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

ADULT PRISONS & JAILS

Date of report: November 22, 2016

Auditor Information			
Auditor name: Bobbi Pohlman-Rodgers			
Address: PO Box 4068, Deerfield Beach, FL 33442-4068			
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Telephone number: 954-818-5131			
Date of facility visit: October 11 & 12, 2016			
Facility Information			
Facility name: Burke CRV			
Facility physical address: 5161 Western Avenue, Morganton, NC 28655			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 828-433-4036			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Prison	☐ Jail	
Name of facility's Chief Executive Officer: Unit Director Mary Marett			
Number of staff assigned to the facility in the last 12 months: 59			
Designed facility capacity: 248			
Current population of facility: 116			
Facility security levels/inmate custody levels: Minimum Custody			
Age range of the population: 20+			
Name of PREA Compliance Manager: Daniel Gilleon		**Title:** Unit Manager II	
Email address: Daniel.gilleon@ncdps.gov		**Telephone number:** 828-433-4036	
Agency Information			
Name of agency: North Carolina Department of Public Safety			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 512 N Salisbury Street, Raleigh, NC 27604			
Mailing address: *(if different from above)* 4201 Mail Service Center, Raleigh, NC 27699-4201			
Telephone number: 919-825-2739			
Agency Chief Executive Officer			
Name: Frank L. Perry		**Title:** Secretary, NCDPS	
Email address: frank.perry@ncdps.gov		**Telephone number:** 919-733-2126	
Agency-Wide PREA Coordinator			
Name: Charlotte Williams		**Title:** PREA Director	
Email address: charlotte.williams@ncdps.gov		**Telephone number:** 919-825-2754	

AUDIT FINDINGS

NARRATIVE

Burke CRV received a PREA audit beginning August 30, 2016. PREA notices were sent to the facility for display to all inmates and staff, and were posted by the appropriate date. The facility provided a flash drive with all documentation required and requested to the auditor by September 13, 2016. After a review of the documents, the on-site audit began on October 11, 2016 and was completed on October 12, 2016

The on-site PREA Audit was conducted by DOJ Certified PREA Auditor Bobbi Pohlman-Rogers. Prior to the on-site, the auditor reviewed all documentation submitted by the facility, including the PREA Pre-Audit Questionnaire. The auditor made contact with the facility prior to the audit to review the on-site process, time-frames, and to request additional information be made available on the first day of the audit. These documents included a current inmate roster and staff assignment/posts.

On October 11 2016, the auditor met with Director Mary Marett, Assistant Director Berry, PREA Compliance/Unit Manager Daniel Gilleon, Unit Manger Bryd, Unit Manager Clark, Unit Manager Tate, Residential Manager Dotson, CPPO Cooper, and Administrative Officer Orders. This brief entrance meeting focused on the audit process, the interim/final report, Corrective Action Plan periods, and additional documentation that would be needed. This meeting was followed by a tour of the facility.

The tour included all 11 buildings and all outside areas. The auditor was able to view PREA Audit notices, Zero Tolerance posters, and reporting methods that were located throughout the facility where both staff and inmates had access. Phones were identified in each unit, accessible to inmates.

Interviewees were selected through the use of the inmate rosters and staff assignment/posts. There were a total of 10 inmates selected for interview. The facility reported that there were no LGBTI, prior or current victims, no Limited English Proficient, no inmates with Disabilities and there is no Restricted Housing. However, during the interviews, one inmate self-reported that he is illiterate. There were 10 random staff selected for interview; these staff were selected from both shifts. Additionally, 13 specialized positions were selected for interview. This included the PREA Manager, Superintendent, Upper Level Management, Medical Staff, Mental Health Staff, Human Resources, Volunteer Coordinator, Investigator, Intake Staff, Risk Screening Staff, Staff who conducted Incident Reviews, Staff who monitors for Retaliation, and a First Responder Staff. The Agency head and Agency PREA Coordinator were interviewed prior to this audit by DOJ Certified Auditor Pete Zeegers, and the information was provided to this auditor.

Staffing includes two 12-hour shifts, as well as 8-5 staff. There are 43 employees, which includes 33 Correctional Officers, 6 Assistant Unit Managers and 4 Unit Managers. There is one trained PREA Investigator and 4 volunteers. There are a total of 20 cameras at the facility. These cameras cover the housing units, day rooms, visitation and the yard.

In the past twelve months, there have been no allegations of sexual abuse or sexual harassment.

Medical services are available at Burke CRV. Medical staff is present 16 hours per day, 5 days per week. Mental Health staff are also present at the facility. Carolina Medical Care Morganton is the local hospital where services are provided that cannot be handled at the facility, including forensic examinations required for sexual abuse investigations.

This facility has two PREA Support Persons (PSP) who have received training to assist victims through all steps of an investigation, including providing assistance in obtaining outside support services. The agency is currently working with the North Carolina Coalition Against Sexual Assault (NCCASA) to create a state-wide system for community based services. In the interim, Options, Inc. is providing services to inmates.

DESCRIPTION OF FACILITY CHARACTERISTICS

Burke CRV is a minimum security prison for 240 adult male inmates run under the North Carolina Department of Public Safety (NCDPS). The NCDPS Mission is to promote the elimination of undue familiarity and sexual abuse amongst the offender population. The Burke CRV Behavior Modification Center mission is to provide a highly structured, confinement program for technical violators which will allow opportunity to modify behavior, learn how to make better life choices and learn new skill sets in order to succeed in the community upon release.

Located in the City of Morganton and within the County of Burke, Burke CRV (Confinement in Response to Violation) provides an intensive behavior modification program for those who have committed technical violations of probation. Provided in the Justice Reinvestment Act of 2011, this is a 90-day residential program in response to violations of probation, parole or post-release supervision. Inmates can serve 2 90-day terms before they face revocation of their probation and a return to the prison. Burke CRV opened in December 2014 on the property of the former Western Youth Institution.

Burke CRV has 4 housing units that house a total of 248 inmates. All units are identical. These open bay units contain telephones, showers, bathrooms, and 2 dayrooms (one of which is used for educational purposes). Each unit has information for inmates regarding the reporting of sexual abuse and sexual harassment, as well as local crisis center information. Each unit offers inmate privacy in regards to toileting, showering, or changing clothing. Unit B is currently closed. There is no Restrictive Housing Unit at Burke CRV.

The remaining buildings on the property house Administration, Medical, Dining facility, Education, Line up Room, Processing, Canteen, Supervisors Office, ID Room, Clothes House, other offices and Warehouse. Outdoor recreation includes Volleyball, Pavilion, Basketball, Weights. The outdoor garden is well tended. The facility reports that the last season they were able to donate 300 pounds of food for the homeless.

Three trailers and a classroom in each unit are used for educational/vocational services. Inmates participate in a variety of CRV programming. Core classes include Moral Reconation Therapy (MRT), Living in Balance (LIB), Career Readiness and life skill training. Additionally a computer lab where inmates work on cognitive skills, education modules, and job searches. Health and STD Classes are offered through the Burke County Health Department. Community Volunteers conduct AA/NA meetings weekly. Additionally, each inmate spends six weeks creating appropriate re-entry plans in preparation for their exit from the program.

Inmates work throughout the facility in jobs such as kitchen workers, janitors, grounds keepers, laundry, and canteen.

SUMMARY OF AUDIT FINDINGS

Burke CRV staff was well prepared for their PREA Audit. Documents requested by the auditor were made available at the start of the audit. Documents requested at the time were also provided. There were initial concerns regarding the lack of privacy for inmates while toileting; however these were resolved within 30 days of the on-site visit. The Maintenance Department was able to fabric swinging doors for all bathrooms. Additionally, during the tour it was noticed by the auditor that the medical window was blocked which prevented sight supervision. This was immediately rectified.

The facility has a Sexual Assault Response Team (SART) and PREA Support Persons (PSP). The SART is activated when there is an allegation of sexual assault. The PSP plays an important role in assisting the victim through the various activities associated with an allegations (investigation, medical exam, interviews, and support services). There are two (2) PREA Support Persons identified.

The facility staff were helpful, very professional, and well versed in PREA activities at the facility level. It was a pleasure to work with them through this process.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 4

Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Policy A.2000, SOP .3405, SOP .0202, Form OPA-A16, NCDPS Organizational Chart, NC General Statute 14-27.7, and NCDPS Memo dated 10/27/15, that identified the PREA Manager were reviewed. The Superintendent and PREA Compliance Manager were interviewed. The Agency Head and Agency PREA Coordinator were interviewed at an earlier time.

The agency has a policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy, along with additional policies and standard operating procedures, outlines the prevention, detecting, reporting, and response to sexual abuse and sexual harassment allegations. Definitions that mirror the PREA Standards are included in the policy, as well as sanctions for those who violate policy. All interviewed shared their knowledge of the strategies and responses towards PREA allegations.

The PREA Compliance Manager/Assistant Superintendent has been employed for 19 years, of which 2 has been at this facility as the PREA Compliance Manager. He reports that he feels he has enough time to complete are duties as the PREA Compliance Manager, roughly 20% of his time is devoted to PREA compliance. His efforts toward compliance include monitoring the High Risk housing lists, ensuring posted information is available, reviewing policies and updating facility procedures, monitoring video, supervising strip searches at intake and implementing changes when needed. He takes the following actions when a challenge is identified: ensuring notifications are made as required, reaching out to other PREA Compliance Managers for additional guidance, and keeping staff updated on changes.

The agency has a Agency PREA Coordinator, Charlotte Jordan-Williams, who reports to general counsel, and who has reported sufficient time to attend to PREA duties. She also has two staff who assist her with PREA related duties. She currently has 140 PREA managers that indirectly report to her. She is very knowledgeable regarding PREA standards and agency policies and practices.

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The standard is Not Applicable as the agency does not contract for the housing of its' inmates.

Standard 115.13 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.1600, Policy F.1601, Staffing Plan Report dated January 2015, Burke PRV Prison Post Chart (reviewed 10/11/16), Shift Narratives noting unannounced rounds, and North Carolina General Statute 143B-709 were reviewed. Additionally, interviews were conducted to further determine compliance.

While North Carolina General Statute requires a staffing analysis every 3 years, the agency policy requires an annual review of the staffing plan, including a review of all required components of the standard, which was completed in January 2015. The facility reviewed its' current Prison Post Chart which identifies the number of posts, number of current staff, and the number of staff needed to fill posts on October 11, 2016. Deviations from the staffing plan are noted on the Shift Narrative. They facility uses a star system hold over for coverage as needed. Unannounced rounds are documented in the unit logs. These are conducted by the PREA Compliance Manager or Assistant Director at random times each week and on all shifts. These were reviewed by the auditor. Unannounced rounds include all areas of the facility.

Standard 115.14 Youthful inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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This standards is Not Applicable as this facility does not house any inmates under 18 years of age.

Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.1600, Policy F.0100, SOP .0103, SOP .1609, Policy TX I-13, Safe Search Practices Training, NCDPS New Employee Orientation (revised 1/1/15), Cross Gender Announcement & Acknowledgement for staff, Training Curriculum: Safe Search Practices, Form OPA-T30 – Cross Gender Acknowledgement, Staff Training Log, and Cross Gender Bulletin Board Poster Memo (dated 4/22/13) were reviewed.

Interviews were also conducted to assist with the determination of compliance.

Training on safe search practices that include cross gender searches was confirmed. Policy requires documentation of any cross gender searches. There were no reported cross gender searches conducted. Training documents reviewed indicated that staff have completed appropriate training. However, interviews will staff indicate there is not a clear understanding of the staff gender who will search transgender or intersex inmates. Prior to this report, the facility conducted facility wide refresher training on the search policy and provided to the auditor proof of the training. Agency policy and facility SOP require the announcement of cross-gender staff entering the housing units. Inmate interviews confirmed that they hear female staff announcing themselves in the units, as well as a general announcement at the beginning of each shift where female staff are present.

Additionally, there are five cells in the processing area. Toilets in these cells are protected from sight.

Each unit within the facility has provided for inmate privacy through doors or screens. During the audit, the auditor identified that none of the unit bathrooms provided inmate privacy. This was rectified through the use of swinging doors that were fabricated and installed prior to this report. Photos of the doors were provided to the auditor.

Standard 115.16 Inmates with disabilities and inmates who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy E.1800, Policy E.2600, Policy F.3400 and a copy of the memo regarding a new Interpreter Service was provided by the Agency PREA Coordinator. Facility PREA documents in English were observed at the facility and Spanish documents are available as needed.

There is a contract that went into effect on March 1, 2016 with Linguistica International, Inc. for the provision of interpreter services by telephone and covered 250 different languages. This contract expires on March 4, 2017 with options for three additional one year renewal periods. Policy prohibits the use of inmate interpreters except in emergent circumstances. There is PREA material in both English and Spanish available at the facility. Staff were clear on how to access interpreter services if needed.

Information is available in both English and Spanish (the most common non-English language at this facility). It was unclear during the audit if there is a system to ensure that inmates with learning disabilities are identified upon intake and when providing information on the facility and PREA reporting. An interview with one inmate who self-reported being illiterate, he stated that he does not read well. He reported during the interview that upon intake he was asked to read and sign the PREA information; however, other inmates reported that they were provided verbal information while reviewing the document themselves. The Agency has a narrative that is required to be read to all inmates at intake and it appears that this is being conducted as required by Agency directive.

Standard 115.17 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Form HR005, Form HR0008, Form HR013, Memo regarding PREA Hiring and Promotions (dated October 2013), Addendum to the Memorandum, List of Disqualifying Factors, 2013 Employee Statement, sample of employee background screenings, and PREA Employee Statement were reviewed. Interviews were conducted to assist with determining compliance.

The agency policy prohibits the hiring or promotion of individuals who have engaged in sexual abuse, or attempting to engage in sexual abuse in a detention facility or in the community, or who have been civilly or administratively adjudicated for the same. The agency requires all staff to annually sign a statement that they have not engaged in the aforementioned activities (PREA Hiring & Promotion Prohibitions and HR005). This information was reviewed through the LMS (Learning Management System) and copies were provided to the auditor for review. All staff are documented as having completed this step of their training. The agency also requires all employees to self-report any such misconduct. Criminal background check are required for contractors and employees, and material omissions regarding misconduct or false information are grounds for termination. The agency does respond to requests from other institutions where a former employee has applied to work. The agency conducts background checks at hiring. Proof of background checks conducted within the last 5 years was reviewed for all staff interviewed. Of the 23 files reviewed, all have had received a background screening within the past 5 years.

Standard 115.18 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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This standard is N/A as reported during the Superintendent's interview that there were no changes to the facility or electronic monitoring.

Standard 115.21 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy F.3400, Policy CP18, Form OPA-A18, Form OPA – I20, OPA-I21, Form OPA-I30, PREA Support Person (PSP) Training Lesson Plan, Chain of Custody Form, Incident Scene Tracking Log, PREA Support Person Roles and Responsibilities, Clinical Practice Guidelines, and NCCASA documentation were reviewed. Interviews also provided information in the determination of compliance.

The agency conducts only administrative investigations. The Burke County Sheriff's Office would complete criminal investigations, and no criminal investigations were conducted in the past 12 months. The agency has sent a letter to all law enforcement agencies in the state on

March 16, 2016 requesting their compliance with PREA standards in the event a criminal investigation is conducted. Additionally, the facility reached out directly to the Sheriff. The Sheriff identified that his office would comply with the Agency policies.

The Clinical Practice Guidelines cover appropriate evidence collection. The Agency has two PREA Support Person (PSP) who are trained for victim advocacy services, and acts as the link to assist victims with the investigative process, professional resources, community based advocates, and mental health professionals. There is an Incident Scene Tracking Log for documenting persons who may enter a possible crime scene before investigators are on-site, as well as a Chain of Custody form for documenting any evidence.

Inmate who experience sexual assault are taken to Carolina Medical Care Morganton. Forensic examinations are conducted; however they currently do not have a SAFE or SANE on staff. There is no cost incurred by an inmate for these services. The agency is currently working with the North Carolina Coalition Against Sexual Assault (NCCASA) to create a state-wide system for community based services and documents were provided. In the interim, the facility has contact with the Options, Inc. who has agreed to provide services for inmates. The PREA Support Person (PSP) will assist the victim in contacting the Options, Inc. if requested.

Standard 115.22 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400 and PREA investigations log were reviewed. Interviews were conducted.

All allegations of sexual abuse or sexual harassment are classified as a major incident. Policy requires that all major incidents receive an investigation. Policy requires that allegations be referred to an inhouse trained investigator for the administrative portion and to the local law enforcement (Burke County Sheriff's Office) for criminal investigations. Policies are available through the NCDPS website.

Standard 115.31 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy F.3400, Training Curriculum's SAH 101- 040812 and SAH 101 2015, Staff and Offender Relations Training, New Employee Orientation, On Boarding Checklist, Form OPA-T10, Employee Training Files, brochures, handbooks, bulletin board documents, red flag posters, and other documents were reviewed. Interviews with staff were also conducted.

The agency policy requires annual training for all staff in topics identified within the standard, including the zero-tolerance policy, staff responsibilities, inmate's rights, retaliation, dynamics, common reactions of victims, detection and response to allegations, inappropriate staff relationships, identifying inappropriate staff relationships, communication and mandatory reporting laws. Interviews with staff

confirmed they complete annual training and understand the material presented, with the exception of elder abuse laws. Training documentation is kept in LMS (Learning Management System). Employee training documentation found that all staff had completed their annual training. Of the 23 staff files reviewed, that three staff have not completed the PREA training as required. Prior to this report, the facility provided documentation that the three staff have completed the required training. Additionally, all staff received refresher information on the elder abuse laws.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy F.3400, Policy F0604; Training Curriculum's SAH 040813 and SAH 101 2015, Staff and Offender Relations Training, New Employee Orientation, Form OPA-T10, "Ways to Report" Poster, Volunteer Brochure, Visitation Reporting Poster, and other documents were reviewed.

The agency requires all volunteers to complete the same PREA training as a staff, with minor deviations. There is also a Volunteer Brochure specifically for volunteers to receive PREA information. This facility reports 4 volunteers that provide services to inmates. There is also a "Ways to Report" poster to remind volunteers and contractors of the various ways to report. The files reviewed contained a signed Acknowledgement form. During the interview with a contractor, she reported annual PREA training through the NCDPS which covered inmate rights, zero tolerance, and common reactions. She stated she is required to report to the Officer-in-Charge, Investigator or Administration staff if she becomes aware of any sexual abuse or sexual harassment.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Diagnostic Procedural Manual Section 201 & 417, PREA Inmate Brochure (English/Spanish), Offender PREA Education Acknowledgement Form T100, Facilitator Talking Points (Education upon Transfer), Education upon Transfer E-mail, Interpreter Services DOC150623, PREA OPUS (Offender Population Unified System) Training Roster, and assorted posters were reviewed. Inmate interviews were conducted.

Burke CRV receives inmates from a reception and diagnostic center, or through a transfer. Agency policy requires all inmates entering into the system to receive intake and comprehensive training at the reception and diagnostic center. Burke CRV inmates arrive at the facility having already received comprehensive education, and therefore receive facility specific information. The comprehensive education was reviewed at Craven Correctional Center and meets the criteria of the standard regarding content. Inmate education is maintained in OPUS

(Offender Population Unified System) and copies were provided to the auditor for review. Interviews with inmates confirmed the receipt of facility specific information at intake and transfer. The facility conducts inmate Orientation upon arrival of inmates. Informational posters were observed around the facility on the PREA boards in the dorms. Staff interviews also confirm Orientation material is appropriate to inmates needs and clear copies of all written material is provided to inmates. Of the 12 inmates files reviewed, 11 have received PREA education upon intake and within 72 hours.

During inmate interviews, one inmate disclosed he is illiterate; however he had never reported this to the facility. After a discussion with the Director, the facility updated their policy to require the Admission Technician to assess all new intakes for any special needs. If special needs are identified, then the inmate will receive a separate orientation to ensure that they have the information that is required and needed to keep themselves safe and report abuse. This process was implemented on October 18, 2016.

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy F.3400, Training Curriculums: Investigator, PPT and Mock Interview; Investigator Understanding Sexual Violence & PPT; and Incident Reporting, OPUS (Offender Population Unified System) Incident Reporting Pamphlet, and the Investigator PREA training file was reviewed. Investigator Interview was also conducted.

The facility has one designated investigators who has completed specialized training for this purpose. The training meets the requirements of the standard. Interview with the investigator found that he was well versed in administrative investigations. The Investigator is aware of requirements for preservation of the scene, preservation and collection of evidence, and requirements for reporting to the Burke County Sheriff's Office and to the Agency PREA Coordinator. He originally completed the specialized training in 2008 and received a refresher course in 2013. Only those who have completed this training have access to the electronic incident report system to allow for the review of investigations and updating the system with new information. The auditor reviewed training documentation of identified investigator, as well as the training provided by the agency to the investigators. The Investigator has also completed the annual PREA training.

The agency only completes administrative investigations. The Burke County Sheriff's Office completes criminal investigations.

Standard 115.35 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy F.3400, and Training Curriculum: PPT, CE Nursing and OSDT Roster were reviewed. Training files for medical staff and mental health staff were reviewed. Interviews were completed.

The agency policy requires that all medical and mental health staff receive PREA 101 and specialized medical and mental health training. The specialized training meets all requirements of the standard. Mental Health staff received both PREA training and specialized training. The medical staff has completed the standard PREA training and the specialized training. This was confirmed with documentation and through interview. Both were able to articulate specific areas of the specialized training.

Forensic examinations are not conducted at this facility and therefore no training was provided. All forensic examinations are conducted at Carolina Medical Care Morganton.

Standard 115.41 Screening for risk of victimization and abusiveness

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

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

Policy F.3400, Diagnostic Procedural Manual 305, and memo dated 08/14/15 were reviewed. A selection of inmate files were also reviewed. Interviews were conducted.

The agency conducts a risk assessment at the reception and diagnostic center upon the initial intake of inmates into the state system. This is completed within 72 hours of arrival. The risk assessment contains all elements of the standard. The agency recently changed their processes to ensure that both inmates at risk of victimization or being aggressive are appropriately identified. This system went into effect March 2016. The agency PREA Coordinator provided to this auditor documentation that the agency now produces a High Risk for Victimization List (HRV) that is reviewed alongside the High Risk for Abusive List (HRA) to ensure that all housing, work, and programming services are assigned with the protection of the inmates as a key factor. Upon intake at a reception center, the inmate and staff complete the Mental Health Screening Inventory. This tool identifies all required components of the standard. From this document, two lists are produced – the HRV and HRA (see above). These lists are protected from viewing by staff who do not have an immediate need to know and access is only provided to those who need to make housing decisions. It is the responsibility of the Assistant Superintendent/PREA Compliance Manager to ensure these lists are reviewed upon intake and weekly for appropriate placement. This was confirmed during the interview. A review of 12 files found that all had been screened on the day of intake.

During interviews it was discovered that the facility was not conducting a review of the screening within 30 days. The Director the Intake Procedures to include a review of the screening tool within 30 days. This was implemented in October 2016.

Standard 115.42 Use of screening information

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

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

Policy F.3400, Policy TX-I-13, Policy C.0100, Screening tool, Learning Management System (LMS) Material, and the Instructions to access the High Risk Abuse Report were reviewed. Interviews were conducted.

The policies addresses clear guidelines, including limits, for housing and work assignments based on the safety of all inmates, a bi-annual review of housing for transgender and intersex inmates, allowing transgender and intersex inmates to shower separately from all other inmates, and assessments for an inmates own perception of risk at the facility. The Classification Committee is a formal process at an inmates initial intake into the NCDPS system, and whenever identified thereafter, whereby all relevant information, screenings, evaluations, criminal behavior history is used to assist in the determination of appropriate housing assignments. Inmates are interviewed for their ideas, opinions, attitudes, preferences and other factors before a final decision is made on housing locations. Bed and work assignments are made at the facility level.

In March 2016, the agency updated their current system to include a review of the High Risk Victimization (HRV) and the High Risk of Aggressive (HRA) list at the facility on a weekly basis, or more often if needed, to ensure that inmates are placed in educational, vocational, and housing that ensures their safety. Inmates who are identified as HRV are now placed in closer proximity to the staff in the housing units. Interviews confirmed that at intake, the results of the screening are used to determine housing and bed assignment. Interviews confirmed that the Assistant Superintendent/PREA Compliance Manager reviews the High Risk lists each week to verify appropriate placement.

Standard 115.43 Protective custody

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

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

Policy F.3400 was reviewed. Interviews were conducted.

Agency policy prohibits the involuntary placement of inmates in restricted housing unless there are no available alternatives. Policy and interviews confirm that services for an inmate who may be placed in protective custody are continued as normal unless there is a specific documented reason for restriction. Policy dictates documentation of the use of protective custody when necessary and 30 day reviews of such placement. Those requiring such housing would be transferred to another, more appropriate facility.

Burke CRV does not provide protective custody facilities (restricted housing). If needed, the inmate would be transferred or released from the facility if determined to be in the best interest of the inmate.

Standard 115.51 Inmate reporting

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

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

Policy F.3400, Policy D.0300, Form OPA-T10, Fraud, Waste, Abuse & Misconduct reporting website page, PREA Internal & External webpage for reporting, Staff Brochure, Offender acknowledgement Form (English/Spanish), Inmate Rule Book, were reviewed and a tour of the facility was completed. Interviews were also conducted.

The agency has numerous ways for an inmate to internally report sexual abuse or sexual harassment. Methods of reporting include telling a staff, writing a grievance or letter to the PREA Coordinator and third-party reporting. Externally, the agency provides the address of the North Carolina Prison Legal Services (PLS) and a phone number to the Options, Inc. Mail boxes are available for inmate mail. It was confirmed through conversation with the administration that mail sent to the PLS or the PREA Coordinator is treated as legal correspondence and is not opened at the facility level. The posters in the facility provided the address for PLS, and inmate brochures detailed this as a method of reporting sexual abuse or sexual harassment.

Interviews confirmed that staff at the program are aware that they may report privately through the Fraud, Waste, Abuse, and Misconduct Hotline or through e-mail to the PREA Coordinator if they do not wish to report through the Chain of Command.

Standard 115.52 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.0300, Policy G.0300, and the Inmate Rule Book were reviewed. Interviews were also conducted.

The agency policy confirms that grievances of sexual abuse or sexual harassment require an immediate notification to the North Carolina Department of Public Safety PREA office preventing a response from the subject of the complaint. Inmates can hand their grievance directly to security staff or to any administrator. There is no disciplinary action if the report is made in good faith. A final response is due within 90 days, as well as notification to the inmate that it has been accepted within 5 days. Grievances are allowed to be prepared by the victim or other third party person who assists the victim. Emergency grievances, those defined as matters that present a substantial risk of physical injury or irreparable harm may be presented directly to the Officer in Charge, are forwarded immediately to the appropriate person, and require an initial response from the facility within 48 hours and a final determination within 5 days. There were 0 grievances in the past 12 months alleging sexual abuse.

Standard 115.53 Inmate access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Options, Inc. Brochure and PREA – The North Carolina Approach were reviewed. Inmate interviews confirmed findings.

The Agency is in the process of working with the North Carolina CASA for the provision of services under this standard. While this is in progress, the facility has reached out to Options, Inc.

The PREA Support Persons (PSP) is aware of the services available and is expected to assist victims in contacting them. Inmates are provided identification of the PREA Support Services through Form OPA-I30, which documents the PREA Support Persons role during the investigation and thereafter to assist in providing support services to the victim. The Options, Inc. Brochure was made available to all inmates through the use of the bulletin boards. Inmate interviews confirmed that while information was posted, there was no verbal discussion regarding what Options, Inc. is and how inmates could contact them for reporting of sexual abuse.

On October 14 & 15, 2016, town hall meetings were held with each unit. Meeting minutes confirm that all inmates were made aware of the services available through Options, Inc.

Standard 115.54 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The NCDPS website and posters were reviewed. Interviews were conducted.

The North Carolina Department of Public Safety (NCDPS) offers opportunities for third party reporting and accepts third party reports. Information on how to report to the NCDPS is provided on their agency website and in the facility. Those concerned will find two separate methods of reporting to the agency. They may write to the agency PREA Coordinator or send an e-mail through the link provided. Both options will result in the agency PREA Coordinator receiving the complaint. The agency PREA Coordinator will then generate an incident report and inform the Superintendent. This information is also available at the facility for visitors, inmates and volunteers.

Standard 115.61 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Coordinated Response Plan, and PREA 101 Staff Training were reviewed. Staff interviews confirmed findings.

The agency policy requires all staff, volunteers and contractors to immediately report any knowledge, information or suspicion of sexual abuse or sexual harassment, and any violation or neglect of responsibility, to administration. Contractor contracts include a requirement for reporting any information regarding sexual misconduct. Policy and interviews confirmed that staff are not allowed to share information with anyone who does not have a need to know. All allegations are reported to both the facility investigators and the agency PREA Coordinator. The Coordinated Response Plan details the notification to the state agency regarding vulnerable adults. Interviews with staff confirmed

their knowledge of how to report internally (chain of command, other administrative staff, or to agency PREA Coordinator) and externally (Fraud, Waste, Abuse, and Misconduct Hotline).

Standard 115.62 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400 was reviewed. Interviews confirmed findings.

The agency requires immediate action to protect inmates who report sexual abuse. All staff, contractors and volunteers are required to report any information to the facility investigators who will assist with taking appropriate steps utilizing the Coordinated Response Plan. Staff were able to articulate this requirement during the interviews. There were no allegations of this type in the past 12 months.

Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400 was reviewed. Staff interviews confirmed findings.

The agency policy requires that any receipt of sexual abuse or sexual harassment that occurred at another facility be immediately reported to the appropriate Superintendent. This notification must be documented. An incident report is also generated, which flags investigators and the agency PREA Coordinator. Allegations made by an inmate at another facility are treated the same as a new allegation, and facility investigators are notified and begin their review of information. There were no incidents that required reporting to another facility.

Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy F.3400, Coordinated Response Plan, and PREA training curriculum were reviewed. Staff interviews confirmed findings.

The agency requires all staff to separate, protect physical evidence and the crime scene, and to report to administration when an allegation of sexual abuse is received. All persons interviewed who have contact with inmates could clearly articulate the required steps; though staff were not familiar with the steps that could be taken to separate a victim from the alleged abuser. It is noted that staff PREA training identifies all staff as first responders. Contractors and volunteers are required to protect the victim and report the information to a security staff, administrative staff, or the PREA Compliance Monitor. There were no allegations of sexual abuse in the past 12 months.

The Director ensured that all staff received refresher training on first responder duties. This was completed prior to the writing of this report.

Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Coordinated Reponses Plan and Coordinated Response Overview were reviewed. Interviews were conducted and confirm findings.

The NCDPS has created a template that includes all PREA related requirements for a proper Coordinated Response Plan. Each facility is provided this draft template, which directs that their facility specific information be included in the plan and thereafter published to facility staff. This plan addresses first responder duties, leadership duties, investigator duties, PREA manager duties, PREA Support Persons duties, SART (Sexual Assault Response Team) duties, Mental Health and aftercare duties, and retaliation duties. There is also a Coordinated Response Overview (flowchart) that clearly details the many steps that the agency expects to be completed.

The facility provided a Coordinated Response Plan that was specific to their facility and addressed all required actions for staff. Interviews confirmed that the majority of staff were aware of the plan that is to be followed when there is an allegation of sexual abuse.

Standard 115.66 Preservation of ability to protect inmates from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is Not Applicable as North Carolina Department of Public Safety does not enter into collective bargaining agreements.

Standard 115.67 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Form OPA-I22 and Form OPA-I24 were reviewed. Interviews confirmed findings.

The agency policy addresses practices to protect both staff and inmates from retaliation as a result of reporting sexual abuse or sexual harassment information. Various protection methods for inmates are identified in policy. The PREA Support Person monitors inmates and the PREA Compliance Manager will monitor staff. There is a form that is used to document the retaliation monitoring at the 90 day mark. The form also prompts and allows for the documentation of periodic status checks. There were no allegations at this facility in the past 12 months that required monitoring for retaliation. The PREA Support Person monitors inmates and the PREA Compliance Manager will monitor staff. Interview with the PREA Support Person confirms that measures used to keep inmates safe may include housing changes or removal of the alleged perpetrator. She also reported that she is required to monitoring inmates or participants of the investigation for 90 days.

Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400 was reviewed. Staff interviews confirm findings.

The agency policy addresses the use of protective custody only if no other alternative means of protection is available, or if inmates request this level of protection. Inmates requesting this level of protection may completed the Request for Protective Custody and must document the reasons for the request. Interviews confirm that there are no facilities for protective custody at this facility. There were no instances of the use of protective custody as a result of a sexual abuse allegation in the past 12 months.

Standard 115.71 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400 and the Coordinated Response Overview were reviewed. Investigation files were reviewed. Staff interviews confirmed findings.

The agency policy requires that criminal investigations are conducted by outside law enforcement, therefore the facility investigators only conduct an initial investigation to determine if outside law enforcement is to be notified and administrative investigations. All investigators identified at the facility have received appropriate investigator specialized training. All evidence is gathered, documented and preserved. Prior allegations involving the same perpetrator or victim are reviewed. The credibility of the victim or alleged abuser is determined on an individual bases. The agency does not use polygraph examinations in order to continue an investigation. Administrative investigations address staff actions, credibility and a review of fact and findings of the criminal investigation (if applicable). All interviews are conducted as approved by the Office of Special Investigations and Compliance. Both criminal and administrative investigations are documented. There were no allegations in the past 12 months at this facility.

Standard 115.72 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400 was reviewed. Interview confirmed the findings.

The agency policy imposes no standard greater than a preponderance of the evidence in determing the outcome of an investigation.

Standard 115.73 Reporting to inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 3400, Form OPA I30, Form OPA-I30A, Coordinated Response Overview and sample forms were reviewed. Investigation files were reviewed. Interviews confirm findings.

The agency policy requires that an inmate be notified of the outcome of an investigations. The agency utilizies Form OPA-I30 to document notification to the victim of the outcome of the investigation, and Form OPA-I30A is used to document the status of the alleged offender. There were no allegations of sexual abuse or sexual harassment in the past 12 months.

Standard 115.76 Disciplinary sanctions for staff

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

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

Policy F.3400, Policy A.0200, New Employee Orientation, Investigation File, and NCDPS internal webpage were reviewed. Interviews confirmed findings.

The agency policy provides for disciplinary action towards staff who violate the zero-tolerance policy, up to and including termination. All disciplinary actions are reviewed individually based on the nature and circumstances of the allegation. Comparable offenses by other staff are also considered in a final determination of disciplinary action. All staff terminations are required to be reported to the state licensing body. There were no instances where a staff violated agency sexual abuse or sexual harassment policies.

Standard 115.77 Corrective action for contractors and volunteers

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

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

Policy F.3400, Policy F.0604, and Form OPA-T10 were reviewed. Interviews confirmed findings.

The agency policy confirms that any contractor or volunteer who violate the zero-tolerance policy will be prohibited from contact with inmates. Outcome of an investigation that is substantiated and involves a licensed contractor or volunteer is reported to the appropriate licensing body, as identified. There were no allegations where a contractor or volunteer was referred to local law enforcement for a violation of the agency zero-tolerance policy.

Standard 115.78 Disciplinary sanctions for inmates

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Policy B.0200, and the Handbook for Success were reviewed. Staff interviews confimed findings.

The agency policy dictates disciplinary actions for inmates who violate the zero-tolerance policy. The Handbook for Success clearly outlines the disciplinary action as a result of sexual abuse and sexual harassment (Level 3 Violation). Services for abusers is available and include counseling and possible transfer for additional interventions. Inmates are not disciplined for behaviors in which staff consent. There is no disciplinary action for inmates who make a report in good faith. There were no inmate-on-inmate sexual abuse incidents that were reported in the program in the past 12 months. The agency does prohibit all sexual activity between inmates.

Standard 115.81 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Policy CP-18, Diagnostic Manual 305, Memos dated 10/09/13 and 11/14/12, North Carolina Authorization for Release of Information, Mental Health Screening Referral system, and Learning Management System (LMS) were reviewed. Interviews confirmed findings.

The agency policy requires immediate referral to medical and mental health services after information of prior sexual victimization or sexual aggressive behaviors is discovered during the screening process. Services are provided within 14 days by facility medical and mental health staff. Interviews confirmed informed consent is obtained before information is shared regarding a victimization that may have occurred prior to incarceration.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy CP-18, North Carolina Authorization for Release of Information, Mental Health Screening Referral system, Nursing Protocol – Sexual Abuse, and the Coordinated Response Overview were reviewed. Interviews confirm findings.

The agency requires that all inmates who report sexual abuse shall be immediately taken for medical services. Mental Health professionals are notified by the medical staff and respond accordingly. Additional counseling services are available as identified and as requested by the victim through the PSP (PREA Support Person) and the Options, Inc. Provisions for STD testing and treatment are provided at the facility level based on physician orders and/or victim request. All treatment related to sexual abuse is offered without financial cost to the victim regardless if they name the perpetrator or not. All medical services provided follow the physician authorized nursing protocols. The Nursing Protocol for sexual abuse includes follow-up care and physician orders for STD testing and treatment.

Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Policy CP-18, Policy CC-8, and the Coordinated Response Overview were reviewed. Interviews confirm findings.

The agency provides on-going medical and mental health services for victims of sexual abuse, whether the incident occurred within an institution or in the community. All care is provided at the facility and is consistent with the community level of care. Follow-up care is provided in one week and as directed by the physician or by inmate request. STD testing and treatment is offered. Again, all services are provided to the victim without financial compensation. The agency also offers evaluations to sexual aggressive inmates when information is present, and services are available at Harnett Correctional Institution through the SOAR program.

Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Form OPA-I10, and Coordinated Response Overview. Interviews confirmed findings.

The agency requires a Post Incident Review (PIR) at the conclusion of any investigations of sexual abuse where the allegation was determined to be substantiated or unsubstantiated. Form OPA-I10 is completed. This is a standardized form that contains all elements of the standard. Participants include PREA Manager and SART members, who are comprised of upper level management and input from other staffing positions. There were no allegations of sexual abuse that were substantiated or unsubstantiated, and therefore there were no PIR's to review.

Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Incident Reporting – OPUS (Offender Population Unified System), and PREA Incident Reports were reviewed. Interviews confirmed findings.

The agency maintains records and data on all allegations of sexual abuse and sexual harassment from all facilities that captures information as identified by the DOJ-SSV. Aggregated annually, this information is included in the annual report.

Standard 115.88 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400, Form OPA-I10, 2015 Sexual Abuse Annual Report, and Coordinated Response Overview were reviewed. Interviews confirmed findings.

The agency utilizes information gathered from investigative reports and completed Post Incident Review forms (OPA-I10) to assess and improve the effectiveness of its zero-tolerance efforts towards prevention, detection and response of sexual abuse incidents. The information gathered assists with identifying problem areas, policy updates, and system updates. The annual report is completed and identifies facility specific issues and resolutions, as well as those specific issues that are agency wide. The annual report is approved by the Agency Head and made public through the NCDPS website.

Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy F.3400 and the 2015 Sexual Abuse Annual Report were reviewed. Interviews confirmed findings.

The agency publishes the annual report on its website. The report contains no personal identifiers. Agency policy requires the maintenance of records that meets the PREA standard.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

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

Bobbi Pohlman-Rodgers December 4, 2016

Auditor Signature Date