

PREA AUDIT REPORT Interim Final
ADULT PRISONS & JAILS

Date of report: 4/18/2016

Auditor Information			
Auditor name: G. Peter Zeegers			
Address: 6302 Benjamin Road Suite 400 Tampa, Florida 33634			
Email: pete.zeegers@us.g4s.com			
Telephone number: 863-441-2495			
Date of facility visit: February 22 and 23, 2016			
Facility Information			
Facility name: Caledonia Correctional Institution			
Facility physical address: 2787 Caledonia Drive Tillery, North Carolina 27887			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 252-826-5621			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Prison	<input type="checkbox"/> Jail	
Name of facility's Chief Executive Officer: Superintendent James Vaughn			
Number of staff assigned to the facility in the last 12 months: 331			
Designed facility capacity: 1038			
Current population of facility: 926			
Facility security levels/inmate custody levels: Medium and Minimum Custody			
Age range of the population: 21 and over			
Name of PREA Compliance Manager: Henry Watson III		Title: Assistant Superintendent	
Email address: henry.watson@ncdps.gov		Telephone number: 252-826-4165 ext. 323	
Agency Information			
Name of agency: North Carolina Department of Public Safety			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 512 N Salisbury Street, Raleigh, NC 27604			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 919-825-2754			
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

Caledonia Correctional Institution received an on-site PREA audit on February 22 and 23, 2016 by DOJ Certified PREA Auditor G. Peter Zeegers. Prior to the on-site visit, the facility provided a completed PREA Questionnaire and a flash-drive with the requested documents. The auditor reviewed the same documents prior to the on-site visit. The auditor contacted the facility one week prior to the audit to review the on-site audit process, time lines, and to request additional information be made available on the first day of the audit. These documents included inmate rosters and staff assignments. There was one inmate letter received before the on-site audit. It was resolved during an interview with that particular inmate and this PREA Auditor.

The on-site audit began with a meeting between the PREA Auditor, Superintendent III, Assistant Superintendent Custody/PREA Compliance Manager, Assistant Superintendent/Programs, Regional Security Coordinator, two Captains, Administrator Service Manager, and Assistant Superintendent IV. The discussion focused on the audit process, the interim/final 30-day report, Corrective Action Plan period, and the final report. It was also noted that two of the standards were currently being discussed with the NC Agency PREA Coordinator. The meeting was followed by a tour of the program.

During the tour, the auditor observed PREA notices and Zero Tolerance posters in the facility where both inmates and staff had access to the information. The tour included administration, visitation, programming offices, inmate receiving, restrictive housing unit, medical/dental, recreation room, education, chapel, dining hall, kitchen/food service, clothes house, maintenance, vocational classrooms, canteen, and the housing units. Each housing unit holds several pods.

Interviewees were randomly selected for both inmates and staff. There were a total of fifteen random inmates interviewed. A total of thirteen random staff were interviewed, as well as fourteen specialized interviews were conducted. The Agency head and Agency-wide PREA Coordinator were interviewed prior to this audit by DOJ Certified Auditor Kevin Maurer, and the information was provided to this auditor.

There were nine allegations of sexual abuse and/or sexual harassment within the facility in the past 12 months. There were two sexual abuse allegations of staff on inmate and there were three sexual abuse allegations, inmate on inmate. There were four inmate on inmate sexual harassment allegations made. One staff on inmate sexual abuse was unsubstantiated with one pending outcome. Two inmate on inmate sexual harassment allegations were unsubstantiated with one pending outcome. There were two sexual harassment inmate on inmate allegations that were unsubstantiated and two that were substantiated. All were investigated in a timely manner according to policy and procedures.

DESCRIPTION OF FACILITY CHARACTERISTICS

Caledonia Correctional Institution is a medium and minimum level security facility for male inmates run by 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.

This facility sits on land in Halifax County and houses a maximum of 1038 inmates. There are 22 individual housing units located within two buildings, and one restricted housing unit. The facility is operated under the Unit Management concept which allows the facility to break down a large inmate population into smaller, more manageable groups. This concept provides more individualized correctional services to inmates, while maintaining safe and humane living conditions. There are approximately 331 staff to accommodate the daily operations.

There are two main housing buildings. Medium and minimum security. There is also a restricted housing unit located in the medium housing unit. At the entrance of each building, there is a PREA bulletin board that provides information regarding the Agency's Zero-Tolerance information, including how to report and access to outside services. Inmates pass these boards multiple times during a 24-hour period moving from the dorms to meals, education, vocation, and recreation. Keeping with the Unit Management concept, each housing building contains a canteen and access to the recreation yard.

All housing units contain toilets and showers that have been modified to provide privacy. Inmates did report a concern that they could be seen from the control unit. A review from the control room confirmed that privacy is provided in both the bathrooms and showers. This allows for privacy from the general population, but allows for security staff to supervise the area as well.

Caledonia Correctional Institution provides educational and vocational programming to inmates. These include ABE Level 1, High School Equivalency, High School Equivalency Prep, Academic Education, Adult Outreach, CE Human Resources, Vocational Education, Small Engine & Equipment Repair, Masonry, Electrical, Plumbing, Food Service Technology, CE Commercial Cleaning, CE Computer Applications, Character Education, Thinking for a Change. Work details include both internal and external opportunities. Externally, some inmates work with Halifax County on the road crew. Internally, inmates are provided jobs as Warehouse Operator, Dog Trainer I and Dog Trainer II, Food Service Apprentice, Egg processing, Cannery, Maintenance, farm Shop, M & C Shop, Poultry, Produce Warehouse, and Fitness and Wellness.

Caledonia Farm includes 7,500 acres, of which 2,500 acres is leased to a local farmer. Caledonia CI farms 2,500 acres which consists of 2,000 acres of soybeans, 150 acres of field corn, 320 acres of wheat, 200 acres of sweet corn, 100 acres of turnip greens, 10 acres of cabbage, 20 acres of sweet potatoes, 4 acres of broccoli, and 300 acres of pasture that is cut for hay. The poultry operation has approximately 42,000 layers and 15,000 baby chicks that are raised from one day old. There are 8 beehives which produce approximately 350 pints of honey. The farm requires 121 minimum custody inmates to work. This is all monitored with assistance of 12 Enterprise employees and 3 correctional officers from Caledonia CI minimum security.

Other programming offered includes religious services, AA/NA, Service Clubs, and Parenting.

Both medical and mental health staff are available at the program. Sexual Assault Forensic Examinations are conducted at Halifax Regional Medical Center. Both medical and mental health staff are located at the facility and are available as requested.

SUMMARY OF AUDIT FINDINGS

During the audit, it was determined that the agency is only identifying inmates who are sexually aggressive based on the completed Risk Assessment. They are gathering all information for identification of Vulnerable to Victimization Inmates; however, this information is not used to determine housing and programming. The agency's current system is to provide appropriate protections from all inmates from those identified as sexually aggressive. A conversation with the PREA Coordinator, and e-mail correspondence with the PREA Resource Center (PRC), confirmed that the standards require both populations to be identified in order to provide appropriate protections. The agency has been responsive to this information and is currently working towards the creation of an objective tool to be implemented in the next 6 months as well as systems for identification and inclusion into the housing/programming/work assignment determination process. In regards to 115.41, on March 17th, 2016, the agency PREA Coordinator provided to PREA Auditor Bobbi Pohlman-Rodgers documentation that the agency now produces a High Risk of Victimization list (HRV) to the facility that is reviewed alongside the High Risk of Abusiveness 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 the HRA (see above). These lists are protected from viewing of staff who do not have an immediate need to know and access is only provided to the Superintendent III, PREA Compliance manager, Assistant Superintendent for Custody and Operations, Assistant Superintendent for Programs, and the Inmate Assignment Coordinators, or IAC. It is the responsibility for the designated staff to run these lists weekly to review for appropriate placement. Caledonia Correctional Institution was then required, and has completed as of March 18th, 2016, a review of all inmates on the HRC and HRA list as well as changes made to ensure the safety of inmates. In regards to standard 115.42, on March 17th, 2016, the agency updated their current system to now include a review of the High Risk Victimization (HRV) and the High Risk of Aggression (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. This information was provided to this auditor to show that on March 29th, 2016, Caledonia Correctional Institution completed the first run of this new system and made changes in order to protect inmates. In regards to standard 115.17, on March 29th, 2016, the agency has updated their systems to include a 5-year background screening for all staff. Proof of these screenings were provided to this auditor by the Agency PREA Coordinator.

The facility has a Sexual Assault Response Team (SART) and PREA Support Persons (PSP). Both groups are 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 allegation (investigation, medical exam, interview, support services).

Computerized Incident Reports are well written and contain documentation of medical/mental health services provided as required. Additionally, outside law enforcement investigations are noted, where appropriate, and the outcome is documented.

The facility staff were very helpful, very professional, and well versed in PREA activities at the facility level. The facility response to privacy concerns were immediately addressed and that confirms the facility commitment to ensuring the safety of all inmates. It was a pleasure to work with the Administrator and his staff.

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 F3400, Policy A2000, SOP 05.09 (a-g), Form OPA-A16, NCDPS Organizational Chart, NC State Statute 14-27.7, and NCDPS Memo dated 10/27/15, that identified the PREA Manager, were reviewed. The Administrator and PREA Manager were interviewed. 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 violated policy. All interviewed shared their knowledge of the strategies and responses towards PREA allegations. The PREA Compliance Manager/Assistant Superintendent of Custody reported sufficient time to attend to PREA duties. This person reports directly to the Administrator, and indirectly to the Agency PREA Coordinator. The agency also has a PREA Coordinator, Charlotte Jordan-Williams, who reports to general counsel, and who has reported sufficient time to attend to PREA duties. She currently has 140 PREA compliance managers that indirectly report to her.

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 F1600, SOP 5.32, Staffing Plan Report dated July 2015, Approved Facility Posting Chart/Staffing Plan approved January 2016, OIC Round Documentation, Unannounced staff rounds documentation for the housing buildings, and North Carolina State Statute 143B-709 were reviewed. Additionally, interviews were conducted to further determine compliance.

While state 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 July 2015. Deviations from the staffing plan are documented on the Daily Shift Report as per policy. Unannounced rounds are clearly documented in the Dorm Logs. These are conducted by the Officer in Charge and documentation includes the date/time and location of the physical rounds. Interviews with the PREA Compliance Manager confirmed that upper level management conducts unannounced regularly and documents in the Dorm Logs as well.

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)

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 standards is Not Applicable as this facility does not house any inmates under 20 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 F1600, Policy F0100, Policy TX I-13, SOP 5.19, Safe Search Practices Training, NCDPS New Employee Orientation (revised 1/1/15), Cross Gender Announcement & Acknowledgement for staff, 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.

The agency has trained all staff on cross-gender viewing and searches. Cross gender staff entering the housing areas are required by policy to announce their presence as observed during the tour. 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. Staff interviews indicated that while the staff have received training, a few were unable to articulate the agency policy regarding transgender/intersex searches.

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 E1800, Policy E2600 and World Wide Telephonic Interpreter Services Contract were reviewed. Facility documents in both English and Spanish were observed during the tour.

The agency has established policy to provide for educational services for inmates with disabilities to be provided information at intake and assistance on PREA allegations, including reporting. Case managers would arrange for education in formats for those inmates identified as disabled. Agency policy also addresses the provision of interpreters to those inmates with a non-English primary language. There is a contract in effect with World Wide Telephonic Interpreter Services Company that was signed on 2/6/2014 and is in effect for a 1 year period, with 2-1 year extensions, for a total of 3 years. Policy prohibits the use of inmate interpreters except in exigent circumstances. There is PREA material in both English and Spanish at the facility. Additionally, this facility offers English as a Second Language (ESL) classes.

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)

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.

Form HR005, Form HR0008, Form HR013, Memo regarding PREA Hiring and Promotions (dated October 2013), and Addendum to the Memorandum, List of Disqualifying Factors, 2013 Employee Statement, 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. The agency also requires all employees to self-report any such misconduct. Criminal background check are required for contractors, 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.

CAP: In regards to standard 115.17, on March 29th, 2016, the agency has updated their systems to include a 5-year background screening for all staff. Proof of these screenings were provided to this auditor by the Agency PREA Coordinator.

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)

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.

There were thirteen cameras installed in the medium security unit to help protect inmates from sexual abuse and harassment. They were installed in 2015.

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)

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 F3400, 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, an agreement with Hannah’s House Victim Advocacy Group, and NCCASA were reviewed. Interviews also provided information in the determination of compliance. The agency conducts only administrative investigations. Halifax County Sheriff’s Office completes all criminal investigations. Uniform Evidence Protocols are in policy and are appropriate. The Institution has PREA Support Persons (PSP) who are trained for victim advocacy services, and acts as the link to assist victims with the investigative process, professional resources, and community based advocates, and mental health professionals. 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. The facility does have an agreement with Hannah’s House victim Advocate Group, a local rape crisis agency in the meantime. The facility PSP (PREA Support Person) will assist the inmate in contacting Scotland County Domestic Violence and Rape Crisis Center. Forensic examinations are conducted at the Halifax Regional Medical Center.

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 F3400 and SOP 05.09 was 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 in-house trained investigator for the administrative portion and to the Halifax 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)

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 F3400, Training Curriculum’s SAH 101 04/08/13 and 07/01/15, Staff and Offender Relations Training, New Employee Orientation, Form OPA-T10, Employee Training Files, brochures, handbooks, and other documents were reviewed. Interviews with staff were also conducted.

The agency policies require annual training for all staff in all areas identified within the standard. Interviews with staff confirmed they complete annual training and understand the material presented. Training documentation is kept in LMS (Learning Management System). Employee training documentation found that all staff had completed their annual training (PREA: Sexual Abuse and Sexual Harassment 101). Staff were able to articulate the training they had received.

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)

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 F3400, Policy F0604; Training Curriculum’s SAH 101 04/08/13 and 07/01/15, Staff and Offender Relations Training, New Employee Orientation, Form OPA-T10, “Ways to Report” Poster, Volunteer Brochure, and other documents were reviewed. Volunteer interview also confirmed training.

The agency requires all volunteers to complete the same training as a staff, with minor deviations. There is also a Volunteer Brochure specifically for volunteers to receive PREA information. An interview with two of the volunteers showed that they understood how to report. The file review contained a signed Acknowledgement form.

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 F3400, 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.

Caledonia Correctional Institution receives inmates from a reception and diagnostic center. Agency policy requires all inmates entering into the system to receive intake and comprehensive training at the reception and diagnostic center. Caledonia inmates arrive at the facility having already received comprehensive education, and therefore receive facility specific information. The comprehensive education was reviewed at a reception and diagnostic 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. Informational posters were observed around the facility on the PREA boards in the housing building.

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)

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 F3400, 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 institution has designated investigators who have completed specialized training for this purpose. The training meets the requirements of the standard. Interview with an investigator found that they were well versed in administrative investigations. 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 agency only completes administrative investigations. All criminal investigations are conducted by the Halifax County Sheriff’s Office. The auditor reviewed training documentation of identified investigators.

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)

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 F3400, 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. Interviews with medical and mental health staff confirmed knowledge of specialized training. Forensic examinations are not conducted at this facility and therefore no training was provided.

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 F3400, 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. However, the current system allows only for the identification of sexually aggressive inmates (High Risk Abuse Report). While information is obtained regarding vulnerability, there is not an objective tool for the identification of inmates who are vulnerable to victimization. This assessment is required to be reviewed within 30 days of intake. If the inmate reports a victimization or identifies as sexually aggressive, notification is made to medical, the Administrator and the PREA Manager to begin services as required by policy. The policy prohibits inmates from being disciplined for refusing to answer questions from the screening. Only those staff with appropriate credentials have access to this electronically maintained information.

CAP: The agency must update the screening tool to include an objective method of identification for those inmates who are vulnerable to victimization. This must be implemented at Caledonia CI for all new inmates, as well as all standing inmates must be reassessed for vulnerability. This tool shall be provided to the auditor for review, along with a sample of those inmates at Caledonia who may now be identified as vulnerable to victimization. There must also be a plan to complete the remaining standing inmate population. In regards to 115.41, on March 17th, 2016, the agency PREA Coordinator provided to PREA Auditor Bobbi Pohlman-Rodgers documentation that the agency now produces a High Risk of Victimization list (HRV) to the facility that is reviewed alongside the High Risk of Abusiveness 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 the HRA (see above). These lists are protected from viewing of staff who do not have an immediate need to know and access is only provided to the Superintendent III, PREA Compliance manager, Assistant Superintendent for Custody and Operations, Assistant Superintendent for Programs, and the Inmate Assignment Coordinators, or IAC. It is the responsibility for the designated staff to run these lists weekly to review for appropriate placement. Caledonia Correctional Institution was then required, and has completed as of March 18th, 2016, a review of all inmates on the HRC and HRA list as well as changes made to ensure the safety of inmates.

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 F3400, Policy TX-I-13, Screening tool, Learning Management System (LMS) Material, and the Instructions to access the High Risk Abuse Report were reviewed. Interviews were conducted.

The policy addresses clear guidelines, including limits, for housing and work assignments based on the safety of all inmates. The policy requires a bi-annual review of housing for transgender and intersex inmates. The policy also provides for all transgender and intersex inmates to shower separately from all other inmates, and are assessed for their own perception of risk at the facility. While the agency has identified those inmates deemed at high risk for sexual aggression, and have implemented methods of reviewing all housing, programs, and work assignments to ensure the safety of all other inmates, the agency does not currently have a system in place for those inmates who are identified as vulnerable to victimization.

CAP: Once the agency has updated their current screening system to include the identification of vulnerable to victimization inmates, the facility will need to review the housing, work assignments and programming to ensure provisions for a safe environment from those inmates identified as sexually aggressive. Proof of this review must be provided to the auditor. In regards to standard 115.42, on March 17th, 2016, the agency updated their current system to now include a review of the High Risk Victimization (HRV) and the High Risk of Aggression (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. This information was provided to this auditor to show that on March 29th, 2016, Caledonia Correctional Institution completed the first run of this new system and made changes in order to protect inmates.

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 F3400 and SOP 4.54 have been reviewed. Interviews were conducted.

There have been no instances where protective custody has been used at this facility in the past 12 months. Agency policy prohibits the involuntary placement of inmates in segregated 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.

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 F3400, Policy D0300, Form OPA-T10, Fraud, Waster, 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). 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 Hotline or through email with 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 F0300, Policy G0300, 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. A box is used by inmates to deposit their grievance. The grievance box is emptied in their housing building daily. There is no requirement to use a less formal method of reporting prior to a written grievance. 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.

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.

There is an agreement with Hannah’s House victim Advocate Group, SOP 4.54A, and PREA – The North Carolina Approach were reviewed. Inmate interviews confirmed findings.

The facility has an agreement for the provision of outside support services for inmates. This agreement provides for telephonic victim support services. The PREA Support Persons are aware of the services through this agreement. Inmates are provided notification of the PREA Support Services through Form I30, which documents the PREA Support Persons role during the investigation and thereafter to assist in providing support services to the victim. The name of the local rape crisis agency and the address were noted posted on the PREA boards in each housing building.

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. Those concerned will find two separate methods of reporting to the agency. They may write to the PREA Coordinator or send an e-mail through the link provided. Both options will result in the PREA Coordinator receiving the complaint. The PREA Coordinator will then generate an incident report and inform the Administrator. This information is also available at the facility for visitors.

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 F3400, SOP 4.54, SOP 4.54A, 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. 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 PREA Coordinator. Agency staff training details the notification to the state agency regarding vulnerable adults.

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 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 this to the facility investigators who will assist with taking appropriate steps for protection. 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 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 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.

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 F3400 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 staff could clearly articulate these steps. 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.

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.

SOP 05.09, Coordinated Response 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. The plan reviewed was facility specific and included specific tasks for each member. The facility was updating contact information within the Plan. Additionally, there is a flowchart that helps staff to comply with the plan.

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 Caledonia Correctional Institution 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.

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. There is a form that is used to document the retaliation monitoring at the 90 day mark. Facility documents confirmed that retaliation monitoring is conducted. While periodic status checks are conducted, they are not well documented. The agency has updated their form to include spaces for documenting the date and information of these status checks and has implemented this agency wide. Caledonia is using this updated form. It is noted that there were not instances of reported retaliation at this facility.

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 F3400 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. Inmates who are placed in involuntary protective custody are seen every seven days by a counselor who documents this check. Unless documented, all inmates are provided the same programs and services as prior to their placement. Additionally, the Classification team reviews all placements of Protective Custody. 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 F3400, 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.

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 F3400 was reviewed. Interview confirmed the findings.

The agency policy imposes no standard greater than a preponderance of the evidence in determining 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 utilizes Form OPA-I30 to document notification to the victim of the outcome of the investigation, and include specific mention of the status of the alleged offender. These forms were found in the files reviewed along with the inmate’s signature, signature of the staff making the notification, and the outcome of the investigation.

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 F3400, Policy A200, 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 staff were disciplined just short of termination in the past 12 months.

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 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 involve a licensed contractor or volunteer is reported to the appropriate licensing body, as identified. There were no allegation 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 F3400, Policy B0200and the Inmate Rule and Policies Booklet were reviewed. Staff interviews confirmed findings. The agency policy dictates disciplinary actions for inmates who violate the zero-tolerance policy. The Inmate Rule and Policies Booklet clearly outline the disciplinary action as a result of sexual abuse and sexual harassment (Class “A” Offenses). 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 criminal 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 F3400, 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, 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 mental health social worker or PREA Support Person (PSP). Mental Health staff confirm notification. Additional counseling services are available as identified and as requested by the victim through the PSP (PREA Support Person). 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.

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 F3400, 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 and consistent with the community level of care. Follow-up care is provided within two weeks, as well as can be requested by the victim. 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.

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 F3400, Form OPA-I10, and Coordinated Response Overview were reviewed. Completed OPA-I10 forms were reviewed. Interviews confirmed findings.

The agency requires a Post Incident Review (PIR) at the conclusion of any investigations of sexual abuse 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, including medical staff. A sample of the completed Post Incident Reviews were reviewed.

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 F3400, 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 F3400, 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 F3400 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.

G. Peter Zeegers _____

04/18/2016 _____

Auditor Signature

Date