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

ADULT PRISONS & JAILS

Date of report: April 15, 2016

Auditor Information			
Auditor name: Bobbi Pohlman-Rodgers			
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Telephone number: 954-818-5131			
Date of facility visit: 12/07/2015			
Facility Information			
Facility name: Craven Correctional Institution			
Facility physical address: 600 Alligator Road, Vanceboro, NC 28586			
Facility mailing address: *(if different from above)* PO Box 839, Vanceboro, NC 28586			
Facility telephone number: 252-244-3337			
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: Superintendent IV Larry Dail			
Number of staff assigned to the facility in the last 12 months: 348			
Designed facility capacity: 796			
Current population of facility: 729			
Facility security levels/inmate custody levels: Medium Custody			
Age range of the population: 21 and over			
Name of PREA Compliance Manager: Valarie Wilcher-Ross		**Title:** Asst. Supt. Of Custody/Operations II	
Email address: valarie.wilcher-ross@ncdps.gov		**Telephone number:** 252-244-8330	
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)* Click here to enter text.			
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

Craven Correctional Institution received an on-site PREA audit on December 9 and December 10, 2015 by DOJ Certified PREA Auditor Bobbi Pohlman-Rodgers and DOJ Certified PREA Auditor Pete Zeegers. Prior to the on-site visit, the facility provided a completed PREA Questionnaire and a flash-drive with requested documentation. The auditor reviewed the same documents prior to the on-site visits. The facility was contacted by the auditor approximately 1 week prior to the on-site date to review the audit process, time lines, and request additional information be available on the first day of the audit.

The on-site audit opened with a meeting between the auditor and facility staff. Present at this entrance were Auditor Bobbi Pohlman-Rodgers, Auditor Pete Zeegers, Superintendent Dail, Assistant Superintendent Vaughn, Assistant Superintendent/PREA Manager Valarie Wilcher-Ross, Program Supervisor Mitchell, Registered Nurse Sittniewski, Costal Region Operations Manager Sapper, and other members of the security staff and administration.

A facility tour was conducted. The auditor observed PREA notices posted in areas where both staff and inmates have access. Additionally, a variety of information was posted or made available to inmates regarding sexual abuse and sexual harassment. This information was observcd both in English and Spanish. The tour included the following areas: Administration, Diagnositics, Medical/Dental, Intake, Restricted Housing, 3 general recreation areas, Programming, Kitchen, Warehouse, Maintenance, Chapel, Library, Dining Hall, and housing units.

Interviewees were randomly selected for inmates and staff. There were a total of 17 random inmates and 10 random staff interviewed, as well as 13 specialized staff interviews. Interviews at this facility were conducted by both DOJ Certified PREA Auditors. The Agency head and PREA Coordinator were interviewed prior to this audit by DOJ Certified Auditor Kevin Maurer, and the information was provided to this auditor.

Thre were 61 allegations of sexual abuse or sexual harassment filed in the past 12 months. Of these, one received a criminal investigation, and all received an administrative investigation. There were no instances where a non-security staff was the first responder.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Craven Correctional Institution is a medium level security facility for male inmates run under North Carolina Department of Public Safety. The NCDPS – OPA mission is to promote the elimination of undue familiarity and sexual abuse amongst the offender population.

The facility, located in Vanceboro, North Carolina, has a capacity of 796. Opened in 1996, this is one of the state's largest prison receiving and diagnostic centers. There are three types of persons at Craven CI – new inmates, safekeeping inmates and general population. New inmates enter the facility from North Carolina jails through processing at this facility. Intake consists of PREA education, testing, evaluation and interviews. Based on the results, inmates are transferred to their permanent prison that can provides appropriate security and services. Intake inmates are kept separate from those who have been permanently assigned to this facility. General population are those inmates who have completed the intake process and have been permanently to this facility. Safekeeping imates are those inmates who have been charged but not convicted, and are housed here as they are not able to be held at local jails for a variety of reasons.

There are 4 main buildings on the property. Two are double housing buildings with 4 pods within each. The largest building hosts administration, medical/dental, chapel, programs, receiving, warehouse, maintenance, master control, visitation, library, kitchen, dining, intake, segregation and inmate housing for diagnostics and safekeeping inmates. The smallest building is the entrance building where all persons entering are subject to searches, metal detectors and identification. There are also 3 outside recreational areas.

Housing for inmates provides for privacy when showering, using the toilet or changing clothing. Bogue unit has individual wet cells and a shower area with a door. The remaining housing units are open bay dorms with curtains in the shower area and bathrooms to provide privacy. A review from the control room confirmed that privacy is provided in both the bathroom and showers.

Both medical and mental health staff are located at the facility and are available as requested. The facility also has a SART (Sexual Assault Response Team) that consists of the Superintendent, PREA Manager, 10 investigators, 4 PREA Support Persons (PSP), 3 medical staff and 2 mental health staff who respond as necessary. PREA Support Persons are those staff who have been trained to assist the victim through all processes, including providing assistance in obtaining outside support services.

Educational and work opportunities are provided at the facility. GED and ABE classes are available for inmates to obtain their educational diplomas. Internal work opportunities are available that include maintenance, housekeeping, kitchen prep, and cooks. The facility also offers Aftercare programming: Cognitive Behavior Intervention and Thinking for a Change.

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.

The facility has a Sexual Assault Response Team (SART) and PREA Support Persons (PSP). Both are activated when an allegation of sexual assault is made. The PSP is an intricate member of the response team in assisting the victim through the various examinations (medical and investigative) as well as assisting with the provision of internal and external 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.

During the corrective action period, the facility provided updated information confirming the steps they have taken to become compliant with all PREA standards.

The facility staff were extremely helpful, very professional, and well versed in PREA activities at the facility level. There is a level of commitment to ensuring that all inmates are kept safe, not just regarding PREA allegations that is clearly apparent to the auditors, and the staff is very involved in all aspects of the running of the facility. It was an extreme pleasure to work with the Superintendent 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, NC State Statute 14-27.7, and NCDPS Memo dated 10/27/15, that identified the PREA Compliance Manager were reviewed. The Superintendent and PREA Compliance 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, 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. All parties interviewed showed knowledge of the strategies and responses towards PREA allegations. The PREA Compliance Manager reported sufficient time to attend to PREA duties. The agency also has a PREA Coordinator, Charlotte Williams, who reports to general counsel, and who has reported sufficient time to attend to PREA duties. She currently has 140 PREA Compliance Managers who report indirectly 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)

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Policy F1600, Policy F3400, Staffing Plan approved 6/11/12, Daily Shift Report, Daily Shift Narrative, Staffing Plan Report dated January

2015, Daily Staffing Rosters, 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 January 2015. Deviations from the staffing plan are documented on the Daily Shift Report. Unannounced rounds are clearly documented on the Daily Shift Narrative. These are conducted by the Officer in Charge (Lieutenant or Captain) and documentation includes the date/time and location of the physical rounds.

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 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, F0100, TX I-13, SOP 9.13, SOP 8.26, Safe Search Practices Training, NCDPS New Employee Orientation (revised 1/1/15), Cross Gender Announcement & Acknowledgement for staff, 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 is a system to assess gender dysphoria in inmates who report transgender or intersex, and a plan is put into place regarding the provisions of a safe environment. Training documents reviewed indicated that staff have completed appropriate training.
Staff clearly understood how to conduct transgender/intersex searches, as determined through interviews. The agency does provide privacy for inmates while showering, changing clothing and performing bodily functions through the use of curtains. This was verified during the tour.

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 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 and assistance on PREA allegations, including reporting. Agency policy also addresses the provision of interpreters to those inmates with a non-English primary language. There is a contract in effect with a Telephonic Interpreter Services Company that was effective on 5/21/2014 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 emergent circumstances. The facility provided an interpreter for the auditor while interviewing one LEP inmate. There is PREA material in both English and Spanish at the facility.

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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Form HR005, Form HR0008, Form HR013, Memo regarding PREA Hiring and Promotions (dated October 2013), Addendum to the Memorandium, 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 adjudicted 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.

On March 17, 2016, the agency has updated their systems to include a 5-year background screening for all staff. Proof of these screenings was 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)

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The standard is Not Applicable as the facility has reported no substantial expansions, modifications or updating of any video/electronic monitoring system has occurred in the past 12 months.

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 F3400, Policy CP18, Form OPA-A18, Form 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, and NCCASA were reviewed. Interviews also provided information in the determination of compliance. The agency conducts only administrative investigations. Craven County Sheriff's Office completes all criminal investigations. Uniform Evidence Protocols are in policy and are appropriate. The Agency has a PREA Support Person (PSP) who is trained for victim advocacy services, and acts as the link to assist victims with the investigative process, professional resoures, 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. 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 agency does have an MOU with Promise Place, a local rape crisis agency in the meantime, which was signed on March 7, 2015. The facility PSP (PREA Support Person) will assist the inmate in contacting the Promise Place. Forensic examinations are conducted at the Carolina East Medical Center in New Bern, NC. The agency has not reached out to local law enforcement to request their compliance with PREA standard 115.21 (a) through (3) subsections.

On March 16, the Agency sent a letter to all law enforcement requesting their compliance with PREA standards when investigating a allegation of sexual abuse.

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 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 inhouse trained investigator for the administrative portion and to the Craven 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 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, 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 Harrassment 101). However, staff could not articulate their responsibility regarding the reporting of Vulnerable Adult Laws as per State Statute.

During the corrective action period, the facility provided additional training regarding the mandatory Vulnerable Adult laws of NC. Beginning February 17, 2016, the agency has documented training provided along with signed rosters. With exception of those staff on a Leave of Absence, all security staff and non-security staff were re-trained.

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 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. This facility reports in excess of 166 volunteers that provide services to inmates. There is also posted in the visitation room a "Ways to Report" poster to remind volunteers, contractors and/or visitors of the various ways to report. The file review showed training along with 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)

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Policy F3400, Diagnostic Procedural Manual Section 201 & 417, SOP 4.54, Craven Correctional Inmate Orientation, Craven Correctional Institution PREA Orientation Upon Transfer, 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, Craven CI Orientation PREA Handout, Craven Correctional Institution PREA OPUS (Offender Population Unified System) Training Roster, and assorted posters were reviewed. Inmate interviews were conducted.
As a reception center, the Craven CI is responsible for initial PREA information on intake, as well as comprehensive education within 10 days. Immediately at intake, an inmate receives the Zero Tolerance Information and How to Report. Within four days, inmates receive a more comprehensive PREA education. Craven CI has systems in place to provide education to those with limited English and to those who are disabled and require assistance. Inmate education is documented in OPUS (Offender Population Unified System). Informational posters were observed around the facility.

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 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 facility has 10 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 could articulate material within the training. 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 facility only completes administrative investigations. All criminal investigations are conducted by the Craven 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)

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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 exams are not conducted at this facility. Documentation is maintained of staff participation in specialized training. Staff file reviews indicated that medical and mental health staff have received both trainings.

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 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 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 Superintendent and the PREA Compliance 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.

On March 17, 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 the Facility Head, PREA Compliance Manager, Asst. Superintendent for Custody and Operations, Asst. 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. This facility was then required, and has completed as of March 15, 2016, a review of all inmates on the HRV 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)

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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.

On March 17, 2016, the agency updated their current system to now 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. This information was provided to the auditor to show that on March 15, 2016, Craven Correctional Institution completed the first run of this new system and made changes in order to protect inmates. The facility has provided clear directions with regards to appropriate housing placement through HRV Matrix, HRA Matrix, Double Cell Housing Screen (OPUS System), Initial Case Management Contact and Central Monitoring. Additionally, the have identified certain jobs that are not appropriate due to the level of security staff supervision available in the area. The facility provided a copy of their most recent log that shows a review of the current inmates on the HRV or HRA Matrix List.

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, SOP 4.54, 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 PSL 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, but the narrative did not include that inmates could report allegations of sexual abuse or sexual harassment to this agency. Prior to the 30-day report, the agency updated all inmate brochures and visitor signs to include the mailing address for PLS. 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 grievance complants 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 box at this facility is located in the activity center. 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 Office 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 13 grievances in the past 12 months and all were resolved within 90 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.

MOU with Promise Place (dated 3/10/15), SOP 4.54A, and PREA – The North Carolina Approach were reviewed. Inmate nterviews confirmed findings.
The facility has a MOU for the provision of outside support services for inmates. This contract provides for telephonic victim support services. The PREA Support Persons are aware of the services through this MOU. Inmates are provided notification of the PREA Support Services through Form 130, 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 in the facility where inmates were able to view.

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.

SOP 4.54, SOP 4.54A, and the NCDPS website 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 Superintendent.

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. Both staff training and SOP 4.54A detail 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 and SOP 4.54A were 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 and SOP 4.54A were reviewed. Staff interviews confimed 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. There was one incident that was reported by another facility. Notification was made to the Craven CI Administrator after the inmate alleged an inappropriate gesture was made by a staff person. This was investigated as per policy.

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, SOP 4.54A, 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 4.54A was 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 Compliance Manager duties, PREA Suppert Persons duties, SART (Sexual Assault Response Team) duties, Mental Health and aftercare duties, and retaliation duties. The plan reviewed was facility specific and included the person's responsible by name, including contact numbers in some instances.

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 Craven 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.

Policy F3400, SOP 4.54, SOP 4.54A, Form OPA-A16, 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. 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 updated their form to include spaces for documenting the date and information of these status checks and has implemented this agency wide. Once the new form was implemented, the auditor was provided with a copy of a completed form that clearly documents the status checks that were conducted and the date they were conducted.

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, SOP 4.54, and SOP 4.54 Memo, dated 11/04/15, were 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 documents 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 in Administrative Segregation. 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, SOP 4.54, SOP 4.54A, 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. Three allegations were referred to law enforcement that resulted in substantiated findings in the past 3 years.

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. Interviews confirmed 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, SOP 4.54A, Form OPA I30, Form OPA-I30A, and sample forms were reviewed. Investigation files were reviewed. Interviews confirm findings.
The agency utilizies Form OPA-I30 to document notification to the victim of the outcome of the investigation. These forms were found in the files reviewed along with the inmates 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, 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 two employees who were reported to law enforcement after their terminated, or resignation prior to termination, as a result of a violation of the agency zero-tolerance policy.

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, Form OPA-T10, Incident Report and Permanent Suspension Letter (Contractor) 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 has been 1 allegation where a contractor (teacher) was referred to local law enforcement for a violation of the agency zero-tolerance policy. The agency response permanently suspended her from entry into any NCDPS facility.

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 B0200, SOP 5.22, SOP 5.27, SOP 8.91, SOP 9.23 and the Inmate Rule and Policies Booklet were reviewed. Staff interviews confimed 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 was one inmate-on-inmate sexual abuse incident that occurred in the program and received an administrative investigation. 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, SOP 4.54, SOP 4.54A, Diagnostic Manual 305, Memos dated 10/09/13 and 11/14/12, 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.

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, SOP 4.54, SOP 4.54A, 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). Additional counseling services are available as identified and as requested by the victim through the PSP. 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, SOP 4.54, 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, Sexual Abuse Review Team (SART) Listing, 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 Compliance Manager and SART members, who are comprised of upper level management and input from other staffing positions, including medical staff.

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.

Bobbi Pohlman-Rodgers April 15, 2016

Auditor Signature Date