health.
- 2010–2014: Correct Care Solutions, health care.
- 2010–2012: MHM Services, behavioral health.
- 2012–2020: Connections Community Support Programs, behavioral health.
- 2014–2020: Connections Community Support Programs, health care.
- 2020–2023: Centurion (formally Centene Corp.), health care and behavioral health.
- 2023–present: VitalCore Health Strategies, health care and behavioral health.
 - Current contract is due to expire on June 30, 2026.

Across these contracts, vendors have experienced recurring operational, clinical, and legal challenges, including those arising after the 2017 Level V security disturbance and during the nationwide COVID-19 pandemic.

The most significant issues occurred during the tenure of Connections Community Support Programs, which was subject to multiple lawsuits, state and federal DOJ investigations, and settlements exceeding \$15M related to allegations of inadequate care, fraudulent billing, and controlled substance violations.⁴⁴ Additional litigation included claims from external providers,

⁴³ U.S. DOJ December 31, 2012 letter terminating the amended memorandum of agreement found at: <https://clearinghouse-umich-production.s3.amazonaws.com/media/doc/74215.pdf>.

⁴⁴ The Associated Press. (May 14, 2019). *Delaware AG investigating prison medical contractor*. Found at: <https://apnews.com/general-news-dbe58429c0b94b19bd005b719986c3d3>; Delaware News Journal. (May 21, 2021). *Despite mounting evidence, Connections dodged state scrutiny for years*. Found at: <https://www.delawareonline.com/story/news/2021/05/03/despite-evidence-connections-skirted-state-scrutiny-years/7293570002>; U.S. Attorney’s Office, District of Delaware, press release dated August 26, 2021 found at: <https://www.justice.gov/usao-de/pr/connections-community-support-programs-agrees-judgments-over-15-million-resolve-health>; WHYY. (August 27, 2021). *Former Delaware prison health care provider to pay \$15M to settle federal lawsuits*. Found at: <https://whyy.org/articles/former-delaware-prison-health-care-provider-to-pay-15m-to-settle-federal-lawsuits>.

such as a lawsuit by Bayhealth Medical Center alleging more than \$6M in unpaid services.⁴⁵

In May 2019, concerns regarding the Connections contract were raised by a member of the Joint Finance Committee who questioned the status and performance of the contract, which had been renewed multiple times without rebidding after its original 2016 expiration.⁴⁶ These events and concerns were not reflected in the Committee’s annual reporting in 2018 or 2019. The Committee’s 2019 annual report reflected minimal engagement with vendor oversight, noting only that DOC was preparing to release bids for future contracts. Additionally, annual reports from 2018 and 2019 did not include dedicated sections addressing vendor performance or information. Annual reports issued between 2020 and 2025 incorporated vendor-related content, but only in the form of high-level overviews, with no accompanying detailed data, performance metrics, or analytical findings. In March 2020, DOC announced it mutually terminated Connections’ contracts 3 months prior to their scheduled end dates following a contracted external review by Christiana Care that included recommendations related to leadership and communication structures.

Subsequent contractors have also faced litigation and operational challenges. As of January 2026, Centene Corporation and Centurion Equity LLC are engaged in competing Delaware Chancery Court lawsuits over responsibility for escalating malpractice-related costs tied to the prison health-care business Centurion purchased from Centene.⁴⁷ This ongoing dispute reflects continued complexity and financial risk within the State’s correctional health care contracting structure.

Despite this history, this review did not identify consistent evidence that ACHRC systematically incorporates information from litigation, external investigations, or contractor performance issues into its oversight activities. The Committee does not maintain formal mechanisms to track contractor performance across contract periods or to integrate lessons learned into ongoing monitoring processes.

External Reviews and Use of Findings in Committee Activities

This review identified 3 external contracted reviews conducted between 2017 and 2019. It is unclear to what extent the Committee reviewed or tracked the findings and recommendations from these reports. Annual reports do not demonstrate sustained follow-up, despite recurring issues—particularly related to grievances and communication—identified across multiple reviews.

⁴⁵ The Associated Press. (March 2, 2020). *Delaware prison officials switch medical care providers*. Found at <https://apnews.com/general-news-f43ad273faa684abf72b982364c4a191>.

⁴⁶ During this timeframe, external reporting and investigations included a 2016 incident involving an incarcerated individual at Sussex Community Corrections Center who did not receive medical care and later died, as well as an investigation by the Delaware Attorney General’s Office into allegations that employees were directed to falsify records in an addiction treatment program.

⁴⁷ Delaware News Journal. (February 6, 2026). *The Delaware fight over who must pay for health care neglect in prison*. Found at: <https://www.delawareonline.com/story/news/2026/01/27/delaware-court-weighs-who-must-pay-for-prison-healthcare-neglect-cases/88047739007/?qnt-cfr=1&qca-cat=p&qca-uir=true&qca-epi=z11xx65p119650c119650e1106xxv11xx65b0042xxd004265&qca-ft=210&qca-ds=sophi>.

These contracted reviews consistently found deficiencies in grievance processes, communication structures, and stakeholder engagement. For example, a 2017 state contracted independent security review at the James T. Vaughn Correctional Center identified the grievance system as dysfunctional and recommended comprehensive reform; a 2018 technical assistance report from NCCHC Resources, Inc. found the health care grievance process unclear and recommended separating non-medical complaints from sick call; and a 2019 quality and safety review from Christiana Care found that grievance data was not effectively used to improve care and that patients and families were not meaningfully involved in improvement efforts. The 2019 review also concluded that there is a lack of effective communication structures, avenues for raising operational concerns, and an environment that supports staff and patient participation significantly limited the system's ability to identify risks and strengthen care delivery.⁴⁸

Similar issues resurfaced in Committee discussions in early 2022, suggesting a lack of sustained tracking or resolution over time. The Committee's discussions were prompted by a news article that raised concerns about whether incarcerated individuals feel safe reporting injuries and highlighted ongoing questions about grievance processing and delays.⁴⁹ During discussion, DOC staff described a unified grievance system with internal sorting of medical complaints, while the Committee also noted limited involvement of incarcerated individuals in system improvement efforts—an issue previously identified in earlier contracted reviews. The persistence of these concerns years later indicates that findings from prior contracted reviews and their published reports were not systematically incorporated into the Committee's oversight activities.

Overall, ACHRC's approach does not reflect a comprehensive or systematic framework for monitoring the quality and appropriateness of contracted health-care services. Limited access to performance data, underutilization of external oversight mechanisms, lack of independent information sources, and internal operational constraints restrict the Committee's ability to assess contractor performance at a system level. Annual reports from 2020 through 2025 included vendor-related sections, but these were limited to high-level overviews and did not provide detailed data or analysis.

As a result, oversight practices do not reflect a longitudinal or data-driven approach to evaluating vendor performance or informing future contracting decisions. Together, these gaps indicate that the Committee's statutory role in vendor oversight is not operationalized. The absence of defined processes, routine data access, external input mechanisms, and structured evaluation practices limits its ability to influence contract design, monitor performance, or provide meaningful advisory input on contractor accountability.

⁴⁸ Committee annual reports from 2019 and 2020 referenced Christiana Care's six-week, no-cost quality-assurance review of DOC health care services and acknowledged receipt of the final report in December 2019. While the Committee stated an intent to develop a process for incorporating the report's recommendations, subsequent annual reports did not describe such a process, summarize the review's findings, or provide any follow-up. After 2020, the Christiana Care review report was no longer referenced, and no rationale was provided.

⁴⁹ News article title was not referenced in meeting minutes.

VIII. Committee Communications

ACHRC's statutory advisory functions are constrained by reporting practices that are outdated and lack meaningful description or analysis. Although annual reports are required, the most recent publicly posted annual report on its website is from 2019, and annual reports reviewed across years 2019 through 2025 are largely uniform in content.⁵⁰ The reports focus on listing expected reporting categories and DOC processes rather than providing system-level assessments, trend analyses, vendor performance measures, or documented follow-up on persistent issues. Accreditation information is limited to review dates without associated findings, scores, or corrective actions, and reports after 2018 omit meeting summaries. The Committee also lacks a formal mechanism for tracking or incorporating its own information requests, limiting its ability to produce and communicate substantive, data-driven findings and advice to the Governor, General Assembly, and DOC Commissioner.

These reporting limitations are compounded by broader deficiencies in the Committee's public transparency and communication practices. The Committee's website has not been updated since 2019, does not reflect current membership, and lacks complete reports as well as a mechanism for public contact, anonymous submissions, or stakeholder engagement.⁵¹ The Committee also does not independently collect or report patient-satisfaction data, conduct facility visits, or solicit feedback from incarcerated individuals or their families. As a result, its communications largely mirror information provided by DOC, without incorporating external perspectives or independent verification.

Annual reporting further reflects limited progress in this area. From 2019 through 2021, annual reports consistently emphasized under the Committee's observations and recommendations the need for CJC staff to work with DOC and the Bureau to develop a formal process for responding to public and family inquiries about incarcerated individuals' health care, while acknowledging existing communication channels and consent limitations. However, beginning in 2022 and continuing through the Committee's 2025 annual report, this proposal was no longer advanced, and no update was provided on whether such a process was implemented. The annual reports shifted to broader recommendations regarding transparency and communication. Notably, progress updates from 2021 through 2025 for the Committee's observations and recommendations are nearly identical year after year, providing no substantive new information and continuing to describe the issue as an ongoing priority, while limiting actions to forwarding correspondence, discussing concerns at meetings, and generally encouraging improved communication, without evidence of a formalized or implemented communication system had been established for managing public or family health care inquiries.

In addition, DOC Policy 8.50, which governs ACHRC's structure and responsibilities, has not been updated since 2015 and contains outdated information, including an incorrect number of voting members. The policy largely restates statutory language and does not define specific data requirements, performance metrics, or reporting frequencies for information provided to

⁵⁰ ACHRC annual reports from 2023–2025 provided in Appendix B of this report.

⁵¹ ACHRC statute has changed since 2019, but the website only shows information from 2019. A screen capture is provided in Appendix C. Website found at: <https://cjc.delaware.gov/achrc>.

the Committee. The absence of clearly defined expectations for information sharing further limits the Committee's ability to produce consistent, comprehensive reporting and communicate informed recommendations.

ACHRC's advisory role is also limited by the absence of independent evaluation. The Committee has not recommended or conducted a fully independent review of DOC's grievance process or contracted health care vendor performance. While it receives some information related to these areas, the data is not independently verified, and the Committee does not have the staffing or authority to conduct audits. As a result, its communications do not include objective assessments of whether grievance procedures are functioning effectively or whether the health care vendor is meeting contractual and quality-of-care standards.

Overall, limited reporting structure, lack of trend-based analysis, inconsistent follow-through on data requests, undefined information-sharing expectations, outdated governing policy, and minimal public transparency constrain ACHRC's ability to communicate meaningful findings and provide effective, data-driven advice to the Governor, General Assembly, and DOC Commissioner.

IX. National Correctional Oversight Framework and Comparison to Delaware

For context into oversight best practices analysis from the National Resource Center for Correctional Oversight (“NRCCO”) is included. NRCCO is a project of the Prison and Jail Innovation Lab at the University of Texas at Austin, and provides research and guidance on the structure and function of correctional oversight systems nationwide.⁵² NRCCO defines correctional oversight as an independent, external process designed to collect and assess accurate information regarding conditions of confinement and the treatment of incarcerated individuals, primarily through direct access to facilities and system data.

NRCCO distinguishes correctional oversight from internal accountability mechanisms, such as grievance systems, internal audits, and administrative reviews. External oversight provides independent monitoring, investigation, data analysis, and reporting functions intended to increase transparency and inform policymakers and the public. NRCCO identifies routine inspections, complaint investigation, data collection and analysis, and public reporting as core oversight functions, and notes that those functions are typically distributed across multiple entities rather than consolidated within a single body.

NRCCO determined that the Federal Bureau of Prisons, District of Columbia, and 17 states satisfy its criteria for external correctional health care oversight.⁵³ Identified states generally use multi-function or hybrid oversight models that combine complaint investigation, facility inspections, data-driven monitoring, and public reporting. Common structures include ombuds offices with authority to receive and investigate complaints and conduct site visits, inspector general models focused on audits and systemic monitoring, and commission-based or advisory models that incorporate public input and policy recommendations. These models typically include formal access to facilities and records, engagement with incarcerated individuals, and production of public reports assessing conditions and trends.

NRCCO also identifies characteristics associated with effective oversight bodies, including structural independence from the correctional agency, authority to conduct regular and unannounced inspections, access to facilities and records, direct engagement with incarcerated individuals and staff, use of multiple information sources, public reporting of findings and recommendations, and statutory requirements for agency cooperation and response.

Delaware’s current structure differs from these models. ACHRC is a single advisory body with statutory responsibilities related to the monitoring of correctional health care services, which includes critical incident, mortality, and grievance reviews. The Committee does not conduct independent inspections, investigate complaints, or maintain its own data collection or public reporting functions comparable to those included in the NRCCO models. In its annual reports from 2019 through 2025, the Committee noted that DOC created anonymous email and phone reporting channels for DOC staff and contracted health-care personnel to submit concerns

⁵² NRCCO information found online at: <https://prisonoversight.org/about-us>.

⁵³ States identified as California, Connecticut, Hawaii, Illinois, Indiana, Iowa, Maryland, Michigan, Minnesota, Nebraska, New Jersey, New York, Oregon, Pennsylvania, Vermont, Virginia, and Washington.

regarding health-care service delivery. However, these reports go directly to DOC, and it is unclear whether any information collected is shared with the Committee since no such data appears in meeting minutes or annual reports, and the Committee has no independent information-collection process. This lack of independent information flow is further reflected in how the Committee is structured and supported administratively.

CJC administratively supports ACHRC. Although CJC is an independent agency, its Executive Director has been appointed by and serves at the pleasure of CJC members, which includes the DOC Commissioner. Accordingly, the Committee's support structure is not fully insulated from the agency subject to review.

In practice, ACHRC relies on DOC as its primary, and often sole, source of information and does not routinely obtain external data, conduct independent research, or directly engage with incarcerated individuals or facility staff. Unlike the layered structures identified by NRCCO, Delaware does not have a separate entity, such as an ombudsperson or inspector general, with authority to conduct routine inspections, investigate complaints, or independently monitor correctional health care services.⁵⁴

NRCCO resources and related oversight literature also identify independence, access, adequate resources, and public reporting as core features of effective oversight structures. Those same resources note that common limitations include insufficient resources, limited independence, and restricted access to information. ACHRC's current structure reflects several of those limitations.

⁵⁴ Delaware recently created an Inspector General's office (Senate Bill No. 4 as amended by Senate Amendment Nos. 1, 2, 3, 153rd Delaware General Assembly, enacted August 2025); however, the office is not assigned duties related to the oversight of correctional health care services.

X. Staff Findings and Recommendations

Staff Finding 1: ACHRC’s operations do not align with the full scope of its statutory duties. This review found that the ACHRC is not currently operating in a manner that aligns with the full scope of its statutory responsibilities. Established in 2008, this is the Committee’s first formal review, and it indicates a need for ACHRC to reassess the feasibility, structure, and operational capacity of its current statutory mandates.

The Committee’s statute assigns a broad range of responsibilities, including reviewing grievances and health care data, advising on vendor contracts, monitoring contractor performance and system-wide health care quality, reviewing accreditation information, identifying reoccurring issues, and communicating findings and recommendations. However, these duties are not supported by consistent processes, defined reporting structures, systematic collection and analysis of information, or formal mechanisms for stakeholder engagement. This review also found that the Committee does not routinely receive the information necessary to carry out these statutory responsibilities, such as detailed grievance data, vendor performance metrics, continuous quality improvement information, accreditation findings, audit results, or other system-level performance indicators. It also lacks formal processes for tracking trends, documenting follow-up actions, evaluating recurring concerns, or assessing whether corrective actions are effective over time.

In addition, ACHRC does not maintain formal mechanisms to obtain information from outside DOC. The Committee does not routinely solicit or receive structured input from incarcerated individuals, family members, employees, vendors, advocacy organizations, or the public, including through confidential or anonymous channels. The Committee also does not regularly coordinate with other relevant public bodies with overlapping subject matter responsibilities, such as the Council on Correction. These limitations reduce the Committee’s ability to obtain independent perspectives, identify emerging concerns, and fulfill its broader advisory and oversight role.

As a result, the Committee’s work reflects only a limited portion of its statutory charge, with many duties performed inconsistently, carried out in a narrow or incomplete manner, or not operationalized through routine activities; accordingly, its annual reports do not demonstrate sustained tracking of data, trends, or outcomes.

Collectively, these findings show that ACHRC has not established a comprehensive framework for determining which responsibilities are feasible, how they should be implemented, what information is required, or how oversight activities should be carried out and sustained over time.

- **Staff Recommendation 1: Reevaluate and Restructure ACHRC Statutory Duties, Processes, Membership, and Oversight Role.** ACHRC will convene structured discussions—including its 2 legislative members, relevant state partners, and stakeholders—to conduct a comprehensive reassessment of the Committee’s statutory responsibilities, operational capacity, oversight role, and long-term structure using the findings of this review.

As part of this effort, ACHRC will reassess each statutory duty to determine its feasibility, the information and input required to perform it, the entities responsible for supplying

that information, the frequency with which materials should be reviewed, and the internal processes and resources needed to sustain the work. This review will also identify statutory clarification, restructuring, or where removal of duties may be necessary.

Following these discussions, ACHRC will develop and formally adopt a structured operational framework specifying how each retained duty will be executed. The framework will establish reporting requirements, information sources, review schedules, documentation and follow-up procedures, methods for tracking trends and corrective actions, mechanisms for obtaining information from outside DOC (including confidential submissions), processes for incorporating stakeholder input, and expectations for annual reporting to the Governor, General Assembly, and DOC Commissioner.

These discussions should incorporate national research regarding best oversight practices and consider whether changes to statute, membership composition, and Committee processes are needed. These discussions should also consider current staff support and determine which statutory duties are appropriate and which should be removed or revised.

The 2 legislative members of ACHRC will participate and help facilitate these discussions. CJC will provide JLOSC with an update on the status of this effort in January 2027, including any recommended statutory or operational changes identified through the reassessment process.

Staff Finding 2: DOC Policy Governing ACHRC Is Outdated. DOC Policy 8.50, which outlines the structure and responsibilities of the ACHRC, has not been updated since April 2015 and contains outdated and inaccurate information, including an incorrect number of voting members. The policy restates statutory language and does not define the specific data, metrics, or reporting frequencies that DOC staff must provide to the Committee.

- **Staff Recommendation 2: Update DOC Policy 8.50 to Reflect Current Committee Structure and Information Requirements.** ACHRC will discuss DOC Policy 8.50 with DOC staff to determine appropriate revisions to accurately reflect the current composition, responsibilities, and information needs of the ACHRC. ACHRC will request DOC update its Policy 8.50 to reflect these discussions and provide the revised policy to ACHRC and its staff. The revised policy will correct outdated elements—such as the number of voting members—and move beyond restating statute by clearly defining the specific data, metrics, and reporting frequencies that DOC staff must provide to the Committee. Establishing clear, current, and operational expectations in policy will support consistent information-sharing and strengthen ACHRC’s ability to carry out its statutory duties.

CJC will provide JLOSC with the Committee’s progress and any policy updates in January 2027, including whether legislation is needed.

Staff Finding 3: Requiring ACHRC to Request Accreditation Reports Results in Significant Gaps in Information and Oversight. Statute and DOC policy state that DOC will forward National Commission on Correctional Health Care (“NCCHC”) and American Correctional Association (“ACA”) surveys, reports, and evaluations to Committee members, but only upon Committee member request. In practice, the Committee typically receives only brief updates from DOC staff indicating when evaluations are scheduled or completed, which are then reflected as dates in a chart within the annual report. The Committee rarely receives findings, conclusions, or other substantive information from these accreditation reviews.

Committee members have not requested to receive or review the full reports. However, the statutory “upon request” structure, combined with the Committee’s current information-flow practices, places members in an awkward position—requiring them to ask for documents that should be routinely provided as part of their oversight role. ACHRC was created to provide independent oversight of DOC and its contracted health care vendor; members should not have to request accreditation reports and should instead receive them automatically and directly from NCCHC and ACA. Likewise, NCCHC and ACA should notify Committee members directly when onsite inspections or reviews are scheduled.

- **Staff Recommendation 3: JLOSC Consider Statute Changes to Ensure ACHRC Automatically Receives Accreditation Reports.** To strengthen ACHRC, JLOSC should consider sponsoring legislation to amend the Committee’s statute so that NCCHC and ACA accreditation reports, surveys, evaluations, and related findings are automatically and directly provided to ACHRC members rather than only upon request.

In addition to providing accreditation reports directly, statutory changes should also require NCCHC and ACA to notify ACHRC of scheduled inspections or evaluations.

Establishing an automatic reporting requirement would eliminate the information gaps created by the current “upon request” structure and ensure the Committee consistently receives information. Direct and routine receipt of both information and notifications is consistent with widely recognized oversight best practices, which stress independent access to key documents and timely awareness of significant activities.

JLOSC and CJC staff will work together to develop statutory revisions, incorporating technical corrections as needed.

Staff Finding 4: ACHRC’s public reporting and public accessibility are limited.

Statute requires ACHRC to issue annual reports; however, the reports produced are largely repetitive across years and do not include system-level analysis, trend identification, or vendor performance metrics. Information related to facility accreditation is limited to a chart of review dates without corresponding scores or results. Annual reports also no longer provide summaries of meetings held, as they did prior to 2019.

The Committee does not systematically track or follow up on its own information requests in its annual reporting. For example, quarterly sick-call timeliness reports requested in 2022 were provided only once in meeting minutes and were neither incorporated into the annual report nor added to the list of information reviewed at each meeting. That list has remained unchanged across annual reports, and the reports do not elaborate on the results of any of these reviews or present data or trends observed.

The Committee's public website has also not been updated and does not list current members or all published reports; the only report available online is from 2019. As a result, public transparency into ACHRC's activities and findings is significantly limited.

Overall, limited reporting structure, lack of trend-analysis reporting, inconsistent follow-through on data requests, undefined information-sharing expectations, and minimal public transparency constrain ACHRC's ability to conduct sustained, system-level oversight and provide meaningful data and advice in its annual reporting.

- **Staff Recommendation 4: Strengthen ACHRC's Reporting, Data-Tracking, and Public Transparency Practices.** ACHRC will implement a structured reporting framework that meets statutory requirements and supports providing meaningful data and advice in its annual reporting. This should include:
 - Producing comprehensive annual reports that incorporate system-level analysis, trend identification, vendor performance metrics, summaries of meetings held, and results of information reviewed throughout the year.
 - Complete accreditation information, such as review scores, findings, and corrective actions, rather than only listing review dates.
 - Establishing a formal process to track and follow up on information requests, ensuring requested data is incorporated into reports and added to the Committee's ongoing review list.
 - Regular updates to the Committee's public website to include current membership, all published reports, and timely information on ACHRC activities.

Implementing these measures would improve transparency, strengthen oversight, and ensure ACHRC's annual reporting provides meaningful, data-driven insight into the conditions of correctional health care.

CJC will provide JLOSC with the Committee's progress in January 2027, including whether legislation is needed.

Staff Finding 5: Holdover.

Staff recommendations include action items that benefit from periodic progress updates. These updates will support JLOSC's future discussions regarding next steps, including whether legislative changes should be explored or whether the entity is ready for release from review.

- **Staff Recommendation 5: Status updates in January 2027.** Beginning in January 2027, status updates will be presented to JLOSC as indicated in adopted recommendations. JLOSC staff will provide CJC staff with instructions.

XI. Additional Staff Observation and Long-term Consideration

ACHRC does not have independent inspection, investigative, or data collection functions. As outlined in this report, ACHRC was created in 2008 in response to discussions from families of and formally incarcerated people that highlighted concerns that DOC healthcare providers and contractors were not providing quality care and oversight was needed. JLOSC has not reviewed ACHRC since its creation; throughout this time, DOC has had multiple healthcare vendors which have all had various levels of controversy, including litigation and federal investigations.

This review highlights that ACHRC as an oversight mechanism relies primarily on information that DOC provides and does not maintain independent mechanisms to verify or supplement that information. The Committee does not conduct:

- Facility visits or inspections.
- Independent complaint investigations.
- Direct engagement with incarcerated individuals or facility staff.
- Independent data collection or analysis.

ACHRC is administratively supported by CJC staff, which is an independent agency. However, the CJC Executive Director serves at the pleasure of the CJC membership, which includes the DOC Commissioner. This structure does not insulate the Committee's administrative support from the agency subject to its review and oversight.

The Committee also relies heavily on DOC as its primary source of information and does not maintain independent data collection or monitoring functions. These structural limitations reduce ACHRC's independence when compared to oversight models identified in national frameworks.

Additionally, **no fully independent review has been conducted of DOC's grievance process or of the performance and oversight of its contracted health care vendors.** While ACHRC receives limited information related to grievances and vendor operations, these materials are not independently verified, and the Committee does not have the staffing resources, authority, or infrastructure necessary to conduct its own independent audits or investigations. As a result, there is no independent external assessment of whether grievance procedures function as intended or whether contracted healthcare vendors are consistently meeting contractual obligations and performance expectations.

An independent evaluation could provide an objective assessment of whether grievance systems are accessible, timely, and effective; whether the contracted healthcare vendors are meeting contractual obligations and quality-of-care standards; and whether systemic deficiencies exist that are not otherwise identified through DOC reporting channels. Such a function could also help address existing oversight gaps and provide policymakers with more reliable information to support operational, policy, and budgetary decisions.

The absence of independent information sources limits the Committee's ability to validate information, identify concerns not raised through DOC channels, or directly assess conditions of care within correctional facilities directly. Consequently, the Committee's oversight role is therefore dependent on the scope and content of information that DOC provides. National

organizations including the National Resource Center for Correctional Oversight have identified independent inspections, investigations, and external reporting mechanisms as important components of effective correctional oversight systems.

The State of Delaware has recently made investments in independent oversight initiatives such as the newly established Inspector General's Office. As this office is developed, the General Assembly should evaluate whether an additional independent oversight function is needed for correctional healthcare such as placing a unit within the Inspector General dedicated to correctional healthcare oversight or creating an ombudsperson within the office. Since the ACHRC does not conduct independent inspections or complaint investigations, it should be further evaluated whether a separate oversight function, such as an ombudsperson, inspector general, or similar structure, is needed to perform those functions.

This report does not include a staff recommendation for the creation of an ombudsperson, inspector general function, or integration in the newly created and not-yet operational Office of Inspector General. Doing so would require research, analysis, budget appropriations, and consideration by the General Assembly that far exceeds the scope of this review. JLOSC reviews and reports are often the start of longer discussions and as with all oversight reports produced by JLOSC staff, this report will remain a document for future reference.

JLOSC Staff Report - Appendix A

POLICY A-04 ADMINISTRATIVE MEETINGS AND REPORTS

<p>POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION</p>	<p>POLICY NUMBER A-04</p>	<p>TOTAL PAGES 5</p>
	<p>RELATED NCCHC / ACA STANDARDS: NCCHC: P-A-04 (Essential), J-A-04 (Essential), MH-A-04 (Essential), O-A-04 ACA: 5-ACI-1A-15, 5-ACI-6D-01</p>	
<p>CHAPTER: 11 BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES</p>	<p>SUBJECT: Administrative Meetings and Reports</p>	
<p>APPROVED BY THE BUREAU CHIEF: Bureau Chief, Michael Records (signature on file with BHSAMH)</p>		
<p>APPROVED BY THE COMMISSIONER AND EFFECTIVE THIS DATE Commissioner Terra Taylor, June 24, 2024 (signature on file with BHSAMH)</p>		
<p>APPROVED FOR PUBLIC RELEASE</p>		

- I. AUTHORITY:** 11 *Del. C.* §6536 Medical Care
- II. PURPOSE:** To create a system of communication that ensures the facility’s healthcare and correctional administrators work together to coordinate the healthcare delivery system through joint monitoring, planning, and problem resolution to promote a healthy working environment.
- III. APPLICABILITY:** All Delaware Department of Correction (DDOC) employees and Contract Provider staff, offenders, and any outside healthcare provider servicing DDOC offenders.
- IV. DEFINITIONS:** See Glossary
- V. SUMMARY OF CHANGES:** This policy was updated to combine all staff meetings at a facility to one wider healthcare staff meeting in accordance with the intent of the NCCHC standard on administrative meetings.
- VI. POLICY:**
 - A. It is the policy of the DDOC that the Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH) in collaboration with the facility’s correctional administrators and healthcare staff coordinate the healthcare delivery system through joint monitoring, planning, and problem resolution. At a minimum, this is accomplished utilizing the following meetings:
 - 1. Healthcare Advisory Committee (HAC) is a committee that facilitates reporting and discussion of relevant correctional, administrative, and healthcare issues.
 - a. HAC shall meet at least quarterly or more often as needed.
 - b. HAC shall be made up of the following staff, at a minimum:
 - i. Facility Health Services Administrator (HSA) – chairs committee,
 - ii. Facility Warden (or designee),
 - iii. Responsible Health Authority (RHA), (or designee),

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- iv. Facility Medical Director (or designee),
 - v. Facility Behavioral Health Director (or designee),
 - vi. Facility Substance Abuse Program Director (or designee),
 - vii. Facility Medication Assisted Treatment (MAT) sponsor (or designee),
 - viii. Healthcare Contract – Chief Medical Officer,
 - ix. Healthcare Contract – Chief Nursing Officer,
 - x. Healthcare Contract – Statewide Health Services Administrator,
 - xi. Behavioral Health Contract – Statewide Behavioral Health Director,
 - xii. Behavioral Health Contract – Substance Use Disorder Program Director,
 - xiii. Facility Pharmaceutical Representative,
 - xiv. Assigned BHSAMH Facility Liaison, and
 - xv. Other healthcare, security, and/or administrative staff as deemed necessary.
- c. Topics to be covered include, but are not limited to the following:
- i. Healthcare services including but not limited to:
 - a) Medical,
 - b) Dental,
 - c) Mental Health,
 - d) Substance Use Treatment,
 - 1. Must include MAT.
 - ii. Quality improvement findings,
 - iii. Infection control efforts
 - iv. Offender grievances,
 - v. Environmental Inspections,
 - vi. Safety Inspections,
 - vii. Staffing levels,
 - viii. Education completed,
 - ix. Training conducted,
 - x. Credentialing status,
 - xi. Emergency Responses,
 - xii. Performance improvement plans, and
 - xiii. Other topics as deemed necessary.
- d. The HAC meeting at each facility shall use a uniform format at all facilities.
- e. Sign-in sheets, summaries of discussions, and meeting minutes will be maintained by the facility HSA and sent to BHSAMH.
- f. Copies of sign-in sheets, summaries, and meeting minutes will be available and reviewed by all appropriate personnel.
2. Healthcare Staff Meetings.
- a. Healthcare staff meetings shall occur at least once monthly for all facilities.
 - b. Healthcare staff meetings must include all healthcare disciplines (medical, dental, mental health, and substance use disorder (SUD) program (MAT services) staff.

- c. Healthcare staff meetings provide an opportunity for healthcare staff to receive and present current information on all aspects of the facility's healthcare delivery system.
 - d. Sign-in sheets, summaries of discussions, and meeting minutes outlining topics discussed will be maintained by the facility HSA and sent to BHSAMH.
 - e. Copies of sign-in sheets, summaries, and meeting minutes will be available and reviewed by all appropriate personnel.
 - f. There must be written documentation to show that staff who were unable to attend the staff meeting were briefed on the vital information presented.
3. Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH) Staff Meetings
- a. BHSAMH Staff Meetings shall occur at least once per quarter or more often as needed.
 - b. BHSAMH staff meetings provide an opportunity for BHSAMH staff to receive and present current information on all aspects of the statewide healthcare delivery system.
 - c. Sign-in sheets, summaries of discussions, and meeting minutes outlining topics discussed will be maintained by the RHA or designee.
 - d. Copies of sign-in sheets, summaries, and meeting minutes will be available and reviewed by all appropriate personnel.
 - e. There should be written documentation to show that staff who were unable to attend the staff meeting were briefed on the vital information presented.
4. Joint Vendor Meeting – a meeting between leadership from all contracted service providers and BHSAMH to ensure collaboration exists among the various services that are delivered statewide.
- a. The Joint Vendor Meeting shall occur at least once quarterly or more often if needed.
 - b. At a minimum, the Joint Vendor Meeting shall be made up of the following staff:
 - i. BHSAMH Bureau Chief – chair,
 - ii. BHSAMH Medical Director,
 - iii. BHSAMH Director of Community Health,
 - iv. BHSAMH Policy and Standards Compliance Director,
 - v. BHSAMH Medical Treatment Services Director,
 - vi. BHSAMH Behavioral Health Treatment Services Director,
 - vii. BHSAMH Quality Assurance Administrator,
 - viii. BHSAMH Social Services Administrator,
 - ix. BHSAMH Registered Nurse II,
 - x. BHSAMH Trainer/Educator/Infection Control Nurse,
 - xi. Healthcare Contract – Contract Administrator,
 - xii. Healthcare Contract – Chief Medical Officer,
 - xiii. Healthcare Contract – Chief Nursing Officer,
 - xiv. Healthcare Contract – Statewide Health Services Administrator,
 - xv. Behavioral Health Contract – Contract Administrator,

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- xvi. Behavioral Health Contract – Statewide Behavioral Health Director,
 - xvii. Behavioral Health Contract – Substance Use Disorder Program Director,
 - xviii. Behavioral Health Contract – Statewide Substance Use Disorder Program Clinical Program Director,
 - xix. Pharmaceutical Contracted Provider, and
 - xx. Other staff members as deemed necessary by the BHSAMH Bureau Chief.
- c. Topics to be discussed are at the discretion of the BHSAMH Bureau Chief.
- 5.Special Needs Multi-Disciplinary Team (MDT)
- a. Meetings of the Special Needs Multi-Disciplinary Team (MDT) shall follow the procedures outlined in BHSAMH Policy *B-07 Communication on Patients Health Needs*.
- 6.Morbidity and Mortality Reviews
- a. Meetings of the Morbidity and Mortality Review Committee shall follow the procedures outlined in BHSAMH Policy *A-09 Procedure in the Event of an Inmate Death*.
- 7.Adverse Clinical and/or Near-Miss Events
- a. Meetings of the Adverse Clinical and/or Near-Miss Events Committee shall follow the procedures outlined in BHSAMH Policy *B-08 Patient Safety*.
- 8.Credentialing Committee
- a. Meetings of the Credentialing Committee shall follow the procedures outlined in BHSAMH Policy *C-01 Credentials*.
- 9.Pharmacy and Therapeutics Committee
- a. Meetings of the Pharmacy and Therapeutics Committee shall follow the procedures outlined in BHSAMH Policy *D-01 Pharmaceutical Operations*.
10. Treatment Review Committee
- a. Meetings of the Treatment Review Committee shall follow the procedures outlined in BHSAMH Policy *G-03 Emergency Psychotropic Medication* and *G-03.1 Non-Emergency Involuntary Medication Administration*.
11. Gender Dysphoria Consultation Group
- a. Meetings of the Gender Dysphoria Consultation Group shall follow the procedures outlined in BHSAMH Policy *E-14 Treatment of Transgender Persons*.
12. Monthly Statistical Reports – these reports shall include service volume and incidences of certain illnesses, diseases, and injuries. These reports may also be used to plan for staffing, space, equipment needs, as well as to compare facilities. This allows for identification of relevant trends and issues that may require additional review through a Continuous Quality Improvement process. These reports shall be shared with the facility warden (or designee) and BHSAMH. Items to be reported include, but are not limited to the following items:

POLICY A-04 ADMINISTRATIVE MEETINGS AND REPORTS

- a. Service volume – number of offenders receiving services from the following:
 - i. Medical,
 - ii. Dental,
 - iii. Optometry,
 - iv. Mental Health,
 - v. Substance Use Treatment,
 - vi. MAT services to include, but not limited to the following:
 - a) The number of referrals and the number of offenders admitted to MAT services.
 - b) The number of offenders receiving MAT services by category of care.
 - c) Referrals to health services facility staff and/or specialists.
 - d) Number of referrals to community MAT providers.
 - b. Referrals to specialists categorized by specialty,
 - c. Deaths,
 - i. Natural.
 - ii. Suicide.
 - d. Incidences of non-fatal suicidal self-injury,
 - e. Incidences of specified illnesses,
 - f. Infectious disease monitoring categorized by specific diseases,
 - g. Emergency responses,
 - h. Outside hospital admissions,
 - i. Access, timeliness of health services, and follow-up,
 - j. Missed appointments,
 - k. Grievance statistics, and
 - l. Other information deemed necessary to assess the quality of healthcare services being delivered.
13. Meeting minutes or summaries should include problems identified, corrective actions initiated, problems resolved since last meeting, and problems with corrective actions.
14. Other staff members should attend other meetings when issues directly related to their area of responsibility or expertise will be discussed.
15. The HSA shall obtain written confirmation that vital information is shared with pertinent staff as needed.
16. Healthcare staff should attend other facility staff meetings in order to promote good working relationships within the facility.
- B. The Contracted Healthcare Provider(s) shall develop within 30 days of the effective date of this policy, a facility-specific procedure for each Level 4 and Level 5 facility implementing this policy and coordinating the procedure with the BHSAMH.

POLICY A-06 CONTINUOUS QUALITY IMPROVEMENT PROGRAM

POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER A-06	TOTAL PAGES 6
	RELATED NCCHC / ACA STANDARDS: NCCHC: P-A-06 (Essential), J-A-06 (Essential), MH-A-06 (Essential), O-A-06 ACA: 5-ACI-6D-02, 5-ACI-6D-08, 5-ACI-6D-09, 4-ALDF-7D-02, 4-ACRS-7D-02	
CHAPTER: 11 BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES	SUBJECT: Continuous Quality Improvement Program	
APPROVED BY THE BUREAU CHIEF: Bureau Chief, Michael Records (signature on file with BHSAMH)		
APPROVED BY THE COMMISSIONER AND EFFECTIVE THIS DATE Commissioner Terra Taylor, June 24, 2024 (signature on file with BHSAMH)		
APPROVED FOR PUBLIC RELEASE		

- I. AUTHORITY:** 11 *Del. C.* §6536 Medical Care
- II. PURPOSE:** To establish continuous quality improvement programs that will monitor and improve healthcare services delivered in all facilities by establishing structured processes to find areas in need of improvement in a facility’s healthcare delivery system early enough to find resolutions before those areas worsen.
- III. APPLICABILITY:** All Delaware Department of Correction (DDOC) employees and Contract Provider staff, offenders, and any outside healthcare provider servicing DDOC offenders.
- IV. DEFINITIONS:** See Glossary
- V. SUMMARY OF CHANGES:** This policy was changed to require the BHSAMH facility liaison to be a member of the site CQI committee. The policy was also modified to require the site CQI committee to conduct a minimum of two process and two outcome studies each year (one each for healthcare and mental health).
- VI. POLICY:**
 - A. It is the policy of the DDOC that there is a Continuous Quality Improvement (CQI) Program that monitors and improves healthcare services (including MAT services) delivered in all facilities. These healthcare services generally fall into one of thirteen major service areas. Those areas are as follows:
 1. Intake Processing
 2. Acute Care (sick call for general population and segregated housing)
 3. Medication Services
 4. Chronic Care Services
 5. Intra-system Transfers services
 6. Scheduled Off-site Services (consults and procedures)
 7. Unscheduled On-site and Off-site Services (urgent/emergent care)
 8. Behavioral Health Services

9. Dental Services
 10. Ancillary Services (e.g., lab and x-ray)
 11. Dietary Services
 12. Infirmary Services
 13. Discharge Planning Services
 14. Medication Assisted Treatment (MAT) Services
- B. The Responsible Health Authority (RHA) will establish a statewide CQI Program that includes multidisciplinary CQI committees at each facility and a statewide CQI committee.
1. These committees shall meet at least once quarterly or more often as needed.
 2. These committees shall have representatives from all major healthcare service areas including but not limited to medical, dental, mental health, substance use treatment, the responsible physician, medical records, pharmacy, and security.
 - a. Other representatives may be included depending on the issues identified.
- C. The CQI committees (statewide and facility level) shall:
1. Collect, trend, and analyze data from various aspects of the healthcare system.
 - a. Includes planning, interventions, and reassessment when necessary.
 - b. Includes the evaluation of data that will result in more effective access, improved quality of care, and better utilization of resources.
 2. Identify aspects of healthcare (includes MAT services) to be monitored and establish thresholds.
 3. Design quality improvement monitoring activities.
 4. Analyze the results for factors that may have contributed to below threshold performance.
 5. Design and implement improvement strategies to correct the identified healthcare concern.
 6. Monitor the performance after implementation of improvement strategies.
 7. When the committee identifies a specific healthcare concern from its monitoring, a process and/or outcome quality improvement study is designed, initiated, and documented.
 - a. At least one process and/or outcome quality improvement study must be conducted each year (at least one must deal specifically with MAT services).
 8. Conduct a patient satisfaction survey at least annually.
 9. Ensure that education and training programs are updated to reflect improvement findings as needed.
 10. Document a written annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative, and/or staff meetings, or other pertinent written materials.
 11. Conduct an annual review of deaths and serious incidents involving offenders with mental illness to identify trends and needed corrective action.
- D. Statewide CQI Committee
1. The Bureau Chief of Correctional Healthcare Services (BHSAMH) or designee will chair the statewide CQI Committee.
 2. The Statewide CQI Committee shall have the following members, at a minimum:
 - a. Bureau Chief of BHSAMH - chair

- b. BHSAMH Medical Director
 - c. BHSAMH Director of Community Health
 - d. BHSAMH Medical Treatment Services Director
 - e. BHSAMH Behavioral Health Treatment Services Director
 - f. BHSAMH Director of Policy and Standards Compliance
 - g. BHSAMH Quality Assurance Administrator
 - h. Chief Medical Officer – Medical Provider
 - i. Statewide Health Services Administrator (HSA)
 - j. Chief Nursing Officer – Medical Contract
 - k. Statewide Behavioral Health Director – Behavioral Health Contract
 - l. Statewide Substance Use Disorder (SUD) Program Director
 - m. Statewide Pharmacy Administrator
 - n. Performance Improvement Director – Medical Contract
 - o. Performance Improvement Director – Behavioral Health Contract
 - p. Other staff members as deemed necessary by the BHSAMH Bureau Chief
3. Confidentiality of peer review is maintained at all times.
 4. The Bureau Chief of BHSAMH, or designee, shall provide and maintain CQI agendas, meeting minutes, and/or summaries for future reference. Copies are available and reviewed by appropriate personnel.
- E. Facility specific CQI Committee
1. The Health Services Administrator (HSA) at each Level 5 and Level 4 facility shall establish a facility level CQI committee at each facility.
 - a. Level 5 and Level 4 facilities may not be combined.
 2. The facility level CQI Committee shall have the following members:
 - a. Facility Health Services Administrator (HSA) – chair.
 - b. Facility Medical Director, or designee.
 - c. Facility Director of Nursing, or designee.
 - d. Facility Behavioral Health Director, or designee (if there is one assigned to the facility).
 - e. Facility Mental Health Director, or designee (if there is one assigned to the facility).
 - f. Facility Substance Use Treatment Director (if there is one assigned to the facility).
 - g. Pharmacist, or designee.
 - h. Infection Control Nurse/Patient Safety Committee.
 - i. Medical records staff member.
 - j. Security Representative designated by the warden.
 - k. BHSAMH facility liaison.
 - l. Other staff as deemed necessary.
 3. Facility level CQI shall include health record reviews (including MAT services records) conducted under the guidance of the responsible physician or designee. The health record reviews are done to ensure that appropriate care is ordered and implemented, and that care is coordinated by all healthcare staff, including medical, dental, behavioral health, and nursing.
 4. The responsible physician is involved in CQI beyond just conducting chart reviews. They may identify certain events such as acute care hospital admissions, medical emergencies, and deaths that must be reviewed routinely.

5. Confidentiality of peer review is maintained at all times.
 6. The HSA shall provide and maintain CQI meeting minutes or summaries for future reference. Copies are available and reviewed by appropriate personnel. CQI minutes should provide sufficient detail to guide future discussions.
 7. Conduct a minimum of two process and two outcome studies each year (one each for healthcare and mental health).
 8. The CQI Committee shall review and report on all offender work-related injuries that occurred since the last CQI meeting.
 9. The CQI Committee at each facility shall prepare a quarterly report on the findings from their CQI internal review activities for the previous quarter. This report shall be submitted to the facility HSA, facility warden, and BHSAMH within 30 days of the end of the quarter.
- F. Process Quality Improvement Studies examine the effectiveness of the healthcare (including MAT services) delivery process by:
1. Identifying a healthcare system concern. Examples include, but are not limited to the following:
 - a. Delayed sick-call appointments
 - b. Discontinuity of medications
 - c. Lack of follow-up on an abnormal lab value
 - d. Long waiting room times
 - e. Lack of treatment continuity on admission or release
 2. Determining a threshold based on the problem identified.
 3. Conducting a baseline study.
 4. Developing and implementing a clinical corrective action plan.
 5. Restudying the problem to assess the effectiveness of the corrective action.
- G. Outcome Quality Improvement Studies examine whether expected outcomes of patient care were achieved by:
1. Identifying a patient clinical problem. Examples include, but are not limited to the following:
 - a. Poor asthma control.
 - b. Poor diabetes control.
 - c. High volume of off-site visits.
 - d. Hypertension admission rate.
 - e. Chronic Obstructive Pulmonary Disease (COPD) admission rate.
 - f. Emergency room transfers of patients, including MAT patients.
 - g. Other clinical problems as indicated.
 2. Determining a threshold based on the problem identified.
 3. Conducting a baseline study.
 4. Developing and implementing a clinical corrective action plan.
 5. Restudying the problem to assess the effectiveness of the corrective action.
- H. CQI Programs shall use one or more of the following quality performance measures when designing studies:
1. Accessibility – Access to care is used to measure primary care, chronic care services, scheduled off-site services, dental services, mental health services, medication services, unscheduled on-site and off-site services, intake processing, and intrasystem transfer services.
 2. Continuity – Continuity of care is measured by the extent to which pre-existing conditions are identified and addressed during the intake process. Continuity

can also be measured or follow-up of unscheduled on-site and off-site services as well as off-site services. This measurement would include the timeliness of receipt of off-site service reports and the timeliness of the follow-up encounter with the primary care provider.

3. Timeliness – can be measured by use of logs and tracking systems. Some services that can be measured for timeliness include, but are not limited to the following:
 - a. Primary Care – time between the sick-call request being retrieved and the nurse face-to-face sick-call encounter.
 - b. Chronic Care – time between initial diagnosis of a chronic illness and the first chronic care visit.
 - c. Medication – time between ordering a critical medication and the receipt by the patient.
 - d. Emergency Services – time between contact with emergency services and arrival of the emergency services.
4. Efficiency – efficiency is usually measured in terms of cost efficiency. Analyses may include the average cost per patient, per year for services provided or the average cost for specific services. Comparisons should occur between various facilities. Efficiency may also be measured through studies of continuity of care.
5. Effectiveness (outcomes) – studies should focus on monitoring clinical outcome measures for certain common chronic diseases. Another method for measuring effectiveness is the percentage of patients with a given disease in a period of time whose disease is measured as in good control.
6. Prescriber-patient interaction – may be accomplished through patient satisfaction surveys that inquire about prescriber attentiveness, communication skills, and so forth. Monitoring the number and type of grievances is another effective method for measuring prescriber-patient interactions. Chronic care patients may also be questioned about their individual knowledge of their disease status.
7. Safety – it is important to review and monitor the safety of the physical environment and the adherence to security requirements. Safety inspections can identify safety concerns related to sanitation, trip hazards, and other potential problems in the physical environment. Other issues of patient safety are promoted by investigating and performing an analysis of all deaths as well as adverse events.
8. Appropriateness of clinical decision making - ensuring that all healthcare staff are up to date on licensing, credentialing, continuing education, as well as certifications is directly related to quality clinical decision making. A clinical performance enhancement program must be used to regularly review and provide feedback for prescribers, nurses, and other licensed practitioners to ensure the probability of clinically appropriate decision making.
9. Patient Satisfaction Survey
 - I. The responsible physician, or designee shall monitor health service outcomes on a regular basis through the following:
 1. Conducting chart reviews to include investigation of complaints and the quality of health records (includes MAT services).
 2. Reviewing prescribing practices and administration of medication practices.

POLICY A-06 CONTINUOUS QUALITY IMPROVEMENT PROGRAM

3. Systematic investigation of complaints and grievances.
 4. Monitoring of corrective action plans.
- J. As a protected Peer Review Process, information from CQI activities shall not be shared outside of the CQI committee membership absent a directive from the Commissioner of the DDOC or a valid Court Order.
 - K. The Contracted Healthcare Provider shall develop within 30 days of the effective date of this policy, a facility-specific procedure for each Level 4 and Level 5 facility implementing this policy and coordinating the procedure with BHSAMH.

POLICY A-09 PROCEDURE IN THE EVENT OF AN OFFENDER DEATH OR INCIDENT OF SELF-DIRECTED VIOLENCE

<p align="center">POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION</p>	<p align="center">POLICY NUMBER A-09</p>	<p align="center">TOTAL PAGES 6 w/ 2 attachments</p>
	<p>RELATED NCCHC / ACA STANDARDS: NCCHC: P-A-09 (important), J-A-09 (important), MH-A-10 (important), O-A-10 ACA: 5-ACI-6C-02, 5-ACI-6C-16, 5-ACI-6D-02 (M) 4-ALDF-4D-23, 4-ACRS-7D-15</p>	
<p>CHAPTER: 11 BUREAU HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES</p>	<p align="center">SUBJECT: Procedure in the Event of an Offender Death or Incident of Self-Directed Violence</p>	
<p>APPROVED BY THE BUREAU CHIEF: Bureau Chief, Michael Records (signature on file with BHSAMH)</p>		
<p>APPROVED BY THE COMMISSIONER AND EFFECTIVEDATE Acting Commissioner Terra Taylor October 16, 2023 (signature on file with BHSAMH)</p>		
<p>APPROVED FOR PUBLIC RELEASE</p>		

- I. **AUTHORITY:** 11 *Del. C.* §6536 Medical Care
- II. **PURPOSE:** To ensure that all deaths in custody as well as incidents of suicidal self-directed violence (formerly referred to as suicide attempts) are reviewed thoroughly to improve care, identify issues that require further study, and ensure that preventable deaths are avoided by reviewing and modifying, where needed, policies, procedures, and practices.
- III. **APPLICABILITY:** All Delaware Department of Correction (DDOC) employees and Contract Provider staff, offenders, and any outside healthcare provider servicing DDOC offenders.
- IV. **DEFINITIONS:** See Glossary
- V. **SUMMARY OF CHANGES:** This policy was updated to update the terminology used regarding the list of attendees for an M&M review. The ITP shall now include language about the efforts being undertaken to reduce future incidents of SDV. And the M&M Report must include reasons if no recommendations are being made as the result of the review.
- VI. **POLICY:**
 - A. It is the policy of the DDOC that all deaths in custody are thoroughly reviewed through a formal Clinical Morbidity and Mortality (M & M) Review Process to improve care and prevent future deaths.
 - B. It is the policy of the DDOC that all incidents of self-directed violence are reviewed to improve care and prevent or reduce the number of future incidents.
 - 1. Incidents of suicidal self-directed violence that require transport to an outside healthcare facility shall be reviewed through the formal M & M review process.
 - 2. Incidents of suicidal or non-suicidal self-directed violence that do not require transport to an outside healthcare facility shall be reviewed by the facility

Mental Health Director and by the Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH) Behavioral Health Treatment Services Director, or designee, to determine if a formal M & M review is warranted.

- a. The facility Mental Health Director shall make a recommendation to the BHSAMH Behavioral Health Director as to whether the case should receive a formal review.
- b. After review of the incident and recommendation of the Facility Mental Health Director, the BHSAMH Behavioral Health Director will make the determination if an M&M is warranted and if so, request a formal M & M review.

3. All cases should have an updated Individual Treatment Plan (ITP) completed within 30 days of an incident of self-directed violence.

- a. If an offender has a repeated incident of non-suicidal self-directed violence within 30 days of a previous incident, an updated ITP is not necessary unless the clinician determines an update is needed, or if the last ITP update was completed more than 30 days prior.
- b. The ITP shall also include what efforts are being undertaken to reduce future incidents for those patients experiencing repeated incidents of SDV.

C. It is the policy of the DDOC that these reviews are conducted for the following reasons:

1. To determine the appropriateness of care provided by medical and/or behavioral health staff.
2. To ascertain whether changes to policies, procedures, or practices are warranted.
3. To identify issues that may require further study.

D. Notification of any incident of death, suicidal and non-suicidal self-directed violence shall be made as soon as possible, not to exceed 2 hours of the event.

VII. PROCEDURES: The following procedures shall be followed in the event of one of the following situations: Any offender death, incident of suicidal self-directed violence that results in transport to an outside healthcare facility, or any incident where BHSAMH requests a formal M&M Review. These actions should take place after documentation and emergency care has been completed. The procedures are as follows:

A. At the time of an offender death or incident of self-directed violence (suicidal or non-suicidal) that results in transport to an outside healthcare facility, the following staff shall be notified of the incident in writing via email (not to exceed 2 hours from the event) with the offender's information along with a summary of the event:

1. Designated institutional staff (Warden, Deputy Warden, Major, Shift Commander, etc.),
2. Facility Health Services Administrator (HSA),
3. Facility Medical Director,
4. Facility Mental Health Director,
5. BHSAMH Bureau Chief,
6. BHSAMH Medical Director,
7. BHSAMH Behavioral Health Director,
8. BHSAMH Medical Treatment Services Director,
9. BHSAMH Behavioral Health Treatment Services Director,
10. BHSAMH Compliance Director,
11. BHSAMH Quality Assurance Administrator,

12. BHSAMH Director of Community Health,
 13. BHSAMH Facility Liaison, and
 14. BHSAMH Medical Records Clerk/Administrative Specialist (for deaths only).
- B. At the time of an incident of self-directed violence (suicidal or non-suicidal) that does not result in transport to an outside healthcare facility, the following staff shall be notified of the incident in writing via email (not to exceed 12 hours from the event) with the offender's information along with a summary of the event:
1. Facility Mental Health Director,
 2. BHSAMH Behavioral Treatment Services Director, and
 3. BHSAMH Quality Assurance Administrator.
- C. In the event of a death within a DDOC facility, the institutional warden, or designee, shall notify the Medical Examiner and request that an autopsy be completed.
1. The medical examiner will determine if an autopsy will be conducted or not.
 2. A toxicology screening should be requested if the death was due to unknown circumstances, under suspicious circumstances, if the offender is not under medical care, and/or other reasons that may warrant such a screening.
 3. If a death occurs at a community healthcare facility, that facility's medical examiner notification process shall be utilized.
- D. Notification of offender's next of kin must be conducted.
1. The facility warden, or designee is responsible for notification of next of kin.
 2. If there is a security concern that prevents immediate notification it should be documented, and notification should occur as soon as possible.
- E. Within 24 hours of the incident an incident summary (Attachment A) must be submitted to the Clinical Morbidity and Mortality Committee. The incident summary shall be completed by either the facility Medical Director, or the facility Mental Health Director, or both, if deemed appropriate for the situation. The incident summary shall include, at a minimum, the following information:
1. Name, DOB, and SBI# of the offender.
 2. Location of incident and housing location (if incident occurred somewhere different).
 3. Medical and behavioral health diagnoses.
 4. Current medications.
 5. Short synopsis of the event.
 6. Disposition/pronouncement – i.e., is the offender deceased? If not, where is offender housed at this time?
 7. Other information deemed important and necessary (e.g., current, or prior Psychological Close Observation (PCO) placements).
- F. The BHSAMH Quality Assurance Administrator shall schedule the M & M review. This review shall occur within 30 days of the death or incident of self-directed violence.
- G. Conducting the M & M review.
1. An M & M review is an assessment of the clinical care and circumstances that led up to a death or incident of self-directed violence. It also reviews the effectiveness of the clinical policies and procedures relevant to the circumstances surrounding the death or incident of self-directed violence.
 - a. There are three questions that should be answered during an M & M review:
 - a. Could the medical response at the time of death be improved?

- b. Was an earlier intervention possible?
 - c. If a death occurred, independent of the cause of death, is there any way to improve patient care?
2. The M & M review must include an administrative review. An administrative review is an assessment and review of the correctional and emergency response actions surrounding a death or self-directed violence incident and reviews the incident and facility procedures used as well as the training received by involved staff.
3. Recommendations may be made, if any are required, for changes in policy, training, physical plant, medical or mental health services/practices, and operational procedures.
 - a. The M&M committee may require a peer review of staff involved in the care of an offender that is the subject of an M&M review.
 - b. All corrective actions should be accomplished within 90 days of the event.
 - c. If the M&M committee makes no recommendations, the report shall be annotated as such with reasons given for no recommendations being made.
4. Upon receipt of autopsy results the clinical and/or administrative reviews may be updated with applicable information from the autopsy report.
5. The M&M Report (Attachment B) shall be completed as a joint effort between the facility Medical Director and the facility Mental Health Director.
 - a. If those positions are vacant the report shall be completed by a regional equivalent.
 - b. The report should be sent to Clinical Morbidity and Mortality Committee at least 7 days prior to the scheduled meeting of the M&M Committee.
6. The Clinical Morbidity and Mortality Committee will include, but is not limited to the following:
 - a. Facility warden, or designee,
 - b. Facility HSA,
 - c. Facility Medical Director,
 - d. Facility Mental Health Director (for incidents of self-directed violence),
 - e. Attending physician or healthcare provider treating the offender,
 - f. Mental health staff treating the offender (for incidents of self-directed violence),
 - g. Facility Pharmaceutical Representative,
 - h. Healthcare Contract – Chief Medical Officer,
 - i. Healthcare Contract – Chief Nursing Officer,
 - j. Healthcare Contract – Statewide Health Services Administrator,
 - k. BHSAMH Bureau Chief – chair,
 - l. BHSAMH Medical Director,
 - m. BHSAMH Director of Community Health,
 - n. BHSAMH Policy and Standards Compliance Director,
 - o. BHSAMH Medical Treatment Services Director,
 - p. BHSAMH Behavioral Health Treatment Services Director,
 - q. BHSAMH Quality Assurance Administrator,
 - r. Assigned BHSAMH Facility Liaison, and
 - s. Other staff members as deemed necessary by the BHSAMH Bureau Chief.

7. The M&M Report should be updated and/or revised because of the collaborative discussions and/or decisions made at the meeting of the M&M Committee.
 8. The BHSAMH Quality Assurance Administrator may reconvene the M&M Committee if there are unresolved questions, e.g., pending autopsy report or toxicology report.
- H. Corrective actions identified through the review process are implemented and monitored through the continuous quality improvement (CQI) program in accordance with BHSAMH Policy A-06 *Continuous Quality Improvement Program*.
1. Corrective actions or recommendations for actions should be completed within 90 days of the review. Documentation of these actions shall be forwarded to the BHSAMH Quality Assurance Administrator upon completion.
 2. Results of reviews are communicated to healthcare staff for lessons learned to be shared with treating staff to prevent similar situations in the future. This review must be documented.
- I. A psychological autopsy shall be conducted by an individual/agency approved by BHSAMH within 30 days on all deaths that result from incidents of self-directed violence.
1. A psychological autopsy is based on a detailed review of all file information on the offender, a careful examination of the suicide location, and interviews with staff and offenders familiar with the deceased offender.
 2. A psychological autopsy must be conducted by a licensed psychologist or psychiatrist not involved in the care of the offender. Deviations of this must be approved in writing by the BHSAMH Bureau Chief.
- J. Once all pertinent information is received and entered, a final M&M Report shall be signed by the facility Medical Director and the facility Mental Health Director and forwarded to the BHSAMH Quality Assurance Administrator.
- K. The BHSAMH Quality Assurance Administrator shall maintain the M&M file and will be responsible to review and determine if the file is ready for signature and closure.
1. The M&M file shall be reviewed and closed within 30 days after receiving satisfactory proof that the recommended actions (if any) have been completed.
 2. A completed M&M file should include, but is not limited to the following documentation:
 - a. Initial Notification of death or incident of self-directed violence (and any other correspondence related to the incident notification).
 - b. Incident Summary.
 - c. Clinical Morbidity and Mortality Review Report.
 - d. Death Certificate (if available).
 - e. Autopsy results.
 - f. Toxicology results.
 - g. Psychological Autopsy (for deaths by self-directed violence).
 - h. Copy of downloaded event reports from the Automatic External Defibrillator (AED).
 - i. Proof of completed corrective action.
 - j. Meeting sign-in sheets for all meetings related to the review.
 - k. All correspondence related to the incident.
- L. The BHSAMH Quality Assurance Administrator shall maintain a log of all deaths (including those resulting from self-directed violence) as well as incidents of non-fatal

suicidal self-directed violence. This log shall include, but is not limited to the following information:

1. Demographic information - offender name, SBI#, date of birth, gender, race,
 2. Facility of occurrence,
 3. Date of death or of incident of suicidal self-directed violence,
 4. Date of clinical mortality review,
 5. Date administrative review is completed,
 6. Cause of death,
 7. Manner of death,
 8. Date pertinent finding(s) of review shared with staff, and
 9. Date of psychological autopsy.
- M. The policies and procedures outlined above also apply to deaths that occur off-site while the facility is responsible for the offender.
1. If known, an offender who dies within 24 hours of release from a Level 4 or Level 5 facility shall have a review completed as well.
- N. The Morbidity and Mortality Review process outlined in this policy is a peer review process pursuant to 24 Delaware Code § 1768 - *Immunity of Boards of Review; Confidentiality of Review Board Record*. Disclosure of Protected Health Information is protected pursuant to 16 Delaware Code § 1212 - *Disclosure of Protected Health Information*. This process may also be covered by other state and federal laws, such as the quality assurance privilege. Accordingly, the records and proceedings of the Clinical Morbidity and Mortality Committee are confidential and may be used by the committee and the members thereof only in the exercise of the proper functions of the committee.
- O. The Contracted Healthcare Provider shall develop within 30 days of the effective date of this policy, a facility-specific procedure for each Level 4 and Level 5 facility implementing this policy and coordinating the procedure with the BHSAMH.



Incident Summary for Death or Suicide Attempt

Delaware Department of Correction
Bureau of Healthcare, Substance Abuse, and Mental Health Services
245 McKee Road
Dover, DE 19904

Basic Information

Type of incident:	<input type="checkbox"/> Natural Death <input type="checkbox"/> Suicide <input type="checkbox"/> Self Directed Violence (SDV)		
If SDV, type of SDV:	<input type="checkbox"/> Suicidal <input type="checkbox"/> Non-Suicidal <input type="checkbox"/> Undetermined		
I/M Name:	SBI#:	DOB:	
Gender at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Offender identifies as transgender: <input type="checkbox"/>	Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other		
Date of incident:	Time of incident:		
Location: Level 5: <input type="checkbox"/> HRYCI <input type="checkbox"/> BWCI <input type="checkbox"/> JTVCC <input type="checkbox"/> SCI Level 4: <input type="checkbox"/> PCCC <input type="checkbox"/> HD Plant <input type="checkbox"/> CVOP <input type="checkbox"/> MCCC <input type="checkbox"/> SWRC <input type="checkbox"/> SVOP	Housing Location at time of incident:		
Classification status:	Housing History last 90 days (include if on PCO):		

Health Information

Current Medical Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?
Current Behavioral Health Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?
Current medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?

Short Synopsis of Event – describe the event with as much detail as is known at this time. Include names of responders, time of response, and other pertinent details.

Disposition/Pronouncement – What was the result of the incident? Where is the offender housed at this time? If the result was death, who pronounced the death, who was notified and by whom, when was the body released and to whom?

Eyewitnesses - List all eyewitnesses to the event.

Other Information – Is there any other information that should be reported?

M&M Review Scheduling (section below to be completed by the facility MH Director)

This was an incident of suicidal self-directed violence that required transport to an outside healthcare facility. An M&M review will be automatically scheduled by the BHSAMH Quality Assurance Administrator.

This was an incident of suicidal or non-suicidal self-directed violence that did not require transport to an outside healthcare facility, therefore a review is discretionary.

Review requested. An M&M review will be scheduled by the BHSAMH Quality Assurance Administrator.

Review not requested. Reason: _____

Title	Printed Name	Signature	Date
Contract Site Medical Director			
Contract Mental Health Site Director			



Clinical Morbidity and Mortality Review Report

Delaware Department of Correction
 Bureau of Healthcare, Substance Abuse, and Mental Health Services
 245 McKee Road
 Dover, DE 19904

Section A: Basic Information

Date of incident:		Time of incident:		Date of M&M Review:	
Type of incident: <input type="checkbox"/> Natural Death <input type="checkbox"/> Suicide <input type="checkbox"/> Self Directed Violence (SDV)					
If SDV, type of SDV: <input type="checkbox"/> Suicidal <input type="checkbox"/> Non-Suicidal <input type="checkbox"/> Undetermined					
Offender Name:			SBI#:		DOB:
Gender at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Offender identifies as transgender? <input type="checkbox"/>		Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other			
Location: Level 5: <input type="checkbox"/> HRYCI <input type="checkbox"/> BWCI <input type="checkbox"/> JTVCC <input type="checkbox"/> SCI Level 4: <input type="checkbox"/> PCCC <input type="checkbox"/> HD Plant <input type="checkbox"/> CVOP <input type="checkbox"/> MCCC <input type="checkbox"/> SWRC <input type="checkbox"/> SVOP			Housing Location at time of incident:		
Date incarcerated:		Charges:			

If death occurred, complete section B. If no death occurred, go to section C.

Section B: Information on Death

Date of Death:		Expected death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of M&M Review:	
Date of Medical Examiners Report:			Medical Examiner's Report #:		
Cause of Death:					
Manner of Death:					
Toxicology Findings (as applicable):					

Was the cause of death the result of a pre-existing medical condition or did the offender develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "pre-existing medical condition.") [Please select one of the choices below]

<input type="checkbox"/> Pre-existing medical condition <input type="checkbox"/> Deceased developed condition after admission <input type="checkbox"/> Could not be determined
--

Excluding emergency care provided at the time of death, did the offender receive any of the following medical services for the medical condition that cause his/her death after admission to the correctional facility?

Evaluated by a physician/medical staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Diagnostic tests (e.g., X-rays, MRI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Treatment/care other than medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Confinement in a special medical unit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Section C: Medical History

This document is protected from disclosure pursuant to state and federal peer review and quality assurance privileges.

A-09 Attachment B

Current Medical diagnosis:	
Current medications:	

Access to Medical Care in the previous 6 months, or longer if clinically relevant (Please provide a narrative summary of the care received):

Section D: Mental Health History

Current Mental Health diagnosis:			
Current medications:			
Is offender on MH Roster? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current BH Category:	Current BH Level of Care:	
Is there a current Behavior Plan in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, date of Behavior Plan:	Date:		
If yes, was the plan followed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, please explain what aspects were not followed, and why.			
What changes are proposed to the Behavior Plan to attempt to reduce future behavior?			

Access to Mental Health Care in the previous 6 months, or longer if clinically relevant (Please provide a narrative summary of the care received):

Section F: Institutional Factors

Were there any institutional factors to be considered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	

Section G: Conclusions and Lessons Learned

Could the medical response at the time of death be improved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	
Was an earlier intervention possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	
Independent of the cause of death or suicide attempt, is there any way to improve patient care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	
Other conclusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	

Section H: Recommendations for Action - must follow S.M.A.R.T. format and include specific documentation to be submitted as proof of completion of recommended action and the specific person responsible for implementing the action.

	Description of recommendation	Date Due	Documentation to be submitted as proof	Person Responsible
A				
B				
C				
D				
E				
F				

Section I: Approval for closure

Title	Printed Name	Signature	Date
Contract Site Medical Director			
Contract Mental Health Site Director			
BHSAMH Medical Director			
BHSAMH Behavioral Health Treatment Services Director			
BHSAMH Bureau Chief			

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

<p align="center">POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION</p>	<p align="center">POLICY NUMBER A-10</p>	<p align="center">TOTAL PAGES 8 ATTACHMENTS none</p>
<p>RELATED ACA/NCCHC STANDARDS: ACA: 5-ACI-6A-01 (Mandatory), 5-ACI-6C-01, 5-ACI-5E-02, 4-ALDF-2A-27, 4-ALDF-6B-01, 4-ACRS-6B-03 NCCHC: J-A-10 (Essential), P-A-10 (Essential), MH-A-10 (Essential), O-A-11</p>		
<p>CHAPTER: 11 BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES</p>	<p>SUBJECT: GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS</p>	
<p>APPROVED BY THE BUREAU CHIEF: Bureau Chief, Michael Records (signature on file with BHSAMH)</p>		
<p>APPROVED BY THE COMMISSIONER AND EFFECTIVE THIS DATE: Commissioner Terra Taylor, April 2, 2026 (signature on file with BHSAMH)</p>		
<p>APPROVED FOR PUBLIC RELEASE</p>		

- I. **AUTHORITY:** 11 *Del. C.* §§ 6502, 6517, 6536; 29 *Del. C.* §§ 8903.
- II. **PURPOSE:** To ensure that the facility protects an individual’s right to disagree with or question the healthcare system.
- III. **APPLICABILITY:** All Delaware Department of Correction (DOC) staff and contract provider staff, patients/incarcerated individuals (individual) in custody of or under the supervision of the Department, and any outside healthcare provider servicing DOC individuals.
- IV. **DEFINITIONS:** See Glossary
- V. **POLICY:** It is the policy of the DOC that the facility protects an individual’s right to disagree with or question the healthcare system through a formal grievance process.

Compliance Indicators:

- A. A grievance process is in place for healthcare-related concerns.
- B. The healthcare-related grievance policy includes the following:
 - 1. A time frame for response.
 - 2. The process for appeal.

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

- C. Responses to healthcare-related grievances:
 - 1. Are timely.
 - 2. Are based on principles of adequate healthcare.
 - 3. Include documentation of response.
- D. Healthcare grievance log is maintained and includes, at a minimum:
 - 1. Patient name or identification number.
 - 2. Date the grievance was received by health services.
 - 3. Nature of grievance (for example, medical, dental, or mental health).
 - 4. Outcome (response, plan of action, resolution of grievance).
 - 5. Date and time the grievance was completed and the individual notified.
 - 6. Name and title of person completing the grievance response.
- E. Healthcare-related grievances are collected, investigated, monitored, and reported to the continuous quality improvement CQI committee.

VI. PROCEDURES:

- A. Healthcare grievances will be submitted in accordance with the DOC Bureau of Prison (BOP) Policy 4.4 *Offender Grievance Process*.
- B. All individuals are informed of the grievance process at the time of admission/intake at a facility. This information shall be provided both verbally and in writing in language that is easily understood by each individual. If a literacy, language, and/or disability prevents an individual from understanding written information, a certified translator (i.e., language line) or teletypewriter (TTY) device will be utilized to assist the individual.
- C. Responses to individual healthcare-related grievances are timely and based on principles of adequate healthcare.
 - 1. Individuals must submit a grievance form to the Institutional Grievance Chair (IGC) within 7 calendar days of the incident (e.g., a sick call encounter).
 - 2. Only one healthcare issue may be addressed in a single grievance submission.

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

3. Individuals must fully utilize the sick call process before submitting a grievance related to a healthcare concern.
- D. The healthcare grievance process will comprise three steps. Those steps and associated processes are outlined as follows:

1. Step 1 - Informal Resolution

- a. Healthcare staff will receive the grievance from the IGC electronically through the Delaware Automated Correctional System (DACS) and attempt to resolve the grievance.
 - i. The IGC shall forward the grievance to the appropriate healthcare staff (based on the nature of the grievance) as follows:
 - (i) Grievances related to medical will be forwarded to the facility Health Services Administrator (HSA), or designee.
 - (ii) Grievances related to mental health concerns will be forwarded to the facility's mental health director or designee.
 - (iii) Grievances related to substance use disorder (SUD) treatment shall be forwarded to the facility's SUD program director or designee.
- b. The designated healthcare staff (as listed above) will review grievances no later than the next business day and attempt to resolve concerns raised by individuals before initiating a Step 2 Grievance Hearing.
 - i. The designated healthcare staff shall attempt to resolve the grievance at Step 1 by utilizing a variety of methods that may include, but are not limited to, the following:
 - (i) Review the grievance.
 - (ii) Investigative actions.
 - (iii) Interview staff.
 - (iv) Make appropriate appointments.
 - (v) Perform necessary follow-up, and/or meet with the individual.
 - ii. Information in the investigation must be entered into DACS and shall include the following:
 - (i) Date of interview.
 - (ii) Date of response.
 - (iii) Nature of response.
 - (iv) Staff response.
 - (v) Resolution category.

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

- c. The designated healthcare staff shall meet with the individual and review the individual's grievance and the possible resolution.
 - d. The individual may accept this Step 1 resolution or request a formal hearing.
 - i. The individual must sign and date the grievance within 7 days, indicating a resolution was accepted or rejected.
 - ii. DACS will be updated accordingly, and the grievance will be returned electronically through DACS to the IGC.
 - e. The Step 1 process must occur and be completed within 14 days of receipt of grievance from the IGC or the grievance proceeds to a Step 2 Grievance Hearing.
 - f. If an individual does not sign and return the grievance to the IGC within 7 days, indicating their acceptance or rejection of the informal resolution, the grievance is deemed abandoned.
 - g. If the IGC receives a rejection within the specified time period, they will schedule the grievance for a Step 2 Medical Grievance Hearing.
2. Step 2 – Medical Grievance Committee (MGC) Hearing
- a. The MGC has at minimum three members of the health service staff, and one of the three must be a licensed healthcare professional (e.g., licensed nurse for medical grievances and a licensed mental health clinician (or licensed SUD staff) for behavioral health grievances).
 - i. The IGC shall also be present to record the MGC results into DACS.
 - ii. Any healthcare staff member who was involved in Step 1 cannot be part of Step 2.
 - b. The MGC shall meet at least twice monthly or more often as needed.
 - i. If there are no grievances to be heard, the MGC is not required to meet.
 - c. The MGC must conduct the hearing within 30 days of receipt of the Step 1 resolution rejection.
 - d. The MGC hearing shall be conducted in the presence of the individual and shall have the following steps, at a minimum:
 - i. A review of the pertinent sections of the health record,
 - ii. A complete review of the grievance,
 - iii. Discussion of the information contained in the grievance, and

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

- iv. Comments from the individual.
 - e. The MGC will then discuss and render a determination to deny or uphold the individual's grievance.
 - f. At the conclusion of the MGC hearing, an MGC Log will be created and/or updated that will include the following information:
 - i. Individual's name and SBI.
 - ii. Grievance number.
 - iii. Nature of grievance.
 - iv. Type of grievance.
 - v. MGC decision.
 - vi. Agreed outcome.
 - vii. Date issue is to be resolved.
 - g. The MGC Log shall be submitted to the Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH) on the 5th of each month for the previous month.
 - h. The MGC's recommendations must be implemented within 7 calendar days of the Step 2 Hearing. If the recommendation involves attendance at an outside healthcare provider beyond the MGC's control, the scheduling of the appointment will suffice.
3. Step 3 – Appeal of MGC Recommendation
- a. An individual who chooses to appeal the Step 2 decision must do so within 7 days of receipt of the decision.
 - b. BHSAMH Bureau Grievance Officer (BGO) - a BHSAMH employee - will review the grievance, investigate as necessary, and submit a recommendation through DACS to the BHSAMH Bureau Chief, or designee, for review and final decision. The BGO must do one of the following:
 - i. Uphold or deny the grievance,
 - ii. The BGO may also partially uphold or deny the grievance, by:
 - (i) Request additional investigation and withhold rendering a recommendation until the results of the investigation are complete, or
 - (ii) Provide a partial accommodation or request that an outside consultation be completed.
 - c. The BHSAMH Bureau Chief, or designee, will then review the BGO's recommendation along with the MGC's recommendation, and the results

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

of the informal resolution, and render a final decision to be entered in DACs.

- d. The decision of the BHSAMH Bureau Chief, or designee, is final and must be followed as directed.
4. The maximum amount of time between initial receipt of the grievance and the Bureau Chief's final decision cannot exceed 180 total calendar days.
5. The individual shall receive a decision in writing from the IGC after the BHSAMH determination is complete.

E. Emergency Medical Grievances

1. In the event of an emergency medical grievance, the IGC shall expedite and forward emergency medical grievances to the BHSAMH Bureau Chief or designee for review.
 - a. The BHSAMH Bureau Chief or designee may forward the emergency grievance to the facility HSA for a determination if the grievance qualifies as a medical emergency.
2. If the grievance qualifies as an emergency, BHSAMH Bureau Chief, or designee (or the HSA) shall provide for a solution and respond in DACS within 24 hours of receipt.
3. If the BHSAMH Bureau Chief, or designee (or the HSA) determines that the grievance is not an emergency, the grievance will be electronically returned to the IGC for regular grievance processing. The IGC shall notify the individual that the grievance does not qualify as an emergency and will proceed with regular processing.

F. Tracking, Reporting, and Trending

1. Grievances shall be tracked and recorded in DACS and maintained for a minimum of three years.
2. The facility HSA or designee shall track the status of medical grievances.
 - a. A log must be maintained indicating the status of each grievance. This log shall include, but is not limited to, the following:
 - i. Name and SBI of the individual.
 - ii. Facility and housing unit.
 - iii. Grievance number.
 - iv. Date grievance was received.
 - v. Description of grievance complaint.

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS


- vi. Date grievance received by medical staff.
- vii. Date seen for Step 1 – Informal Resolution.
- viii. Date of Step 1 Resolution.
- ix. Details of informal resolution.
 - (i) Date and Time.
 - (ii) Staff member completing Step 1.
 - (iii) Accepted or rejected.
 - (iv) Individual notified.
- x. If not accepted, date of Step 2 – Formal resolution.
- xi. Date seen for Step 2.
- xii. Details of formal resolution.
 - (i) Date and Time.
 - (ii) Staff member completing Step 2.
 - (iii) Accepted or rejected.
 - (iv) Individual notified.
- xiii. If not accepted, date of Step 3 – bureau grievance final resolution.
- xiv. Results of Step 3.
- xv. Details of final resolution.
 - (i) Date and time.
 - (ii) Staff member completing Step 3.
 - (iii) Individual notified.

b. A copy of the Tracking Log shall be provided to BHSAMH monthly.

- 3. The status and trending of grievances shall be reported at quarterly Healthcare Advisory Committee (HAC) meetings.
- G. Grievances that pertain to key healthcare systems or functions should be discussed at monthly Continuous Quality Improvement (CQI) meetings at each facility, where grievances are reviewed to identify recurrent issues and associated corrective action plans as needed.
- H. BHSAMH may audit grievances and the grievance process for timeliness of grievance referrals, effectiveness of proposed resolutions, and completion, or follow-through, on upheld grievances.
- I. Copies of individual grievances shall never be placed in an individual's healthcare record.
- J. The grievance system must be evaluated annually by the facility's Continuous Quality Improvement (CQI) Committee (In accordance with BHSAMH Policy *A-06*

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

Continuous Quality Improvement Program) to determine its efficiency and effectiveness. This will include an analysis of both the quantity and nature of individual grievances for the previous year. The results of these evaluations shall be reported to the Statewide CQI Committee annually.

POLICY OF STATE OF DELAWARE	POLICY NUMBER 8.50	PAGE NUMBER 1 of 3
DEPARTMENT OF CORRECTION	RELATED STANDARDS:	
CHAPTER: 8 ADMINISTRATION	SUBJECT: ADULT CORRECTIONAL HEALTHCARE REVIEW COMMITTEE	
APPROVED BY THE COMMISSIONER AND APPROVED THIS DATE:	 4/2/2015	
APPROVED FOR PUBLIC RELEASE		

I. AUTHORITY: 11 *Del. C.*, §6518

II. PURPOSE: The Adult Correction Healthcare Review Committee serves in an advisory capacity to the Commissioner of the Department of Correction (DOC) on all matters in the DOC relating to the provision of inmate healthcare services, and the review of all statistics relating to the inmate healthcare.

III. APPLICABILITY: All Department of Correction employees, all offenders under the supervision of the Bureau Prisons, the Bureau of Community Corrections – Community Correction Centers and Violation of Probation Centers, and Bureau of Correctional Healthcare Services and all contracted providers of medical or substance abuse treatment.

IV. DEFINITIONS:

Committee: The Adult Correction Healthcare Review Committee

Members: An appointed individual who is a part of the Adult Correction Healthcare Review Committee. Members of the Committee shall be appointed by the Governor and confirmed by the Senate. The Committee member shall serve no more than two (2) consecutive 3-year terms.

V. POLICY:

A. The Committee consists of seven (7) members as identified in the statute, 11 *Del. C.* §6518, with at least one representative appointed by each of the following organizations: the Medical Society of Delaware, the Delaware Psychiatric Society, the Delaware Psychological Association, the Delaware Nurses Association, the Delaware State Bar Association, an expert in the field of substance abuse treatment and the Bureau Chief of Correctional Healthcare Services.

B. The chair of the Committee shall be selected by majority vote of the Committee.

C. Pursuant to 11 *Del. C.* §6518, the responsibility of the Committee shall include:

1. performing advisory reviews of medical records of inmates who have died while incarcerated;

POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER 8.5	PAGE NUMBER 2 of 3
SUBJECT: ADULT CORRECTIONAL HEALTHCARE REVIEW COMMITTEE		

2. reviewing and monitoring the quality and appropriateness of healthcare services rendered in DOC facilities;
 3. reviewing critical incident and mortality and morbidity review reports;
 4. receiving and reviewing monthly summaries of inmate, staff, public and other grievances and the resolutions of these grievances in order to be fully appraised of the state of healthcare services in DOC facilities;
 5. receiving and reviewing monthly reports of inmate hospital admissions and infectious disease diagnoses, such as Hepatitis C, tuberculosis, human immunodeficiency virus (HIV), methicillin resistant staphylococcus aureus (MRSA) and meningitis from all DOC facilities;
 6. having access to any and all otherwise protected healthcare information relating to current and former inmates supervised by the DOC notwithstanding any other statute to the contrary; and
 7. reviewing and advising on any other matters relating to inmate health care that the Committee considers reasonable and worthwhile including , but not limited to, the following:
 - a. assurance that all inmates receive appropriate and timely services in a safe environment;
 - b. systematic monitoring of treatment environment;
 - c. assisting in the reduction of professional and general liability risks;
 - d. enhancing efficient utilization of resources;
 - e. assisting in credential review;
 - f. enhancing the identification of continuing educational needs;
 - g. facilitating the identification of strengths, weaknesses, and opportunities for improvement;
 - h. facilitating the coordination and integration of information systems; and
 - i. assuring the resolution of identified problems.
 8. Referring to the appropriate licensing board grievance cases in which there is a serious deviation from the community standard of care by a healthcare worker or other employee of a prison healthcare contractor, if the healthcare worker or other employee's profession or occupation is governed under Title 24 of the Delaware Code.
 9. Submitting a report by December 31 of each year to the Governor and the General Assembly on the state of adult inmate healthcare.
- D. The DOC shall forward copies of National Commission of Correctional Health Care (NCCHC) and American Correctional Association (ACA) surveys, reports, and evaluations to the Committee upon their request. Whenever a survey, evaluation or similar act is conducted by or on behalf of NCCHC or ACA, the Committee may be contacted and be allowed to contribute to the survey, evaluation, or other activity. The transmission of documents in the possession of the DOC to the Committee shall not be considered a waiver of any statutory or common law privilege.

<p style="text-align: center;">POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION</p>	<p style="text-align: center;">POLICY NUMBER 8.5</p>	<p style="text-align: center;">PAGE NUMBER 3 of 3</p>
<p>SUBJECT: ADULT CORRECTIONAL HEALTHCARE REVIEW COMMITTEE</p>		

- E. The DOC shall forward copies of National Commission of Correctional Health Care (NCCHC) and American Correctional Association (ACA) surveys, reports, and evaluations to the Committee upon their request. Whenever a survey, evaluation or similar act is conducted by or on behalf of NCCHC or ACA, the Committee may be contacted and be allowed to contribute to the survey, evaluation, or other activity. The transmission of documents in the possession of the DOC to the Committee shall not be considered a waiver of any statutory or common law privilege.

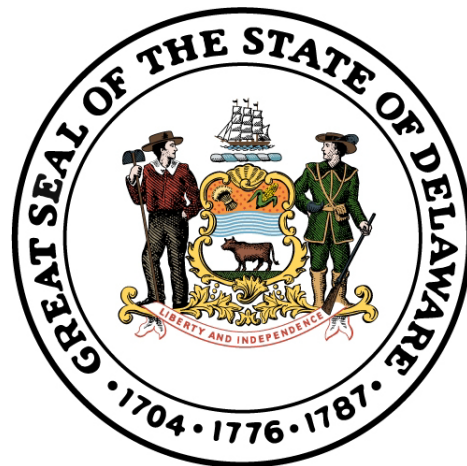
VI. PROCEDURES:

The Committee shall meet on a quarterly basis. The agenda shall include those items identified in Section 3. The Committee will receive information from the Bureau of Correctional Healthcare Services. Bureau staff will provide administrative support to the Committee. Any document received or generated by the Committee is excluded from the definition of public record as set forth in *29 Del. C. Section 10002(g)*.

**State of Delaware
Adult Correction Healthcare Review
Committee**

**Annual Report
Calendar Year
2023**

Mandell Much, Ph.D.
Chair



State of Delaware
Adult Correction Healthcare Review Committee

MEMORANDUM

TO: The Honorable John C. Carney, and
Members of the General Assembly

FROM: Adult Correction Healthcare Review Committee, Criminal Justice Council
staff, and
Mandell Much, Ph.D.
Chair, Adult Correction Healthcare Review Committee

DATE: December 28, 2023

SUBJECT: Adult Correction Healthcare Review Committee -
2023 Annual Report

cc: Terra Taylor, Acting Commissioner, Delaware Department of Correction
Paul Shavack, Chief of Staff, Delaware Department of Correction

We are pleased to present to you the fourteenth Annual Report of the Delaware Adult Correction Healthcare Review Committee (“ACHRC or Committee”). This report, prepared by the Committee in accordance with 11 *Del. C.* § 6518 (v), provides a summary of the accomplishments and work product of the Committee this past year, observations and recommendations of the Committee, and the Committee’s future goals and plans.

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Appendix A - Revised Work Plan

I. Background

This is the fourteenth Annual Report of the ACHRC. Established by 11 *Del. C.* § 6518 in 2009 and revised by House Bill 173 in 2019 and House Bill 7 in 2021. The Committee was created to serve “in an advisory capacity to the Governor, the General Assembly, and the Commissioner of the Department of Correction (DOC) on all matters in Delaware's adult correction system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, and the review of all statistics relating to inmate healthcare. The Committee shall not be considered a public body as defined by 29 *Del. C.* § 10002(c).” 11 *Del. C.* §6518 (m).

In April 2023, House Bill 52 was signed into law that modified the membership of the ACHRC. The Bill restored the Delaware licensed psychiatrist position at the request of the Committee.

II. Committee Members

The nine voting members of the Committee appointed by the Governor and confirmed by the Senate are:

1. Janet P. Kramer, MD, CCHP, a Delaware licensed physician.
2. Dr. Laura Cooney-Koss, a Delaware licensed psychologist.
3. Mandell Much, PhD, a Delaware licensed Forensic psychologist.
4. Ashley Istenes, RN, a Delaware licensed registered nurse.
5. Vacant currently, a member of the Delaware State Bar.
6. Wm. James Harrison, MHS, an expert in the field of substance abuse treatment.
7. Sandra J Nolan, PhD, RN AHN-BC, any additional healthcare professional who by virtue of training, education, and specialization holds expertise in correctional healthcare.
8. Bernice Edwards, an individual representing a non-profit that is serving the families of inmates or the inmates themselves, or a local civil rights organization.
9. Vacant currently, a Delaware licensed psychiatrist;¹

As per the revision in HB 52 (changes are underlined):

(c) The Committee shall consist of 9 voting members, appointed by the Governor, and confirmed by the Delaware State Senate which shall include all the following: (1) A Delaware licensed physician. (2) A Delaware licensed forensic psychologist. (3) A Delaware licensed psychologist. (4) A Delaware licensed registered nurse. (5) A member of the Delaware Bar. (6) An expert in the field of substance abuse treatment. (7) Any additional healthcare professional who by virtue of training, education, and specialization holds expertise in correctional healthcare. (8) An individual representing

¹ Mustafa Mufti, MD, is currently completing the application process and pending consideration.

a non-profit that is serving the families of inmates or the inmates themselves, or a local civil rights organization. (9) A Delaware licensed psychiatrist.

(d) The Committee shall also consist of the following 3 nonvoting ex-officio members: (1) The Chief of the Bureau of Healthcare, Substance Abuse, and Mental Health Services. (2) Chairperson of the House Corrections Committee. (3) Chairperson of the Senate Corrections and Public Safety Committee.

Mandell Much, PhD served as Chair of the Committee. In addition to the appointed members of the Committee, other non-voting participants include Deputy Attorneys General (“DAG”) Michael Tipton, Esquire, served as counsel for the Committee; DAG Gregory Smith, Esquire, served as counsel for the DOC; Nicole Hartman, served as counsel for CJC; Michael Records, Chief of Bureau of Healthcare, Substance Abuse and Mental Health Services at DOC; Awele Maduka-Ezeh MD MPH., Medical Director of the DOC; Vanessa Bennifield, PsyD, Behavioral Health Treatment Director; Susan Conley, APRN, ACNS-BC then replaced by Victoria Bryant, Director of Medical Treatment Services; and Anneke Cerri, Behavioral Healthcare Services for the DOC. Valarie Tickle and Kim Kirk are the Criminal Justice Council staff assigned to the Committee.

During 2021 and 2022, the Chairperson of the House Corrections Committee and the Chairperson of the Senate Corrections and Public Safety Committee were voting members of the Committee however this provision expired in 2023. Both members, Senator Marie Pinkney and Representative Nnamdi Chukwuocha remain active participants and provide valuable input.

With the additional members and intermittent vacancies, the group at times encounter challenges reaching a quorum. The Committee has worked very diligently to seek and recommend appropriate candidates to fill vacancies. Membership continues to be discussed to maximize the efficiency of the group and fulfil the mandated charge and mission. The group continues to nominate candidates to fill the vacant positions and anticipates that the positions will be filled by early 2024.

Special Recognition - Brenda James-Roberts, Esq. JD, RN, served as a dedicated member of the ACHRC as a representative of the Delaware State Bar for over 10 years. It is with deep sadness that the members received news of Brenda passing away in October 2023. Brenda’s insight and passion helped advance the efforts and mission of the ACHRC in many heartfelt ways.

III. Committee Charge

The Committee is tasked with advising the Commissioner of the DOC along with the Governor and the General Assembly on all matters in Delaware’s adult correctional system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, the review of all statistics relating to inmate healthcare, and any matters relating to adult inmate healthcare that the Committee considers reasonable and worthwhile, including assuring the resolution of identified problems and enhancing the efficient utilization of resources.

Certain State agencies and contractors providing medical services to inmates must provide information requested by the Committee. Additionally, the Committee may request the appearance of any contractor providing medical and behavioral health services to an inmate under the direction of the DOC at a Committee meeting to provide information to the Committee. Another highlight notes that the Committee is not a public body, and Committee members must abide by federal and state laws regarding the privacy of protected health information and provides penalties for violations of the privacy of such information. 11 *Del. C.* § 6518 (v) requires the Committee to report to the Governor, the General Assembly, and the Commissioner of the DOC each year regarding the status of inmate healthcare services in Delaware.

IV. Committee Work Product - Reports Reviewed During the Year

The Committee held seven (7) formal meetings during the 2023 year, to fulfill the legislative mandate of providing oversight of the healthcare services provided in the DOC. For ease of scheduling, the ACHRC continued working smoothly and consistently met virtually. The members are able to meet virtually since this is a non-public entity. The Criminal Justice Council (CJC) assisted the members and maintained the schedule including notifications of meetings and information sharing. Below is a summary of the meeting highlights and major accomplishments of the Committee during the past year.

A. Review and Monitoring of DOC Health Services by the ACHRC

The Committee continues to review monthly hospital reports, mortality reports, health services practices, outcomes, and utilization with the goal of advising the Commissioner on health service areas that meet best practice standards and those that need improvement. The Committee also discusses news articles, any pending lawsuits, and inmate grievances and provides input regarding the DOC medical provider contract.

Reports Reviewed

Below are the number of cases the ACHRC reviewed for January through November. The data for December is still being compiled therefore could not be included in this report.

	Emergency Room Runs	Hospital Inpatient	Morbidity & Mortality reviewed	Autopsies reviewed	Deaths	Critical cases reviewed	Naloxone deployments
Total	517	316	12	5	18	1	68
In Depth Review	87	90					

Disease	Total
STD	176
Ectoparasites	8
Meningitis	0
MRSA	62
Active TB	5
Flu	4

Members would like to highlight the proactive measures Ms. Anneke Cerri and DOC took with the screening and monitoring of a TB case. Staff was diligent in watching the case and preventing a TB outbreak.

Disease	Average Cases Per Month on the tracking log
Hep A	0
Hep B	9
Hep C	139
HIV/AIDS	40

COVID 19

While COVID incidents have greatly improved, it remains a topic of focus for the Committee. DOC has extensive policies and procedures in place for COVID testing and management. COVID testing was first available 3/15/21. ACHRC members discuss successes and areas of concern when needed and continue to make recommendations in medical situations.

2023 Season	Number of COVID Cases
Covid Winter Dec 22- Mar 23	136
Spring Mar 23- June 23	10
Summer June 23- Sep 23	102
Fall Sep 23- Nov 23	93

Grievances

The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances. DOC has outlined the process for medical and behavioral health grievances with the group.

Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff/contractors and/or within a specific facility. It was recognized that there is an attempt to resolve the grievance in each stage of the process and the individual has an opportunity to communicate understanding and degree of satisfaction. Some grievances get resolved, however, the incarcerated individual still pushes the item, so leadership learns about the issue. DOC examines all grievances. Medical and other grievances are all submitted through the same process.

B. Recognition of Accomplishments and Meeting Highlights

It must be highlighted that DOC continues to receive national recognition. The Department objectively reviews practices and strives to implement innovative approaches to healthcare. The Committee would like to highlight and applauds DOC for the numerous cases where staff performed life saving measures quickly and efficiently for individuals that may have likely died in the community. These measures span everything from CPR to deployment of naloxone. ACHRC continues to be impressed with the professionalism within the department and the DOC's eagerness to improve processes.

Patient Companion Project

The Patient Companion Project was developed for qualified and selected offenders who are then trained to provide personalized assistance to other offenders/patients who are unable to provide care for themselves. The functions of this program include companionship, emotional support, activities of daily living (ADLs) (feeding, hygiene, dressing, walking) and comfort measures. The training consists of classroom hours and 80 hours of on-the-job training with healthcare staff in the infirmary. The Patient Companion also learns about proper skin care, and signs and symptoms of distress. Individuals provide companionship during the dying process and care of those with cognitive impairment. The participants are evaluated for the retention of the information learned and graded. Graduation occurs after training and all the competencies have been successfully completed. Participants are eligible for a state CNA certification license which may lead to employment in the community. This program continues to receive national recognition and has been highlighted in various news reports. DOC continues to expand the project statewide and include additional facilities when possible.

Mental health peer companions have been successful at Howard R. Young and are being established at Sussex Correctional Institution. Mental health peer companions were also added to the Baylor facility. SCI has currently declined to set up the Patient Care Companion project at that facility and felt the mental health peer companions were a more pressing item.

One patient testimonial stated that the "Patient companion was later praying with a patient who was very appreciative." Companions are making a difference and very supportive especially for people reaching end of life. DOC also has numerous wellness and care measures in place for the companions themselves. Hospice also takes care of people, families, the DOC family, and companions. Susan Conley regularly follows-up with the

companions and the chaplain ministry reaches out as well. Hospice is helping with education and end of life training for the companions.



Ms. Susan Conley received the Governor's Compassionate Champion Award. ACHRC congratulates Ms. Conley on the well-deserved award and thanks her for her dedication and exemplary service.

DOC Healthcare Provider

VitalCore was selected as the new contractor for DOC and took over the medical contract on July 1, 2023. The transition has gone well. VitalCore remains very responsive to requests and sustains deliverables. DOC provides ACHRC with updates on staffing and progress at each meeting. As is true nationally, the struggle for consistent staffing and the difficulty in hiring remains a concern. Staffing fluctuates to some degree however the contractor maintains staffing rates around 80% of capacity on the medical side and 70% on the behavioral health side. This is an improvement from the previous year. Efforts are made to fill vacant critical leadership positions quickly. Committee members, especially those who work or teach in healthcare, promote internship opportunities and careers in correctional healthcare, and work to establish correctional career pathways with universities. DOC coordinates with Widner University to seek post-doctoral candidates. DOC continues to coordinate with Arcadia to host rotations for Behavioral Health Physician Assistant Students as well.



Accreditations

DOC continued to move forward with the National Commission of Correctional Health Care (NCCHC) and American Correctional Association (ACA) surveys, reports, and evaluations. DOC provides the ACHRC updates at every meeting on which facilities reached accreditation or reaccreditation. The DOC facilities, including the Administration Building and Training Academy, go through the process of accreditation. Delaware DOC favors well through the process and diligently completes the process in a timely manner as required to maintain standards. DOC tracks the process which is outlined in the table below.

	ACA			PREA			NCCHC - medical	
Facility	Last Audit	Accreditation Granted	Due	Last date done	Due	Facility	Last date done	Due
MCCC	November 11-12, 2020	3/30/2021	N/A	Jan 28-30, 2019	N/A	MCCC	N/A	N/A
HRYCI	September 9-11, 2020	3/30/2021	Fall 2023	July 15-17, 2022		HRYCI	May 4-5, 2021	May 1, 2024
PCCC	July 15-16, 2021	1/8/2022	Summer 2024	May 24-25, 2021	2024	PCCC	May 6-7, 2021	May 1, 2024
SCI	Sept 27-29, 2021	1/8/2022	Fall 2024	September 14-17, 2020	March 6-8, 2023	SCI	May 17-18, 2021	May 1, 2024
SCCC	Oct 12-15, 2021	1/8/2022	Fall 2024	October 7-9, 2020	March 9-10, 2023	SCCC	May 19-20, 2021	May 1, 2024
BWCI	July 12-14, 2021	1/8/2022	Summer 2024	June 21-23, 2021	2024	BWCI	June 1-2, 2021	June 1, 2024
HD Plant	Nov 9-10, 2020	3/30/2021	Fall 2023	May 26-27, 2021	2024	HD Plant	June 3-4, 2021	June 1, 2024
CCTC	October 10-11, 2022	Hearing will be at Winter 2023 ACA Conference	Fall 2025	June 13-14, 2022		CCTC	December 2021	December 2024
JTVCC	Nov 8-10, 2021	8/6/22	Fall 2024	July 13-15, 2022		JTVCC	December 2021	December 2024

Continuity of Care

The Committee routinely discusses various types of medications along with best practices and evidence-based medicine. Scholarly articles with emerging studies and data are often shared among ACHRC members and discussed during the meetings. Members share local and community trends and perspectives.

ACHRC continues to monitor and discuss patient care. Improvements are suggested at the meetings and the Department ensures follow-up internally and with the provider. All enhancements to the policies and practices are reported back to the members at the next meeting. The Committee addressed topics including efficient record keeping and documentation, administration of medication, complexities on treating individuals on detentioner status, and average response time for medical & behavioral health call requests.

The Committee discussed changes in federal restrictions on the prescribing of buprenorphine. A separate license is not necessary to prescribe buprenorphine. While the federal modifications do not change the Department's practices, they did open the pathway for more people to be able to prescribe the medication. Many individuals at DOC had already obtained a waiver. The Committee also reviewed DOC's reentry process regarding prescriptions and discussed efficiency.

Substance Use Disorder (SUD) Management

ACHRC discusses the identification and treatment of individuals with substance use disorders as well as national trends in improving treatment options for individuals under DOC supervision. Narcan kits have been distributed within the DOC facilities for use immediately and are now provided to individuals leaving the facilities to hopefully decrease the overdose fatalities. The DOC Bureau of Healthcare, Substance Abuse and Mental Health Services also visits Probation & Parole locations weekly to provide education, training and Narcan kits to probationers and other community members to improve mortality and increase community knowledge.

While medication assisted treatment (MAT) has been deemed an evidence-based practice, personal opinions on the use of MAT can hinder progress and administration of MAT. The Committee discusses the complexities of MAT and ways training may be increased to address and ensure the use of MAT in the DOC facilities. The group will continue to explore implementing training knowing it can be challenging due to shift work and staff shortages.

DOC has successfully implemented a normalized MAT pilot at Howard R. Young Correctional Institution which improves the distribution of the medication to individuals. DOC mirrored best practices for the normalized medication pass and trained correctional officers, medical staff, and individuals at the facility. This process has yielded significant time savings and increased satisfaction as well as the number of individuals served. DOC would like to expand this to other facilities.

V. Observations and Recommendations

The mission of the Committee as stated in the legislative mandate is to advise on all matters in Delaware's adult correctional system relating to the provision of inmate healthcare services. Based on the reports reviewed and the items discussed during the meetings, ACHRC has made the following observations and continues to propose recommendations²:

1. ACHRC will research and identify the cost of care for patients with severe mental health challenges and that have self-directed violence - including security, medical, mental health, and all ancillary costs involved to determine an annualized dollar amount.
 - a. ACHRC will work to schedule presentations to the legislature, Joint Finance Committee, and the Governor's office to highlight recommendations and seek funding assistance. Grant funds may also be explored to address issues and needs.

² Progress has been added to observations and recommendations from the previous year report as well as progress made during the year for new items.

2. We know about 1/3 of individuals in Delaware with opioid overdose deaths had contact with DOC.
 - a. Monitor MAT options and secure additional funding for MAT and SUD treatment expansion within DOC.

Progress – DOC continues to make progress with expanding and providing MAT at the facilities. DOC has increased the use and deployment of Narcan kits to individuals. DOC continues to respond to the needs of individuals in creative ways such as the use of virtual options and peer counselors.

- b. In 2024 – explore ways to increase education and training on MAT for DOC staff.
 - c. DOC to explore applying for the Opioid Abatement and Remediation Grant Program funding offered through the Lt. Governor’s Office.
 - d. Explore using canines to detect illegal substances and prevent them from being brought into the facilities.
3. Improve treatment and services for the detentioner population at DOC.
 - a. Explore various solutions for medical follow-up and the possibility of conducting a pilot program at one of the facilities. It should be noted that DOC is currently doing as much as possible to address the detentioner population and everything is completed according to policy.
4. Continue transparency regarding the medical care and treatment of incarcerated individuals. DOC has established an anonymous email and phone line for DOC staff and contracted healthcare staff to report any concerns related to health care services. DOC/Bureau of Healthcare, Substance Abuse and Mental Health Services often receives correspondence about health care from multiple sources. DOC/the Bureau also tracks and addresses each matter. Concerns may also be forwarded to the DOC Public Relations staff. DOC must receive consent from the individual in custody prior to discussing anything with other parties or communicating with family.
 - a. Establish regular updates on the status and availability of health care and sending the updates to the public, staff, and inmates.

Progress – This remains a priority and will continue to be addressed. Any correspondence CJC received was forwarded to the ACHRC, DOC and the DOC Public Relations staff. The Senator and Representative continue to communicate concerns from constituents and correspondence received from incarcerated individuals. The Committee discusses all matters brought to the attention of the group which range from items such as access to healthcare, information sharing and timeliness including test results, access

to additional services including commissary, and general health and living conditions. ACHRC will continue to work with DOC regarding communication to the public, loved ones/family members and the incarcerated individuals themselves.

Communication on the policies and procedures is critical. The Commissioner has worked hard with media relations, and it is difficult to show DOC has good healthcare and change public perceptions. Increasing awareness and promoting the positive DOC efforts would be helpful. It was noted that focusing on how corrective actions have been made by DOC with difficult situations and any proactive measure taken would be helpful to communicate publicly.

5. Overall staff and nursing vacancies pose challenges as well as difficulties in recruiting and retaining staff exist.

- a. Develop additional ways to increase recruitment of health care staff and secure additional training opportunities.

Progress – Committee members promote internship opportunities and careers in correctional healthcare, and work to establish correctional career pathways with universities.

6. Critical moments such as initial incarceration, anniversaries, holidays, and individuals receiving long sentences pose a risk for incarcerated individuals and may impact behavior and mental health.

- a. DOC should explore implementing an assessment for critical events and risk factors.
- b. If any mental health and/or substance use disorder assessments are completed prior to incarceration, improvements must be made around information sharing with DOC.

The ACHRC will continue to monitor progress on recommendations and include additional items as needed.

VI. Concerns

Special Behavioral Health Unit

The Committee discussed, at great length, the need to establish a more intense special behavioral health unit with specialized trained staff at DOC to handle unique and challenging psychiatric patients in the facilities. The need is high even though the numbers are small. Some patients require a very high level of care, monitoring, and treatment. The ACHRC strongly supports and recommends funding and creating an intensive special behavioral health unit within DOC. This is highlighted as a major concern and priority.

DOC is working on alternative solutions since the creation of a special unit is not feasible currently. DOC does follow numerous best practices and adheres to established policies put in place for such cases. Outside consultants are sometimes called in for very challenging patients. Staff makes every effort to ensure the best care and treatment possible.

ACHRC wants to emphasize that the Committee is disappointed that a specialized behavioral health unit is not being funded within the DOC. There is a lack of services and resources for people experiencing severe mental health challenges, self-directed violence, and are a danger to themselves and others. Due to pending charges, DOC is not able to explore transfer options out of state for a more appropriate prison care system. Once an individual is sentenced, DOC can then review out of state placement and the transfer process. Although it is not many cases, when they arise, they are severe. The Committee will continue addressing this topic in 2024.

Staff shortages and Hiring

Delaware, along with the rest of the nation, has been impacted by staff shortages. The struggle for consistent staffing and the difficulty in hiring remain a concern. This is true for both DOC and the contracted provider at numerous levels. The agencies continue to boost recruitment and offer incentives. ACHRC will continue to monitor this challenge in 2024 and help in all possible ways.

Autopsies

Obtaining autopsies, medical and psychological, has been a challenge for the DOC for many years. Currently, the DOC may wait more than six months to obtain an autopsy on an uncomplicated inmate case. Because the Committee is tasked with reviewing the circumstances behind inmates' deaths, the inability to obtain autopsies in a timely fashion is discouraging and prevents the Committee from carrying out its charge.

Critical Moments and Transfers

A reoccurring topic over the year was handling individuals at critical moments such as initial incarceration, anniversaries, holidays, and individuals receiving long sentences. ACHRC suggests DOC continue to explore incorporating some best practices supported in literature and conduct additional screening to determine those critical points. It could be helpful to have mental health professionals on site and available at the Courthouse as well. ACHRC member will work with DOC to examine establishing a real time process for situations when an individual comes from Court to the facility after receiving a lengthy prison sentence. Some individuals may be evaluated by a mental health professional either from the Dept. of Justice or Office of Defense Services however that information is not transferred to DOC.

DOC is not made aware of additional risk factors such as preexisting mental health and/or SUD diagnosis in a timely fashion, if at all. Members recognize that even with DOC being fully staffed, it is difficult to increase assessments and monitoring for mental health. DOC medical staff is also not made aware of an individual's criminal charges or the

severity of those charges which could impact a suicide, attempted suicide, and any self-harming behavior. Developing an inventory/checklist as a follow-up with cases could help. DOC maybe can conduct a group debriefing with newly incarcerated people, particularly ones with a SUD. ACHRC members offered to obtain additional resources such as an assessment for critical events and risk factors.

Another area of focus during the year was the DOC use of personal close observation (PCO) measures which include increasing the intensity of interventions and heightens the frequency of treatment visits for individuals. The Committee discussed facility housing options and the pros and cons of having someone in a single cell versus having a cellmate. ACHRC members suggest utilizing peers/patient companions to assist in addressing these types of needs within the Department when appropriate.

Increased Overdoses and Xylazine in Facilities

The Committee often discussed at length suspected overdoses. The Committee has concerns about amount of fentanyl within facilities and the number of overdoses. ACHRC would like to receive information on the outcome of the suspected overdose investigations and how the individuals may have obtained the substance if determined. Members feel it would be beneficial to know if the suspected overdoses at the same facilities are connected in any way. It would benefit ACHRC in its mission to know what is happening and what security determines regarding these cases. This is something that seems to be trending and needs extra attention. The Committee recognizes and appreciates the many prompt successful resuscitations through Narcan and first-responder efforts made by DOC staff.

DOC is also seeing an increase in the number of people coming into the facilities with wounds. DOC is not yet able to test for xylazine and it is not captured on routine drug screens. This is a concern. New rapid test kits that detect fentanyl and xylazine are being used in Delaware and need to be available to DOC.

Individuals with Chronic Physical Pain

Members discussed at three of the meetings the issues involved with those on pain medications for physical pain such as sickle cell disease, post traumatic orthopedic pain and neuropathy. Individuals with chronic pain need to be identified, followed, and medicated by the appropriate medical specialists-orthopedist, neurologist, hematologist (sickle cell specialist) on admission to DOC. DOC staff must be made aware of the treatment and need to work with the identified treating physician on the process for the pain medication distribution.

VII. Future Goals and Plans

The Committee is profoundly aware of the responsibility entrusted to it by the Governor and the Delaware Legislature. In 2024, the Committee will continue to monitor healthcare service reports from the DOC. In addition, Committee members will continue to review health service standards and service provisions to evaluate the quality of health services provided within the DOC.

The Committee intends to assist DOC in advocating for additional funds to care for incarcerated individuals. DOC has a duty to care for the individuals in their custody and as the population ages and becomes more ill, healthcare becomes more costly. Members will continue to advocate for the establishment of a more intense special behavioral health unit with specialized trained staff at DOC to handle unique cases in the facilities. Furthermore, all Committee members continue to contribute to updates and discussions on current correctional healthcare services, best practices, and recommendations presented in healthcare service literature.

Goal – Explore funding, technology, and placement opportunities to find a solution to improve the quality of services for people experiencing severe mental illness who have self-directed violence and are a danger to themselves and others.

The Committee will explore the process and timing of being able to receive a gross autopsy report. Currently the Division of Forensic Science completes the whole autopsy report and sends it as a complete package to DOC. A gross autopsy is a preliminary review while waiting for test results and usually happens in the first few days of an incident. Laboratory reports many times take well over a month.

Goal – Find a solution and improve the timeliness of receiving autopsy reports.

Goal – Improve monitoring and response surrounding critical moments that impact incarcerated individuals.

Goal – Evaluate the overdose trends and increase appropriate responses and treatments accordingly.

Goal – ACHRC members will continue assisting the DOC to identify training and supervision needs for the staff and contractors as it relates to working with specialized incarcerated populations.

Finally, the Committee is pleased with the cooperation and the efforts to resolve healthcare services concerns by the Commissioner of the DOC, the Bureau of Healthcare, Substance Abuse and Mental Health Services, and the staff of DOC. We are confident that such cooperation, time, and attention will continue as we work together to fulfill the mission of the Committee.

Respectfully submitted,

The Adult Correction Healthcare Review Committee

December 28, 2023

Enclosure

APPENDIX A
Work Plan ACHRC
(House Bill 446)

Frequency of Meetings—Every one to two months but no less than four times a year

Reports expected for review at meeting:

- ✓ Critical Incident Reports involving injury to staff or inmates or public in DOC
- ✓ M/M Reports; Psychological autopsy when appropriate
Mortality reports from deaths occurring between ACHRC meetings will be reviewed following the mortality review for that death.
- ✓ PREA and ADA grievances
- ✓ Health staff disciplinary reports
- ✓ Notification of NCCHC and ACA survey dates at each facility
- ✓ Reports from public sources on issues affecting health and safety in DOC
- ✓ Pending lawsuits and professional disciplinary actions filed with licensing boards
- ✓ Other information concerning the health and safety of inmates as it becomes available.
- ✓ Monthly summaries of health-related grievances from inmates, their families, and DOC health staff. This will include DOC plans for the resolution of frequently occurring health related grievances.

Reports expected for quarterly meetings (January, April, July, October):

- ✓ Sick call response time for medical and behavioral call requests.

Reports expected prior to each 6-month meeting (January and July) November and December will focus on report to the Governor and Legislature

- ✓ Quality Improvement reports from each facility
- ✓ Internal quality monitoring reports
- ✓ NCCHC and ACA yearly reports
- ✓ Inmate hospital admissions; infectious disease report; quarterly report on inmates in DPC
- ✓ Reports on federal or state inspections including but not limited to pharmacy, dietary, radiation medicine, infectious disease, and safety reports routinely conducted as per state licensing agency requirements.
- ✓ Status reports on numbers of inmates in chronic care clinics and cumulative diagnosis—for instance, insulin dependent diabetes, active TB, Hepatitis C with drug treatment, Hepatitis C without drug treatment; identified with major psychiatric diagnosis including addictions and numbers in specific treatment including counseling (group and/or individual), and those on psychiatric medications.
- ✓ Re-hospitalization rate of inmates who had been hospitalized in public or private psychiatric or general hospitals within 6 months of previous hospitalization.

Committee members may arrange to visit facilities after giving appropriate notice to the Warden and Chief of Health Services to observe the conduct of health services or to review

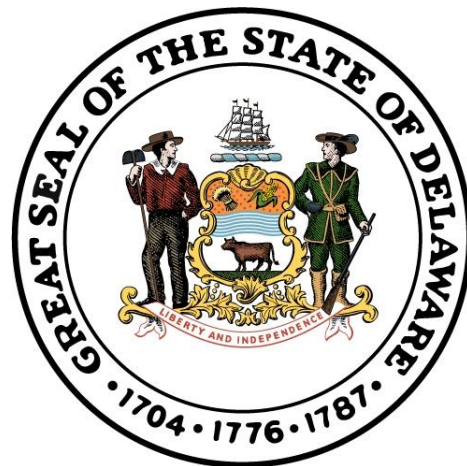
practices and/or patient charts. If members wish to observe treatment or observe direct patient encounters, agreement by the patient will be first obtained.

Original Adopted October 26, 2009; Revision Adopted August 19, 2010; Revision Adopted November 18, 2011; Reviewed and Adopted without change December 2012; Reviewed and Adopted without change December 2013; Revision Adopted December 15, 2017.

**State of Delaware
Adult Correction Healthcare Review
Committee**

**Annual Report
Calendar Year
2024**

Laura Cooney-Koss, Psy.D.
Chair



State of Delaware
Adult Correction Healthcare Review Committee

MEMORANDUM

TO: The Honorable John C. Carney, and
Members of the General Assembly

FROM: Adult Correction Healthcare Review Committee, Criminal Justice Council
staff, and
Laura Cooney-Koss, Psy.D.
Chair, Adult Correction Healthcare Review Committee

DATE: December 30, 2024

SUBJECT: Adult Correction Healthcare Review Committee -
2024 Annual Report

cc: Terra Taylor, Commissioner, Delaware Department of Correction
Paul Shavack, Chief of Staff, Delaware Department of Correction

We are pleased to present to you the fourteenth Annual Report of the Delaware Adult Correction Healthcare Review Committee (“ACHRC or Committee”). This report, prepared by the Committee in accordance with 11 *Del. C.* § 6518 (v), provides a summary of the accomplishments and work product of the Committee this past year, observations and recommendations of the Committee, and the Committee’s future goals and plans.

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Appendix A - Revised Work Plan

I. Background

This is the fourteenth Annual Report of the ACHRC. Established by 11 *Del. C.* § 6518 in 2009 and revised by House Bill 173 in 2019 and House Bill 7 in 2021. The Committee was created to serve “in an advisory capacity to the Governor, the General Assembly, and the Commissioner of the Department of Correction (DOC) on all matters in Delaware's adult correction system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, and the review of all statistics relating to inmate healthcare. The Committee shall not be considered a public body as defined by 29 *Del. C.* § 10002(c).” 11 *Del. C.* §6518 (m).

In April 2023, House Bill 52 was signed into law that modified the membership of the ACHRC. The Bill restored the Delaware licensed psychiatrist position at the request of the Committee.

II. Committee Members

The nine voting members of the Committee appointed by the Governor and confirmed by the Senate are:

1. Janet P. Kramer, MD, CCHP, a Delaware licensed physician.
2. Mandell Much, PhD, a Delaware licensed forensic psychologist.
3. Laura Cooney-Koss, Psy.D., a Delaware licensed psychologist.
4. Ashley Istenes, RN, a Delaware licensed registered nurse.
5. Vacant currently, a member of the Delaware State Bar.
6. Wm. James Harrison, MHS, an expert in the field of substance abuse treatment.
7. Sandra J Nolan, PhD, RN AHN-BC, any additional healthcare professional who by virtue of training, education, and specialization holds expertise in correctional healthcare.
8. Bernice Edwards, an individual representing a non-profit that is serving the families of inmates or the inmates themselves, or a local civil rights organization.
9. Mustafa Mufti, MD, a Delaware licensed psychiatrist;

As per the revision in HB 52 (changes are underlined):

(c) The Committee shall consist of 9 voting members, appointed by the Governor, and confirmed by the Delaware State Senate which shall include all the following: (1) A Delaware licensed physician. (2) A Delaware licensed forensic psychologist. (3) A Delaware licensed psychologist. (4) A Delaware licensed registered nurse. (5) A member of the Delaware Bar. (6) An expert in the field of substance abuse treatment. (7) Any additional healthcare professional who by virtue of training, education, and specialization holds expertise in correctional healthcare. (8) An individual representing a non-profit that is serving the families of inmates or the inmates themselves, or a local civil rights organization. (9) A Delaware licensed psychiatrist.

(d) The Committee shall also consist of the following 3 nonvoting ex-officio members: (1) The Chief of the Bureau of Healthcare, Substance Abuse, and Mental Health Services. (2) Chairperson of the House Corrections Committee. (3) Chairperson of the Senate Corrections and Public Safety Committee.

Laura Cooney-Koss, Psy.D. served as Chair of the Committee. In addition to the appointed members of the Committee, other non-voting participants include Deputy Attorneys General (“DAG”) Michael Tipton, Esquire, served as counsel for the Committee; DAG Gregory Smith, Esquire, and DAG Patrick Smith, Esquire served as counsel for the DOC; Nicole Hartman, served as counsel for CJC; Michael Records, Chief of Bureau of Healthcare, Substance Abuse and Mental Health Services at DOC; Carolyn Ianni, MD, Medical Director of the DOC; Vanessa Bennifield, PsyD, Behavioral Health Treatment Director; Susan Conley, APRN, ACNS-BC then replaced by Victoria Bryant, Director of Medical Treatment Services; and Anneke Cerri, Behavioral Healthcare Services for the DOC. Kim Kirk is the Criminal Justice Council staff assigned to the Committee.

During 2021 and 2022, the Chairperson of the House Corrections Committee and the Chairperson of the Senate Corrections and Public Safety Committee were voting members of the Committee however this provision expired in 2023. Both members, Senator Marie Pinkney and Representative Nnamdi Chukwuocha remain active participants and provide valuable input.

With the additional members and intermittent vacancies, the group at times encounter challenges reaching a quorum. The Committee has worked very diligently to seek and recommend appropriate candidates to fill vacancies. Membership continues to be discussed to maximize the efficiency of the group and fulfil the mandated charge and mission. The group continues to discuss potential candidates for the vacant Delaware Bar position and anticipates that the position will be filled by early 2025.

III. Committee Charge

The Committee is tasked with advising the Commissioner of the DOC along with the Governor and the General Assembly on all matters in Delaware’s adult correctional system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, the review of all statistics relating to inmate healthcare, and any matters relating to adult inmate healthcare that the Committee considers reasonable and worthwhile, including assuring the resolution of identified problems and enhancing the efficient utilization of resources.

Certain State agencies and contractors providing medical services to inmates must provide information requested by the Committee. Additionally, the Committee may request the appearance of any contractor providing medical and behavioral health services to an inmate under the direction of the DOC at a Committee meeting to provide information to the Committee. Another highlight notes that the Committee is not a public body, and Committee members must abide by federal and state laws regarding the privacy of

protected health information and provides penalties for violations of the privacy of such information. 11 *Del. C.* § 6518 (v) requires the Committee to report to the Governor, the General Assembly, and the Commissioner of the DOC each year regarding the status of inmate healthcare services in Delaware.

IV. Committee Work Product - Reports Reviewed During the Year

The Committee held eight (8) formal meetings during the 2024 year, to fulfill the legislative mandate of providing oversight of the healthcare services provided in the DOC. For ease of scheduling, the ACHRC continued working smoothly and consistently met virtually. The members are able to meet virtually since this is a non-public entity. The Criminal Justice Council (CJC) assisted the members and maintained the schedule including notifications of meetings and information sharing. Below is a summary of the meeting highlights and major accomplishments of the Committee during the past year.

A. Review and Monitoring of DOC Health Services by the ACHRC

The Committee continues to review monthly hospital reports, mortality reports, health services practices, outcomes, and utilization with the goal of advising the Commissioner on health service areas that meet best practice standards and those that need improvement. The Committee also discusses news articles, any pending lawsuits, and inmate grievances and provides input regarding the DOC medical provider contract.

Reports Reviewed

Below are the number of cases the ACHRC reviewed for January through November. The data for December is still being compiled therefore could not be included in this report.

	Emergency Room Runs	Hospital Inpatient	Morbidity & Mortality reviewed	Autopsies reviewed	Deaths	Critical cases reviewed	Naloxone deployments
Total	537	393	1	6	10	1	75
In Depth Review	106	100					
Disease	Total						
STD	244						
Ectoparasites	13						
Meningitis	0						
MRSA	51						

Active TB	0
Flu	16

Disease	Average Cases Per Month on the tracking log
Hep A	0
Hep B	5
Hep C	130
HIV/AIDS	47

COVID 19

While COVID incidents have greatly improved, it remains a topic of focus for the Committee. DOC has extensive policies and procedures in place for COVID testing and management. Positive COVID cases have significantly decreased in 2024. COVID testing was first available 3/15/21. ACHRC members discuss successes and areas of concern when needed and continue to make recommendations in medical situations.

2024 Season	Number of COVID Cases
Covid Winter Dec 23- Mar 24	39
Spring Mar 24- June 24	1
Summer June 24- Sep 24	88
Fall Sep 24- Nov 24	31

Grievances

The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances. DOC has outlined the process for medical and behavioral health grievances with the group. Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility’s decision. Review of the grievances has helped the Bureau identify system level issues with specific staff/contractors and/or within a specific facility. It was recognized that there is an attempt to resolve the grievance in each stage of the process and the individual has an opportunity to communicate understanding and degree of satisfaction. Some grievances get resolved, however, the incarcerated individual still pushes the item, so leadership learns about the issue. DOC examines all grievances. Medical and other grievances are all submitted through the same process.

B. Recognition of Accomplishments and Meeting Highlights

It must be highlighted that DOC continues to receive national recognition. The Department objectively reviews practices and strives to implement innovative approaches to healthcare. The Committee would like to highlight and applauds DOC for the numerous cases where staff performed life saving measures quickly and efficiently for individuals that may have likely died in the community. These measures span everything from CPR to deployment of naloxone. ACHRC continues to be impressed with the professionalism within the department and the DOC's eagerness to improve processes.

Patient Companion Project

The Patient Companion Project was developed for qualified and selected offenders who are then trained to provide personalized assistance to other offenders/patients who are unable to provide care for themselves. The functions of this program include companionship, emotional support, activities of daily living (ADLs) (feeding, hygiene, dressing, walking) and comfort measures. The training consists of classroom hours and 80 hours of on-the-job training with healthcare staff in the infirmary. The Patient Companion also learns about proper skin care, and signs and symptoms of distress. Individuals provide companionship during the dying process and care of those with cognitive impairment. The participants are evaluated for the retention of the information learned and graded. Graduation occurs after training and all the competencies have been successfully completed. Participants are eligible for a state CNA certification license which may lead to employment in the community. This program continues to receive national recognition and has been highlighted in various news reports. DOC has expanded this project to include Howard R. Young Correctional Institution, James T. Vaughn Correctional Center, and Sussex Correctional Center. There has been a total of over 36,000 hours of Companion Care since 2021, including 26,895 hours at JTVCC, 7,968 hours at HRYCI, and 1,139 hours at SCI. Eight individuals graduated in a ceremony at Howard R. Young Correctional Institution in May. Four individuals had family members present and multiple ACHRC Committee and DOC leadership attended. The project hopes to include expansion to Baylor Women's Correctional Institution in 2025.

Peer Support Specialists are connected with individuals with behavioral health and mental health diagnoses concerns. The program has been successful at Howard R. Young, Sussex Correctional Institution, and is hopeful to expand to James T. Vaughn Correctional Center. Peer Support Specialists are also at Baylor Women's Correctional Institution.

Companions are making a difference and very supportive especially for people reaching end of life. DOC also has numerous wellness and care measures in place for the companions themselves. Hospice also takes care of people, families, the DOC family, and companions. Susan Conley regularly follows-up with the companions and the chaplain ministry reaches out as well. Hospice is helping with education and end of life training for the companions.



Patient Care Companion graduates at Howard R. Young Correctional Institution, with instructor Linda Lucas, RN MSN-CNS PHN (left); Susan Conley, DOC Director of Community Health (right); and instructor Janie Bebbler, BSN, RN (far right).

DOC Healthcare Provider

VitalCore remains very responsive to requests and sustains deliverables as the contractor for DOC. DOC provides ACHRC with updates on staffing and progress at each meeting. DOC also facilitated a presentation by VitalCore key staff, which included the Chief Executive Officer, Chief Medical Officer, Chief Operating Officer of Prisons, Vice President of Operations - Delaware, and Senior Vice President of Operations. VitalCore noted that they have increased training opportunities, reduced the number of backlogs of individuals seeking community-based care, and implemented care management calls. As is true nationally, the struggle for consistent staffing and the difficulty in hiring remains a concern. Staffing fluctuates to some degree however the contractor maintains staffing rates around 88% of capacity on the medical side and 80% on the behavioral health side. This is an improvement from the previous year. Efforts are made to fill vacant critical leadership positions quickly. Committee members, especially those who work or teach in healthcare, promote internship opportunities and careers in correctional healthcare, and work to establish correctional career pathways with universities. DOC coordinates with Widener University to seek post-doctoral candidates.

Accreditations

DOC continued to move forward with the National Commission of Correctional Health Care (NCCHC) and American Correctional Association (ACA) surveys, reports, and evaluations. DOC provides the ACHRC updates at every meeting on which facilities reached accreditation or reaccreditation. The DOC facilities, including the Administration Building and Training Academy, go through the process of accreditation. Delaware DOC

favors well through the process and diligently completes the process in a timely manner as required to maintain standards. DOC tracks the process which is outlined in the table below.

	ACA			PREA			NCCHC - medical	
Facility	Last Audit	Accreditation Granted	Due	Last date done	Due	Facility	Last date done	Due
MCCC	November 11-12, 2020	3/30/2021	N/A	Jan 28-30, 2019	N/A	MCCC	May 4-5, 2021	May 1, 2024
HRYCI	September 25-27, 2023	1/6/2024	Fall 2026	June 15-17, 2022	2025	HRYCI	May 6-7, 2021	May 1, 2024
PCCC	June 10-11, 2024	8/17/2024	Summer 2027	June 19, 2024	2027	PCCC	May 17-18, 2021	May 1, 2024
SCI	September 30-October 2, 2024	Pending	Fall 2027	March 6-8, 2023	2026	SCI	May 19-20, 2021	May 1, 2024
SCCC	October 3-October 4, 2024	Pending	Fall 2027	March 3, 2023	2026	SCCC	June 1-2, 2021	June 1, 2024
BWCI	June 12-14, 2024	8/17/2024	Summer 2027	June 17, 2024	2027	BWCI	June 3-4, 2021	June 1, 2024
HD Plant	December 5-6, 2023	8/17/2024	Winter 2026	June 18, 2024	2027	HD Plant	March 13-14, 2023	March 1, 2026
CCTC	October 10-11, 2022	1/7/2023	Fall 2025	June 13-14, 2022	2025	CCTC	June 22, 2022	December 2025
JTVCC	November 4-6, 2024	Pending	Fall 2027	July 13-15, 2022	2025	JTVCC	May 4-5, 2021	May 1, 2024

Continuity of Care

The Committee routinely discusses various types of medications along with best practices and evidence-based medicine. Scholarly articles with emerging studies and data are often shared among ACHRC members and discussed during the meetings. Members share local and community trends and perspectives.

ACHRC continues to monitor and discuss patient care. Improvements are suggested at the meetings and the Department ensures follow-up internally and with the provider. All enhancements to the policies and practices are reported back to the members at the next meeting. The Committee addressed topics including efficient record keeping and documentation, administration of medication, complexities on treating individuals on detentioner status, and average response time for medical & behavioral health call requests.

Substance Use Disorder (SUD) Management

ACHRC discusses the identification and treatment of individuals with substance use disorders as well as national trends in improving treatment options for individuals under DOC supervision. Narcan kits have been distributed within the DOC facilities for use immediately and are now provided to individuals leaving the facilities to hopefully decrease the overdose fatalities.

While medication assisted treatment (MAT) has been deemed an evidence-based practice, personal opinions on the use of MAT can hinder progress and administration of MAT. The Committee discusses the complexities of MAT and ways training may be increased to address and ensure the use of MAT in the DOC facilities. The group will continue to explore implementing training knowing it can be challenging due to shift work and staff shortages.

DOC has successfully implemented a MAT program at all facilities, except for Sussex Community Corrections Center. This program will be implemented in SCCC in 2025. DOC mirrored best practices for the medication pass and trained correctional officers, medical staff, and individuals at the facility. This process has yielded significant time savings and increased satisfaction as well as the number of individuals served.

V. Observations and Recommendations

The mission of the Committee as stated in the legislative mandate is to advise on all matters in Delaware's adult correctional system relating to the provision of inmate healthcare services. Based on the reports reviewed and the items discussed during the meetings, ACHRC has made the following observations and continues to propose recommendations¹:

1. ACHRC will research and identify the cost of care for patients with severe mental health challenges and that have self-directed violence - including security, medical, mental health, and all ancillary costs involved to determine an annualized dollar amount.
 - a. ACHRC will work to explore standards of care and associated costs to manage these patients and reduce critical events and burden on staff . Once associated costs are determined, securing required funding may also be explored to address issues and needs.
2. We know about 1/3 of individuals in Delaware with opioid overdose deaths had contact with DOC.

¹ Progress has been added to observations and recommendations from the previous year report as well as progress made during the year for new items.

- a. Monitor MAT options and secure additional funding for MAT and SUD treatment expansion within DOC.

Progress – DOC continues to make progress with expanding and providing MAT at the facilities. DOC has increased the use and deployment of Narcan kits to individuals. DOC continues to respond to the needs of individuals in creative ways such as the use of virtual options and peer counselors.

- b. In 2025 – continue exploring ways to increase education and training on MAT for DOC staff.
 - c. Continue using canines to detect illegal substances and prevent them from being brought into the facilities.
 - d. Develop response(s) to many known and suspected overdoses of unknown substances.
3. Continue transparency regarding the medical care and treatment of incarcerated individuals. DOC has established an anonymous email and phone line for DOC staff and contracted healthcare staff to report any concerns related to health care services. DOC/Bureau of Healthcare, Substance Abuse and Mental Health Services often receives correspondence about health care from multiple sources. DOC/the Bureau also tracks and addresses each matter. Concerns may also be forwarded to the DOC Public Relations staff. DOC must receive consent from the individual in custody prior to discussing anything with other parties or communicating with family.
 - a. Establish regular updates on the status and availability of health care and sending the updates to the public, staff, and inmates.

Progress – This remains a priority and will continue to be addressed. Any correspondence CJC received was forwarded to the ACHRC, DOC and the DOC Public Relations staff. The Senator and Representative continue to communicate concerns from constituents and correspondence received from incarcerated individuals. The Committee discusses all matters brought to the attention of the group which range from items such as access to healthcare, information sharing and timeliness including test results, access to additional services including commissary, and general health and living conditions. ACHRC will continue to work with DOC regarding communication to the public, loved ones/family members and the incarcerated individuals themselves.

Communication on the policies and procedures is critical. The Commissioner has worked hard with media relations, and it is difficult to show DOC has good healthcare and change public perceptions. Increasing awareness and promoting the positive DOC efforts would be helpful. It was noted that focusing on how corrective actions have been made by DOC with difficult situations and any proactive measure taken would be helpful to

communicate publicly.

4. Overall staff and nursing vacancies pose challenges as well as difficulties in recruiting and retaining staff exist.
 - a. Develop additional ways to increase recruitment of health care staff and secure additional training opportunities.

Progress – Committee members promote internship opportunities and careers in correctional healthcare, and work to establish correctional career pathways with universities.

5. Critical moments such as initial incarceration, anniversaries, holidays, and individuals receiving long sentences pose a risk for incarcerated individuals and may impact behavior and mental health.
 - a. DOC should explore implementing an assessment for critical events and risk factors.
 - b. If any mental health and/or substance use disorder assessments are completed prior to incarceration, improvements must be made around information sharing with DOC.

The ACHRC will continue to monitor progress on recommendations and include additional items as needed.

VI. Concerns

Special Behavioral Health Unit

The Committee continued to discuss the need to establish a more intense special behavioral health unit with specialized trained staff at DOC to handle unique and challenging psychiatric patients in the facilities. The need is high even though the numbers are small. Some patients require a very high level of care, monitoring, and treatment. The ACHRC strongly supports and recommends funding and creating an intensive special behavioral health unit within DOC. This is highlighted as a major concern and priority.

While this unique specialized unit was referenced in the last RFP, DOC is working on alternative solutions since the creation of a special unit is not feasible currently. DOC does follow numerous best practices and adheres to established policies put in place for such cases. Outside consultants are sometimes called in for very challenging patients. Staff makes every effort to ensure the best care and treatment possible.

ACHRC wants to emphasize that the Committee is disappointed that a specialized behavioral health unit is not being funded within the DOC. The Committee discussed utilizing Patient Companions and Peer Supports to support this population. There is a lack of services and resources for people experiencing severe mental health challenges, self-directed violence, and are a danger to themselves and others. Due to pending charges, DOC is not able to explore transfer options out of state for a more appropriate prison care system.

Once an individual is sentenced, DOC can then review out of state placement and the transfer process. Although it is not many cases, when they arise, they are severe. The Committee will continue addressing this topic in 2025.

Staff shortages and Hiring

Delaware, along with the rest of the nation, has been impacted by staff shortages. The struggle for consistent staffing and the difficulty in hiring remain a concern. This is true for both DOC and the contracted provider at numerous levels. The agencies continue to boost recruitment and offer incentives. ACHRC will continue to monitor this challenge in 2025 and help in all possible ways.

Autopsies

Obtaining medical autopsies has been a challenge for the DOC for many years. Currently, the DOC may wait more than six months to obtain an autopsy on an uncomplicated inmate case. Because the Committee is tasked with reviewing the circumstances behind inmates' deaths, the inability to obtain autopsies in a timely fashion is discouraging and prevents the Committee from carrying out its charge.

Critical Moments and Transfers

Handling individuals at critical moments such as initial incarceration, anniversaries, holidays, and individuals receiving long sentences continues to be a reoccurring topic. ACHRC suggests DOC continue to explore incorporating some best practices supported in literature and conduct additional screening to determine those critical points. It could be helpful to have mental health professionals on site and available at the Courthouse as well. ACHRC member will work with DOC to examine establishing a real time process for situations when an individual comes from Court to the facility after receiving a lengthy prison sentence. Some individuals may be evaluated by a mental health professional either from the Dept. of Justice or Office of Defense Services however that information is not transferred to DOC.

DOC is not made aware of additional risk factors such as preexisting mental health and/or SUD diagnosis in a timely fashion, if at all. Members recognize that even with DOC being fully staffed, it is difficult to increase assessments and monitoring for mental health. DOC medical staff is also not made aware of an individual's criminal charges or the severity of those charges which could impact a suicide, attempted suicide, and any self-harming behavior. Developing an inventory/checklist as a follow-up with cases could help. DOC maybe can conduct a group debriefing with newly incarcerated people, particularly ones with a SUD. ACHRC members offered to obtain additional resources such as an assessment for critical events and risk factors.

Another area of focus during the year was the DOC use of personal close observation (PCO) measures which include increasing the intensity of interventions and heightens the frequency of treatment visits for individuals. The Committee discussed facility housing options and the pros and cons of having someone in a single cell versus

having a cellmate. ACHRC members suggest utilizing peers/patient companions to assist in addressing these types of needs within the Department when appropriate.

Increased Overdoses and Emerging Drugs in Facilities & Community

The Committee often discuss at length suspected overdoses. The Committee has concerns about amount of fentanyl within facilities and the number of overdoses. Additionally, the Committee has noted an increase in the number of overdoses related to unknown substances. ACHRC would like to receive information on the outcome of the suspected overdose investigations and how the individuals may have obtained the substance if determined. Members feel it would be beneficial to know if the suspected overdoses at the same facilities are connected in any way. It would benefit ACHRC in its mission to know what is happening and what security determines regarding these cases. This is something that seems to be trending and needs extra attention. The Committee recognizes and appreciates the many prompt successful resuscitations through Narcan and first-responder efforts made by DOC staff.

DOC continues to see a number of people coming into the facilities with wounds. There continues to be a surge in emerging drugs, including Tianeptine, Bromazolam, and Medetomidine, in the community. These emerging drugs, in addition to an increase in withdrawals from unknown substances within the facilities, continue to be a concern.

VII. Future Goals and Plans

The Committee is profoundly aware of the responsibility entrusted to it by the Governor and the Delaware Legislature. In 2025, the Committee will continue to monitor healthcare service reports from the DOC. In addition, Committee members will continue to review health service standards and service provisions to evaluate the quality of health services provided within the DOC.

The Committee intends to assist DOC in advocating for additional funds to care for incarcerated individuals. DOC has a duty to care for the individuals in their custody and as the population ages and becomes more ill, healthcare becomes more costly. Members will continue to advocate for the establishment of a more intense special behavioral health unit with specialized trained staff at DOC to handle unique cases in the facilities. Furthermore, all Committee members continue to contribute to updates and discussions on current correctional healthcare services, best practices, and recommendations presented in healthcare service literature.

Goal – Explore funding, technology, and placement opportunities to find a solution to improve the quality of services for people experiencing severe mental illness who have self-directed violence and are a danger to themselves and others.

The Committee will explore the process and timing of being able to receive a gross autopsy report. Currently the Division of Forensic Science completes the whole autopsy report and sends it as a complete package to DOC. A gross autopsy is a preliminary review

while waiting for test results and usually happens in the first few days of an incident. Laboratory reports many times take well over a month.

Goal – Find a solution and improve the timeliness of receiving medical autopsy reports.

Goal – Improve monitoring and response surrounding critical moments that impact incarcerated individuals.

Goal – Evaluate the overdose trends and increase appropriate responses and treatments accordingly.

GOAL – Evaluate the difficulties with provision of care for individuals that have committed sex offenses. This includes examining enhanced training opportunities and exploring training credentials for treatment providers.

Finally, the Committee is pleased with the cooperation and the efforts to resolve healthcare services concerns by the Commissioner of the DOC, the Bureau of Healthcare, Substance Abuse and Mental Health Services, and the staff of DOC. We are confident that such cooperation, time, and attention will continue as we work together to fulfill the mission of the Committee.

Respectfully submitted,

The Adult Correction Healthcare Review Committee

December 30, 2024

Enclosure

APPENDIX A
Work Plan ACHRC
(House Bill 446)

Frequency of Meetings—Every one to two months but no less than four times a year

Reports expected for review at meeting:

- ✓ Critical Incident Reports involving injury to staff or inmates or public in DOC
- ✓ M/M Reports; Psychological autopsy when appropriate
Mortality reports from deaths occurring between ACHRC meetings will be reviewed following the mortality review for that death.
- ✓ PREA and ADA grievances
- ✓ Health staff disciplinary reports
- ✓ Notification of NCCHC and ACA survey dates at each facility
- ✓ Reports from public sources on issues affecting health and safety in DOC
- ✓ Pending lawsuits and professional disciplinary actions filed with licensing boards
- ✓ Other information concerning the health and safety of inmates as it becomes available.
- ✓ Monthly summaries of health-related grievances from inmates, their families, and DOC health staff. This will include DOC plans for the resolution of frequently occurring health related grievances.

Reports expected for quarterly meetings (January, April, July, October):

- ✓ Sick call response time for medical and behavioral call requests.

Reports expected prior to each 6-month meeting (January and July) November and December will focus on report to the Governor and Legislature

- ✓ Quality Improvement reports from each facility
- ✓ Internal quality monitoring reports
- ✓ NCCHC and ACA yearly reports
- ✓ Inmate hospital admissions; infectious disease report; quarterly report on inmates in DPC
- ✓ Reports on federal or state inspections including but not limited to pharmacy, dietary, radiation medicine, infectious disease, and safety reports routinely conducted as per state licensing agency requirements.
- ✓ Status reports on numbers of inmates in chronic care clinics and cumulative diagnosis—for instance, insulin dependent diabetes, active TB, Hepatitis C with drug treatment, Hepatitis C without drug treatment; identified with major psychiatric diagnosis including addictions and numbers in specific treatment including counseling (group and/or individual), and those on psychiatric medications.
- ✓ Re-hospitalization rate of inmates who had been hospitalized in public or private psychiatric or general hospitals within 6 months of previous hospitalization.

Committee members may arrange to visit facilities after giving appropriate notice to the Warden and Chief of Health Services to observe the conduct of health services or to review

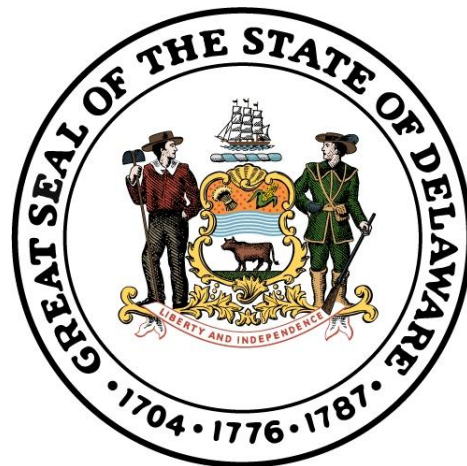
practices and/or patient charts. If members wish to observe treatment or observe direct patient encounters, agreement by the patient will be first obtained.

Original Adopted October 26, 2009; Revision Adopted August 19, 2010; Revision Adopted November 18, 2011; Reviewed and Adopted without change December 2012; Reviewed and Adopted without change December 2013; Revision Adopted December 15, 2017.

**State of Delaware
Adult Correction Healthcare Review
Committee**

**Annual Report
Calendar Year
2025**

Laura Cooney-Koss, PsyD
Chair



State of Delaware
Adult Correction Healthcare Review Committee

MEMORANDUM

TO: The Honorable Matthew Meyer, and
Members of the General Assembly

FROM: Adult Correction Healthcare Review Committee, Criminal Justice Council
staff, and
Laura Cooney-Koss, PsyD.
Chair, Adult Correction Healthcare Review Committee

DATE: December 30, 2025

SUBJECT: Adult Correction Healthcare Review Committee -
2025 Annual Report

cc: Terra Taylor, Commissioner, Delaware Department of Correction
Paul Shavack, Chief of Staff, Delaware Department of Correction

We are pleased to present to you the sixteenth Annual Report of the Delaware Adult Correction Healthcare Review Committee (“ACHRC or Committee”). This report, prepared by the Committee in accordance with 11 *Del. C.* § 6518 (v), provides a summary of the accomplishments and work product of the Committee this past year, observations and recommendations of the Committee, and the Committee’s future goals and plans.

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Appendix A - Revised Work Plan

I. Background

This is the sixteenth Annual Report of the ACHRC. Established by 11 *Del. C.* § 6518 in 2009 and revised by House Bill 173 in 2019 and House Bill 7 in 2021. The Committee was created to serve “in an advisory capacity to the Governor, the General Assembly, and the Commissioner of the Department of Correction (DOC) on all matters in Delaware's adult correction system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, and the review of all statistics relating to inmate healthcare. The Committee shall not be considered a public body as defined by 29 *Del. C.* § 10002(c).” 11 *Del. C.* §6518 (m).

In April 2023, House Bill 52 was signed into law that modified the membership of the ACHRC. The Bill restored the Delaware licensed psychiatrist position at the request of the Committee.

II. Committee Members

The nine voting members of the Committee appointed by the Governor and confirmed by the Senate are:

1. Janet P. Kramer, MD, CCHP, a Delaware licensed physician.
2. Mandell Much, PhD, a Delaware licensed forensic psychologist.
3. Laura Cooney-Koss, PsyD, a Delaware licensed psychologist.
4. Ashley Istenes, RN, a Delaware licensed registered nurse.
5. Lisa Schwind, a member of the Delaware State Bar.
6. Wm. James Harrison, MHS, an expert in the field of substance abuse treatment.
7. Sandra J Nolan, PhD, RN AHN-BC, any additional healthcare professional who by virtue of training, education, and specialization holds expertise in correctional healthcare.
8. Bernice Edwards, an individual representing a non-profit that is serving the families of inmates or the inmates themselves, or a local civil rights organization.
9. Mustafa Mufti, MD, a Delaware licensed psychiatrist;

As per the revision in HB 52 (changes are underlined):

(c) The Committee shall consist of 9 voting members, appointed by the Governor, and confirmed by the Delaware State Senate which shall include all the following: (1) A Delaware licensed physician. (2) A Delaware licensed forensic psychologist. (3) A Delaware licensed psychologist. (4) A Delaware licensed registered nurse. (5) A member of the Delaware Bar. (6) An expert in the field of substance abuse treatment. (7) Any additional healthcare professional who by virtue of training, education, and specialization holds expertise in correctional healthcare. (8) An individual representing a non-profit that is serving the families of inmates or the inmates themselves, or a local civil rights organization. (9) A Delaware licensed psychiatrist.

(d) The Committee shall also consist of the following 3 nonvoting ex-officio members: (1) The Chief of the Bureau of Healthcare, Substance Abuse, and Mental Health Services. (2) Chairperson of the House Corrections Committee. (3) Chairperson of the Senate Corrections and Public Safety Committee.

Laura Cooney-Koss, PsyD served as Chair of the Committee. In addition to the appointed members of the Committee, other non-voting participants include Deputy Attorneys General (“DAG”) Abigail de Uriate, Esquire, served as counsel for the Committee; DAG Michael Gordon, Esquire served as counsel for the DOC; Nicole Hartman, served as counsel for CJC; Michael Records, Chief of Bureau of Healthcare, Substance Abuse and Mental Health Services at DOC; Carolyn Ianni, MD, Medical Director of the DOC; Vanessa Bennifield, PsyD, Behavioral Health Treatment Director; Susan Conley, APRN, ACNS-BC then replaced by Victoria Bryant, Director of Medical Treatment Services; and Anneke Cerri, Behavioral Healthcare Services for the DOC. Kim Kirk is the Criminal Justice Council staff assigned to the Committee.

During 2021 and 2022, the Chairperson of the House Corrections Committee and the Chairperson of the Senate Corrections and Public Safety Committee were voting members of the Committee however this provision expired in 2023. Senator Ray Seigfried and Representative Larry Lambert are assigned legislators to the Committee.

III. Committee Charge

The Committee is tasked with advising the Commissioner of the DOC along with the Governor and the General Assembly on all matters in Delaware’s adult correctional system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, the review of all statistics relating to inmate healthcare, and any matters relating to adult inmate healthcare that the Committee considers reasonable and worthwhile, including assuring the resolution of identified problems and enhancing the efficient utilization of resources.

Certain State agencies and contractors providing medical services to inmates must provide information requested by the Committee. Additionally, the Committee may request the appearance of any contractor providing medical and behavioral health services to an inmate under the direction of the DOC at a Committee meeting to provide information to the Committee. Another highlight notes that the Committee is not a public body, and Committee members must abide by federal and state laws regarding the privacy of protected health information and provides penalties for violations of the privacy of such information. 11 *Del. C.* § 6518 (v) requires the Committee to report to the Governor, the General Assembly, and the Commissioner of the DOC each year regarding the status of inmate healthcare services in Delaware.

IV. Committee Work Product - Reports Reviewed During the Year

The Committee held ten (10) formal meetings during the 2025 year, to fulfill the legislative mandate of providing oversight of the healthcare services provided in the DOC. For ease of scheduling, the ACHRC continued working smoothly and consistently met virtually. The members are able to meet virtually since this is a non-public entity. The Criminal Justice Council (CJC) assisted the members and maintained the schedule including notifications of meetings and information sharing. Below is a summary of the meeting highlights and major accomplishments of the Committee during the past year.

A. Review and Monitoring of DOC Health Services by the ACHRC

The Committee continues to review monthly hospital reports, mortality reports, health services practices, outcomes, and utilization with the goal of advising the Commissioner on health service areas that meet best practice standards and those that need improvement. The Committee also discusses news articles, any pending lawsuits, and inmate grievances and provides input regarding the DOC medical provider contract.

Reports Reviewed

Below are the number of cases the ACHRC reviewed for January through November. The data for December is still being compiled therefore cannot be included in this report.

	Emergency Room Runs	Hospital Inpatient	Morbidity & Mortality reviewed	Autopsies reviewed	Deaths	Critical cases reviewed	Naloxone deployments
Total	554	490	1	0	2	0	89
In Depth Review	75	82					
Disease	Total						
STD	214						
Ectoparasites	5						
Meningitis	0						
MRSA	20						
Active TB	0						
Flu	28						

Disease	Average Cases Per Month on the tracking log
Hep A	0
Hep B	4
Hep C	29
HIV/AIDS	34

COVID 19

COVID incidents have greatly improved, and positive COVID cases have continued to significantly decrease. COVID testing was first available 3/15/21. ACHRC members discuss successes and areas of concern when needed and continue to make recommendations in medical situations.

2023 Season	Number of COVID Cases
Covid Winter Dec 24- Mar 25	48
Spring Mar 25- June 25	0
Summer June 25- Sep 25	3
Fall Sep 25- Nov 25	2

Grievances

The ACHRC members continue to discuss and review grievances including what information they would like to receive from DOC regarding the grievances. DOC has outlined the process for medical and behavioral health grievances with the group. Grievances are initially heard at the facility level but are then transferred to the Bureau if the individual appeals the facility's decision. Review of the grievances has helped the Bureau identify system level issues with specific staff/contractors and/or within a specific facility. It was recognized that there is an attempt to resolve the grievance in each stage of the process and the individual has an opportunity to communicate understanding and degree of satisfaction. Some grievances get resolved, however, the incarcerated individual still pushes the item, so leadership learns about the issue. DOC examines all grievances. Medical and other grievances are all submitted through the same process.

B. Recognition of Accomplishments and Meeting Highlights

It must be highlighted that DOC continues to receive national recognition. The Department objectively reviews practices and strives to implement innovative approaches to healthcare. The Committee would like to highlight and applauds DOC for the numerous cases where staff performed life saving measures quickly and efficiently for individuals that may have likely died in the community. These measures span everything from CPR to deployment of naloxone. ACHRC continues to be impressed with the professionalism within the department and the DOC's eagerness to improve processes.

Patient Companion and Peer Specialist Programs

The Patient Companion Project was developed for qualified and selected offenders who are then trained to provide personalized assistance to other offenders/patients who are unable to provide care for themselves. The functions of this program include companionship, emotional support, activities of daily living (ADLs) (feeding, hygiene, dressing, walking) and comfort measures. The training consists of classroom hours and 80 hours of on-the-job training with healthcare staff in the infirmary. The Patient Companion also learns about proper skin care, and signs and symptoms of distress. Individuals provide companionship during the dying process and care for those with cognitive impairment. The participants are evaluated for the retention of the information learned and graded. Graduation occurs after training, and all the competencies have been successfully completed. Participants are eligible for a state CNA certification license which may lead to employment in the community. This program continues to receive national recognition and has been highlighted in various news reports. DOC has expanded this project to include Howard R. Young Correctional Institution, James T. Vaughn Correctional Center, Sussex Correctional Center, and now Baylor Women's Correctional Institution, beginning in December. In 2025, the Patient Companion Project began a partnership with DelTech in Sussex County, due to the desire to add the service to the infirmary area and an additional housing unit at SCI. This partnership will expand to DelTech Wilmington campus in early 2026. Twelve (12) Companions graduated from the program this year, and family members, DOC staff, and ACHRC members were in attendance to show support. There are currently sixteen (16) Care Companions employed at all Level-5 facilities combined. There has been a total of over 66,364 hours of Companion Care since 2021, including 39,505 hours at JTVCC, 16,948 hours at HRYCI, and 9,911 hours at SCI.

Multiple Patient Companions have re-entered the community and have started the process of securing interviews in the field. This includes an individual that is actively seeking employment with the Delaware Division of Health and Social Services for a Health Program Representative as a community liaison.

Companions are making a difference and very supportive, especially for people reaching end of life. DOC also has numerous wellness and care measures in place for the companions themselves. Hospice also takes care of people, families, the DOC family, and companions. Susan Conley regularly follows up with the Companions, and the chaplain ministry reaches out as well. Hospice is helping with education and end of life training for the Companions.



Bureau of Healthcare, Substance Abuse, and Mental Health Services Chief Michael Records (left) and DOC Director of Community Health Susan Conley (right) with two Patient Care Companion graduates at their July graduation.

Since its launch in January 2022, the Delaware DOC Certified Peer Program—developed in partnership with DSAMH and the Mental Health Association (MHA)—has expanded its reach and strengthened its impact across Level 5 facilities. Certified Peers, individuals with lived experience of mental illness or substance use, receive training to provide recovery support, facilitate groups, assist with de-escalation, and reduce staff burden while promoting inmate well-being. Since its initial implementation, the program has expanded across multiple facilities and advanced a standardized certification pipeline that includes training, supervised experience, and certification examination. The program has now been successfully implemented at Howard R. Young, Sussex Correctional Institution, James T. Vaughn Correctional Center, and Baylor Women’s Correctional Institution. Program efforts in 2025 focused on peer training and certification, foundational behavioral health education, suicide-prevention capacity building, and documentation of reentry outcomes to inform subsequent QI measurement and implementation.

A total of fifteen (15) Peers completed training, and twelve (12) of those individuals have passed their Certified Peer certification exams. As of the end of 2025, eight (8) Certified Peers have been released from custody and were employed, many in community-based recovery support or related behavioral health roles.

DOC Healthcare Provider

VitalCore remains very responsive to requests and sustains deliverables as the contractor for DOC. DOC provides ACHRC with updates on staffing and progress at each meeting. DOC also facilitated a presentation by VitalCore key staff, which included the Chief Operating Officer of Prisons, Vice President of Operations - Delaware, facility psychiatrist, and facility licensed psychologist. VitalCore provided an overview of programming offered at Level-4 and Level-5 facilities and noted that they continue to monitor needs within the community to determine gaps in programming and treatment. As is true nationally, the struggle for consistent staffing and the difficulty in hiring remains a concern. However, staffing rates are consistently higher than other states' with VitalCore contracts. Staffing fluctuates to some degree however the contractor continues to maintain staffing rates around 87% of capacity on the medical side and 81% on the behavioral health side. Efforts are made to fill vacant critical leadership positions quickly. Committee members, especially those who work or teach in healthcare, promote internship opportunities and careers in correctional healthcare, and work to establish correctional career pathways with universities. DOC coordinates with Widener University to seek clinical post-doctoral candidates. The current contract with VitalCore expires in June 2026.

Accreditations

DOC continued to move forward with the National Commission of Correctional Health Care (NCCHC) and American Correctional Association (ACA) surveys, reports, and evaluations. DOC provides updates to ACHRC at each meeting regarding facilities that have achieved accreditation or reaccreditation, and ACHRC communicates any concerns or recommendations for improvement to the accreditation process. The DOC facilities, including the Administration Building and Training Academy, go through the process of accreditation. Delaware DOC adheres to the process and diligently completes all requirements in a timely manner, as required to maintain established standards. DOC tracks the process which is outlined in the table below.

	ACA			PREA			NCCHC - medical	
Facility	Last Audit	Accreditation Granted	Due	Last date done	Due	Facility	Last date done	Due
MCCC	November 11-12, 2020	3/30/2021	N/A	Jan 28-30, 2019	N/A	MCCC	N/A	N/A
HRYCI	September 9-11, 2020	3/30/2021	Fall 2026	July 15-17, 2022		HRYCI	May 4-5, 2021	Fall 2026
PCCC	June 10-11, 2024	8/17/2024	Summer 2027	June 19, 2024	2027	PCCC	May 6-7, 2021	

SCI	Sept 27-29, 2021	1/8/2022	Fall/Winter 2026	March 6-8, 2023	March 9-11, 2026	SCI	May 17-18, 2021	Fall/Winter 2026
SCCC	Oct 12-15, 2021	1/8/2022	Fall/Winter 2026	March 3, 2023	March 12-13, 2026	SCCC	May 19-20, 2021	Fall/Winter 2026
BWCI	June 12-14, 2024	8/17/2024	Summer 2027	June 17, 2024	2027	BWCI	June 3-4, 2021	Summer 2027
HD Plant	Dec 5-6, 2023	8/17/2024	Winter 2026	June 18, 2024	2027	HD Plant	June 3-4, 2021	Fall 2026
CCTC	October 10-11, 2022	Hearing will be at Winter 2023ACA Conference	Fall 2025	June 13-14, 2022	2025	CCTC	March 13-14, 2023	March 1, 2026
JTVCC	Nov 8-10, 2021	8/6/22	Fall/Winter 2026	July 13-15, 2022	2025	JTVCC	June 2, 2022	December 2025

Continuity of Care

The Committee routinely discusses various types of medications along with best practices and evidence-based medicine. Scholarly articles with emerging studies and data are often shared among ACHRC members and discussed during the meetings. Members share local and community trends and perspectives.

ACHRC continues to monitor and discuss patient care. Improvements are suggested at the meetings and the Department ensures follow-up internally and with the provider. All enhancements to the policies and practices are reported back to the members at the next meeting. The Committee addressed topics including efficient record keeping and documentation, administration of medication, complexities on treating individuals on detentioner status, and average response time for medical & behavioral health call requests.

Substance Use Disorder (SUD) Management

ACHRC discusses the identification and treatment of individuals with substance use disorders as well as national trends in improving treatment options for individuals under DOC supervision. Narcan kits have been distributed within the DOC facilities for use immediately and are now provided to individuals leaving the facilities to hopefully decrease the overdose fatalities.

While medication assisted treatment (MAT) has been deemed an evidence-based practice, personal opinions on the use of MAT can hinder progress and administration of MAT. The Committee discusses the complexities of MAT and ways training may be increased to address and ensure the use of MAT in the DOC facilities. The group will continue to explore implementing training knowing it can be challenging due to shift work and staff shortages.

DOC has successfully implemented MAT programs at all facilities. DOC mirrored best practices for the medication pass and trained correctional officers, medical staff, and individuals at the facility. On average, 16% of the total DOC is on MAT week-

to-week. Several DOC staff have presented nationally on DDOC-MAT efforts and successes. This process has yielded significant time savings and increased satisfaction as well as the number of individuals served.

V. Observations and Recommendations

The mission of the Committee as stated in the legislative mandate is to advise on all matters in Delaware's adult correctional system relating to the provision of inmate healthcare services. Based on the reports reviewed and the items discussed during the meetings, ACHRC has made the following observations and continues to propose recommendations¹:

1. ACHRC will research and identify the cost of care for patients with severe mental health challenges and that have self-directed violence - including security, medical, mental health, and all ancillary costs involved to determine an annualized dollar amount.
 - a. ACHRC will work to explore standards of care and associated costs to manage these patients and reduce critical events and burden on staff . Once associated costs are determined, securing required funding may also be explored to address issues and needs.
2. We know about 1/3 of individuals in Delaware with opioid overdose deaths had contact with DOC.
 - a. Monitor MAT options and secure additional funding for MAT and SUD treatment expansion within DOC.

Progress – DOC continues to provide MAT at all facilities. DOC has increased the use and deployment of Narcan kits to individuals. DOC continues to respond to the needs of individuals in creative ways such as the use of virtual options and peer counselors.

- b. Continue using canines to detect illegal substances and prevent them from being brought into the facilities.
- c. Develop response(s) to many known and suspected overdoses of unknown substances.

¹ Progress has been added to observations and recommendations from the previous year report as well as progress made during the year for new items.

3. Continue transparency regarding the medical care and treatment of incarcerated individuals. DOC has established an anonymous email and phone line for DOC staff and contracted healthcare staff to report any concerns related to health care services. DOC/Bureau of Healthcare, Substance Abuse and Mental Health Services often receives correspondence about health care from multiple sources. DOC/the Bureau also tracks and addresses each matter. Concerns may also be forwarded to the DOC Public Relations staff. DOC must receive consent from the individual in custody prior to discussing anything with other parties or communicating with family.
 - a. Establish regular updates on the status and availability of health care and sending the updates to the public, staff, and inmates.

Progress – This remains a priority and will continue to be addressed. Any correspondence CJC received was forwarded to the ACHRC, DOC and the DOC Public Relations staff. The Committee discusses all matters brought to the attention of the group which range from items such as access to healthcare, information sharing and timeliness including test results, access to additional services including commissary, and general health and living conditions. ACHRC will continue to work with DOC regarding communication to the public, loved ones/family members and the incarcerated individuals themselves.

Communication on the policies and procedures is critical. The Commissioner has worked hard with media relations, and it is difficult to show DOC has good healthcare and change public perceptions. Increasing awareness and promoting the positive DOC efforts would be helpful. It was noted that focusing on how corrective actions have been made by DOC with difficult situations and any proactive measure taken would be helpful to communicate publicly.

4. Overall staff and nursing vacancies pose challenges as well as difficulties in recruiting and retaining staff exist.
 - a. Develop additional ways to increase recruitment of health care staff and secure additional training opportunities.

Progress – Committee members continue to promote internship opportunities and careers in correctional healthcare, and work to establish correctional career pathways with universities.

5. Critical moments such as initial incarceration, anniversaries, holidays, and individuals receiving long sentences pose a risk for incarcerated individuals and may impact behavior and mental health.
 - a. DOC should explore implementing an assessment for critical events and risk factors.

- b. If any mental health and/or substance use disorder assessments are completed prior to incarceration, improvements must be made around information sharing with DOC.

Progress - the courts have begun sharing critical information with DOC, including unfavorable sentencing. This information prompts mental health checks for those individuals.

6. ACHRC recommended surveying individuals' patient care feedback as they are released from the emergency room and/or hospitalization and re-enter DOC facilities. DOC was receptive to implementing a patient care hospital survey upon re-entry.
 - a. Patient care surveys now administered by DOC upon re-entry to DOC facilities.
 - b. Aggregate survey scores and narrative responses will be provided to ACHRC for review at each meeting – Committee would like to discuss negative feedback specifically and identify potential patterns, if any.

Progress – Generally, initial survey data suggests that hospitalized individuals are having a positive experience with receiving healthcare in community.

The ACHRC will continue to monitor progress on recommendations and include additional items as needed.

VI. Concerns

Staff shortages and Hiring

Delaware, along with the rest of the nation, has been impacted by staff shortages. The struggle for consistent staffing and the difficulty in hiring remain a concern. This is true for both DOC and the contracted provider at numerous levels. However, staffing has remained consistent at 85-87% weekly and has seen improvement over the last year. Delaware consistently has a higher staffing rate than other states with VitalCore contracts. The agencies continue to boost recruitment and offer incentives. ACHRC will continue to monitor this challenge in 2026 and help in all possible ways.

Autopsies

Obtaining medical autopsies has been a challenge for the DOC for many years. Currently, the DOC may wait more than six months to obtain an autopsy on an uncomplicated inmate case. Because the Committee is tasked with reviewing the circumstances behind inmates' deaths, the inability to obtain autopsies in a timely fashion is discouraging and prevents the Committee from carrying out its charge.

The DOC Medical Director met with the Chief Medical Examiner in early 2025 to discuss DOC's desire to obtain autopsy reports. Straightforward (i.e. natural death, absence of drugs/alcohol, and no observed trauma) cases should be completed within ninety days. However, if there is suspicion of homicide, accidental drug overdose, and/or suspicion of criminal activity, the Division of Forensic Science requires approval from Delaware Department of Justice before they can release the autopsy report. Multiple state agencies are waiting an extensive amount of time for autopsy reports in these cases.

Critical Moments and Transfers

Handling individuals at critical moments such as initial incarceration, anniversaries, holidays, and individuals receiving long sentences continues to be a reoccurring topic. ACHRC suggests DOC continue to explore by incorporating some best practices supported in literature and conduct additional screening to determine those critical points. It could be helpful to have mental health professionals on site and available at the Courthouse as well. ACHRC member will work with DOC to examine establishing a real time process for situations when an individual comes from Court to the facility after receiving a lengthy prison sentence. Some individuals may be evaluated by a mental health professional either from the Dept. of Justice or Office of Defense Services, however that information is not transferred to DOC.

DOC is not made aware of additional risk factors such as preexisting mental health and/or SUD diagnosis in a timely fashion, if at all. Members recognize that even with DOC being fully staffed, it is difficult to increase assessments and monitoring for mental health. DOC medical staff is also not made aware of an individual's criminal charges or the severity of those charges which could impact a suicide, attempted suicide, and any self-harming behavior. Developing an inventory/checklist as a follow-up with cases could help. DOC maybe can conduct a group debriefing with newly incarcerated people, particularly ones with a SUD. ACHRC members offered to obtain additional resources such as an assessment for critical events and risk factors.

Another area of focus during the year was the DOC use of personal close observation (PCO) measures which include increasing the intensity of interventions and heightens the frequency of treatment visits for individuals. The Committee discussed facility housing options and the pros and cons of having someone in a single cell versus having a cellmate. ACHRC members suggest utilizing peers/patient companions to assist in addressing these types of needs within the Department when appropriate.

Increased Overdoses and Emerging Drugs in Facilities & Community

The Committee continues to discuss at length suspected overdoses. The Committee has concerns about emerging substances, including Medetomidine, within facilities and the number of overdoses. Additionally, the Committee has noted an increase in the number of overdoses related to unknown substances. ACHRC would like to receive information on the outcome of the suspected overdose investigations and how the individuals may have obtained the substance if determined. Members feel it would be beneficial to know if the suspected overdoses at the same facilities are connected in any way. It would benefit ACHRC in its mission to know what is happening and what security determines regarding

these cases. This is something that seems to be trending and needs extra attention. The Committee recognizes and appreciates the many prompt successful resuscitations through Narcan and first-responder efforts made by DOC staff.

DOC continues to see a number of people coming into the facilities with wounds. There continues to be a surge in emerging drugs, including Tianeptine, Bromazolam, Medetomidine, and Nitazine, in the community. These emerging drugs, in addition to an increase in withdrawals from unknown substances within the facilities, continues to be a concern.

Compassionate Release – Healthcare Facility Placement

The Committee discussed concerns surrounding barriers to community care with newly adopted compassionate release legislation. The DOC must coordinate care with nursing homes and long-term care facilities when an individual is medically paroled. Those facilities have complete discretion over patient acceptance. DOC has experienced barriers to securing placement for these individuals, delaying their parole. There are concerns that this will be exasperated under Senate Bill 10.

VII. Future Goals and Plans

The Committee is profoundly aware of the responsibility entrusted to it by the Governor and the Delaware Legislature. In 2026, the Committee will continue to monitor healthcare service reports from the DOC. In addition, Committee members will continue to review health service standards and service provisions to evaluate the quality of health services provided within the DOC.

The Committee intends to assist DOC in advocating for additional funds to care for incarcerated individuals. DOC has a duty to care for the individuals in their custody and as the population ages and becomes more ill, healthcare becomes more costly. Members will continue to advocate for more specialized management of inmates who require unique services, in addition to specialized trained staff at DOC to handle unique cases in the facilities. Furthermore, all Committee members continue to contribute to updates and discussions on current correctional healthcare services, best practices, and recommendations presented in healthcare service literature.

Goal – Explore funding, technology, and placement opportunities to find a solution to improve the quality of services for people experiencing severe mental illness who have self-directed violence and are a danger to themselves and others.

The Committee will explore the process and timing of being able to receive a gross autopsy report. Currently the Division of Forensic Science completes the whole autopsy report and sends it as a complete package to DOC. A gross autopsy is a preliminary review while waiting for test results and usually happens in the first few days of an incident. Laboratory reports many times take well over a month.

GOAL – Improve monitoring and response surrounding critical moments that impact incarcerated individuals.

- a. ACHRC recommends providing additional one-on-one peer support for individuals with high risk for self-harm and repeat offenders of self-harm behavior. DOC has acknowledged the benefit of this and advised that security concerns would need to be addressed before implementation.

GOAL – Evaluate the overdose trends and increase appropriate responses and treatments accordingly.

GOAL – Evaluate the difficulties with provision of care for individuals that have committed sex offenses. This includes examining enhanced training opportunities and exploring training credentials for treatment providers.

GOAL - Continue to explore medication needs for DOC population, including appropriate treatments for ADHD.

Finally, the Committee is pleased with the cooperation and the efforts to resolve healthcare services concerns by the Commissioner of the DOC, the Bureau of Healthcare, Substance Abuse and Mental Health Services, and the staff of DOC. We are confident that such cooperation, time, and attention will continue as we work together to fulfill the mission of the Committee.

Respectfully submitted,

The Adult Correction Healthcare Review Committee

December 30, 2025

Enclosure

APPENDIX A
Work Plan ACHRC
(House Bill 446)

Frequency of Meetings—Every one to two months but no less than four times a year

Reports expected for review at meeting:

- ✓ Critical Incident Reports involving injury to staff or inmates or public in DOC
- ✓ M/M Reports; Psychological autopsy when appropriate
Mortality reports from deaths occurring between ACHRC meetings will be reviewed following the mortality review for that death.
- ✓ PREA and ADA grievances
- ✓ Health staff disciplinary reports
- ✓ Notification of NCCHC and ACA survey dates at each facility
- ✓ Reports from public sources on issues affecting health and safety in DOC
- ✓ Pending lawsuits and professional disciplinary actions filed with licensing boards
- ✓ Other information concerning the health and safety of inmates as it becomes available.
- ✓ Monthly summaries of health-related grievances from inmates, their families, and DOC health staff. This will include DOC plans for the resolution of frequently occurring health related grievances.

Reports expected for quarterly meetings (January, April, July, October):

- ✓ Sick call response time for medical and behavioral call requests.

Reports expected prior to each 6-month meeting (January and July) November and December will focus on report to the Governor and Legislature

- ✓ Quality Improvement reports from each facility
- ✓ Internal quality monitoring reports
- ✓ NCCHC and ACA yearly reports
- ✓ Inmate hospital admissions; infectious disease report; quarterly report on inmates in DPC
- ✓ Reports on federal or state inspections including but not limited to pharmacy, dietary, radiation medicine, infectious disease, and safety reports routinely conducted as per state licensing agency requirements.
- ✓ Status reports on numbers of inmates in chronic care clinics and cumulative diagnosis—for instance, insulin dependent diabetes, active TB, Hepatitis C with drug treatment, Hepatitis C without drug treatment; identified with major psychiatric diagnosis including addictions and numbers in specific treatment including counseling (group and/or individual), and those on psychiatric medications.
- ✓ Re-hospitalization rate of inmates who had been hospitalized in public or private psychiatric or general hospitals within 6 months of previous hospitalization.

Committee members may arrange to visit facilities after giving appropriate notice to the Warden and Chief of Health Services to observe the conduct of health services or to review

practices and/or patient charts. If members wish to observe treatment or observe direct patient encounters, agreement by the patient will be first obtained.

Original Adopted October 26, 2009; Revision Adopted August 19, 2010; Revision Adopted November 18, 2011; Reviewed and Adopted without change December 2012; Reviewed and Adopted without change December 2013; Revision Adopted December 15, 2017.



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Adult Correctional Healthcare Review Committee

Established by [11 Del. C. § 6518](#), and revised by [House Bill 173](#), the Adult Correctional Healthcare Review Committee was created to serve “in an advisory capacity to the Governor, the General Assembly, and the Commissioner of the Department of Correction (DOC) on all matters in Delaware’s adult correction system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, and the review of all statistics relating to inmate healthcare. The Committee shall not be considered a public body as defined by [29 Del. C. § 10002\(c\)](#).” [11 Del. C. §6518 \(m\)](#).

Committee Members:


The six voting members of the Committee appointed by the Governor and confirmed by the Senate are:

1. Janet P. Kramer, MD, CCHP, a Delaware licensed physician;
2. Mustafa Mufti, MD, a Delaware licensed psychiatrist;
3. Mandell Much, PhD, a Delaware licensed psychologist;
4. Sandra J Nolan, PhD, RN AHN-BC, a Delaware licensed registered nurse;
5. Brenda James-Roberts, Esq. JD, RN, a member of the Delaware State Bar; and
6. James Harrison, MHS, an expert in the field of substance abuse treatment.

Mustafa Mufti, MD serves as Chair of the Committee and Dr. Mandell Much continues to serve as Vice Chair. In addition to the appointed members of the Committee, other non-voting participants include Deputy Attorneys General (“DAG”) Joanna S. Suder, Esquire, served as counsel for the Committee, DAG Gregory Smith, Esquire, served as counsel for the DOC, Awele Maduka-Ezeh MD MPH., Medical Director of the DOC, Director, Behavioral Healthcare Services for the DOC, Vanessa Bennifield, Behavioral Health Treatment Administrator, Susan Conley, APRN, ACNS-BC, Director of Medical Treatment Services, Tera Young, Behavioral Healthcare Services for the DOC.

Committee Charge

In June of 2019, the code related to ACHRC was modified with [HB173](#). The bill tasks the Committee with advising not only the Commissioner of the Department of Correction but also the Governor and the General Assembly on all matters in Delaware’s adult correctional system relating to the provision of inmate healthcare services, the review of all inmate deaths and autopsies relating to those deaths, the construction of healthcare contracts that provide inmate healthcare services, the review of all statistics relating to inmate healthcare, and any matters relating to adult inmate healthcare that the Committee considers reasonable and worthwhile, including assuring the resolution of identified problems and enhancing the efficient utilization of resources.

[The 2019 Adult Correctional Healthcare Review Committee Annual Report](#)  available for your review, and contains additional information about the ACHRC.



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