

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

**Date of report:** 10/28/2016

|   |  |   |   |
|---|--|---|---|
| <b>Auditor Information</b>  |  |   |   |
| <b>Auditor name:</b> G. Peter Zeegers   |  |   |   |
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| <b>Telephone number:</b> 863-441-2495   |  |   |   |
| <b>Date of facility visit:</b> September 27th-28th, 2016  |  |   |   |
| <b>Facility Information</b>   |  |   |   |
| <b>Facility name:</b> Robeson CRV Behavior Modification Center  |  |   |   |
| <b>Facility physical address:</b> 803 North Carolina Hwy 711 Lumberton, North Carolina 28360                  |  |   |   |
| <b>Facility mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>   |  |   |   |
| <b>Facility telephone number:</b> 910-618-5535  |  |   |   |
| <b>The facility is:</b>   | <input type="checkbox"/> Federal                               | <input checked="" type="checkbox"/> State | <input type="checkbox"/> County                               |
|   | <input type="checkbox"/> Military                              | <input type="checkbox"/> Municipal        | <input type="checkbox"/> Private for profit                   |
|   | <input type="checkbox"/> Private not for profit                |   |   |
| <b>Facility type:</b>   | <input type="checkbox"/> Community treatment center            |   | <input type="checkbox"/> Community-based confinement facility |
|   | <input type="checkbox"/> Halfway house                         |   | <input type="checkbox"/> Mental health facility               |
|   | <input type="checkbox"/> Alcohol or drug rehabilitation center |   | <input checked="" type="checkbox"/> Other                     |
|   |  |   |   |
| <b>Name of facility's Chief Executive Officer:</b> Director Stephen Jacobs                                    |  |   |   |
| <b>Number of staff assigned to the facility in the last 12 months:</b> 47                                     |  |   |   |
| <b>Designed facility capacity:</b> 192  |  |   |   |
| <b>Current population of facility:</b> 141  |  |   |   |
| <b>Facility security levels/inmate custody levels:</b> Minimum Custody  |  |   |   |
| <b>Age range of the population:</b> 18 and over   |  |   |   |
| <b>Name of PREA Compliance Manager:</b> Sherry Hinson   |  | <b>Title:</b> Residential Manager         |   |
| <b>Email address:</b> sherry.hinson@ncdps.gov   |  | <b>Telephone number:</b> 910-618-5535     |   |
| <b>Agency Information</b>   |  |   |   |
| <b>Name of agency:</b> North Carolina Department of Public Safety   |  |   |   |
| <b>Governing authority or parent agency:</b> <i>(if applicable)</i> <a href="#">Click here to enter text.</a> |  |   |   |
| <b>Physical address:</b> 512 N Salisbury Street, Raleigh, NC 27604  |  |   |   |
| <b>Mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>            |  |   |   |
| <b>Telephone number:</b> 919-825-2775   |  |   |   |
| <b>Agency Chief Executive Officer</b>   |  |   |   |
| <b>Name:</b> Frank L. Perry   |  | <b>Title:</b> Secretary, NCDPS            |   |
| <b>Email address:</b> frank.perry@ncdps.gov   |  | <b>Telephone number:</b> 919-733-2126     |   |
| <b>Agency-Wide PREA Coordinator</b>   |  |   |   |
| <b>Name:</b> Charlotte Williams   |  | <b>Title:</b> PREA Director               |   |
| <b>Email address:</b> charlotte.williams@ncdps.gov  |  | <b>Telephone number:</b> 919-825-2754     |   |

## **AUDIT FINDINGS**

### **NARRATIVE**

The Robeson CRV Behavior Modification Center (RCRVBMC) received an on-site PREA audit on 9/27 and 9/28, 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 were no resident letter received before the on-site audit.

The on-site audit began with a meeting between the PREA Auditor, Director, Administration Officer, Assistant Director, Unit Manager I and II, and Residential Manager/PREA Compliance Manager. The discussion focused on the audit process, the interim/final 30-day report, Corrective Action Plan period, and the final report. 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 residents and staff had access to the information. The tour included the administration building, Chapel, A/B building (classrooms, offices, clothes house, kitchen/dining hall), outdoor recreation, C/D building (offices), and the (3) dormitories (E/F, G/H, and I/J). There were no privacy issues in the dorms.

Interviewees were randomly selected for both residents and staff. There were a total of 10 random residents interviewed. A total of 10 random staff were interviewed, as well as 13 specialized interviews were conducted. The Agency head and Agency-wide PREA Director were interviewed by this auditor.

There was one allegation of sexual abuse and/or sexual harassment within the facility in the past 12 months. It was unsubstantiated.

## **DESCRIPTION OF FACILITY CHARACTERISTICS**

The Robeson CRV Behavior Modification Center (RCVRBMC) is a minimum security facility for male residents, run by the North Carolina Department of Public Safety. Confinement in Response to Violation (CRV) centers house and provide intensive behavior modification programs for those who have committed technical violations of probation. CRV centers incarcerate violators for 90-day periods in response to violations of probation, parole or post-release supervision as provided in the Justice Reinvestment Act of 2011.

The CRV centers utilize dormitory style housing similar to a minimum-security prison and offer intensive programming designed to modify behavior of probation violators. Probation officers and case managers work closely with offenders as they progress through treatment and programming including cognitive behavioral therapy, substance abuse interventions, employment readiness and life skills training.

Under the Justice Reinvestment Act, violations of probation that involve committing new crimes or absconding can still result in revocation of probation, activation of the suspended prison sentence and incarceration in the regular prison population. Technical violators, including those who miss appointments, curfews or fail drug tests, can serve two 90-day CRV periods before they face probation revocation and return to prison.

This facility sits in the city of Lumberton, NC, and houses a maximum of 190 residents. There are approximately 47 staff to accommodate the daily operations. At the entrance of each building, there is a PREA bulletin board that provides information regarding the agencies zero-tolerance policy information, including how and to whom to report allegations to and access to outside services. Residents and staff pass these boards multiple times during a 24 hour period moving from the dorms to meals, education, programming, and recreation. The dorms contain toilets and showers that have been modified to provide privacy.

Both medical and mental health staff are available at the program. Sexual Assault Forensic Exams are conducted at Southeastern Regional Medical Center. The facility also has a SART (Sexual Assault Response Team) that consists at a minimum of the Director, PREA Compliance Manager, and a PREA Support Person who respond as necessary. PREA Support Persons are staff who have been trained to assist the victim through all processes, including providing assistance in obtaining outside support services.

## **SUMMARY OF AUDIT FINDINGS**

The facility has a Sexual Assault Response Team (SART) and PREA Support Persons (PSP). Both groups are activated if 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, any 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 residents. It was a pleasure to work with the Facility Director and his staff.

Number of standards exceeded: 4

Number of standards met: 32

Number of standards not met: 0

Number of standards not applicable: 3

### **Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator**

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

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

Policy F.3400, Policy A.2000, 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 Facility Manager 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 reported sufficient time to attend to PREA duties. This person reports indirectly to the Agency PREA Director. The agency also has a PREA Director, 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 115.212 Contracting with other entities for the confinement of residents**

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

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

### **Standard 115.213 Supervision and monitoring**

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

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**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 5.32, Facility Posting Chart/Staffing Plan approved in December 2015, OIC Round Documentation, Unannounced staff rounds documentation for the dormitory 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 December 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 115.215 Limits to cross-gender viewing and searches**

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

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Policy F.0100, 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.

#### **Standard 115.216 Residents with disabilities and residents who are limited English proficient**

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

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

Policy E.1800, Policy E.2600 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 residents 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 residents identified as disabled. Agency policy also addresses the provision of interpreters to those residents with a non-English primary language. There is a contract in effect with World Wide Telephonic Interpreter Services Company that was signed on 2/25/2014 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 resident interpreters except in emergent 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 115.217 Hiring and promotion decisions**

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

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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. 5 year background screenings are conducted and were verified during the on-site audit.

### **Standard 115.218 Upgrades to facilities and technologies**

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

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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 115.221 Evidence protocol and forensic medical examinations**

- Exceeds Standard (substantially exceeds requirement of standard)

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

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Policy F.3400, Policy CP18, Form OPA-A18, Form OPA – I20, OPA-I21, Form OPA-I30, PREA Support Person (PSP) Training Lesson Plan, Chain of Custody Form, Incident Scene Tracking Log, PREA Support Person Roles and Responsibilities, agreement with Rape Crisis Center, and NCCASA were reviewed. Interviews also provided information in the determination of compliance. The agency conducts only administrative investigations. Robeson 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 has an agreement with the Rape Crisis Center where a memo of an attempt to get an MOU signed was provided to this auditor. The facility PSP (PREA Support Person) will assist the resident in contacting Rape Crisis Center. Forensic examinations are conducted at the Southeastern Regional Medical Center.

**Standard 115.222 Policies to ensure referrals of allegations for investigations**

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

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

Policy F.3400 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 Robeson County Sheriff’s Office for criminal investigations. Policies are available through the NCDPS website.

**Standard 115.231 Employee training**

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

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Policy F.3400, 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 115.232 Volunteer and contractor training**

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

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Policy F.3400, 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. There is also a “Ways to Report” poster to remind volunteers and contractors of the various ways to report. An interview with one of the volunteers showed that they understood how to report. The file review contained a signed Acknowledgement form.

**Standard 115.233 Resident education**

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

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Policy F.3400, Diagnostic Procedural Manual Section 201 & 417, PREA Resident 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. Resident interviews were conducted.

Upon entry to Robeson CRV Behavior Modification Center (RCRVBMC) residents receive comprehensive education and meets the criteria of the standard regarding content. Resident education is maintained in OPUS (Offender Population Unified System) and copies were provided to the auditor for review. Interviews with residents 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 115.234 Specialized training: Investigations**

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

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

The program has a designated investigator, 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 Robeson County Sheriff’s Office. The auditor reviewed training documentation of identified investigators.

#### **Standard 115.235 Specialized training: Medical and mental health care**

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

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

The agency policy requires that all medical and mental health staff receive PREA 101 and specialized medical and mental health training. The specialized training meets all requirements of the standard. 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 115.241 Screening for risk of victimization and abusiveness**

- Exceeds Standard (substantially exceeds requirement of standard)

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

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

Robeson CRV Behavior Modification Center (RCRVBMC) conducts a risk assessment upon the initial intake. This is completed within 72 hours of arrival. The risk assessment contains all elements of the standard. This assessment is required to be reviewed within 30 days of intake. If the resident reports a victimization or identifies as sexually aggressive, notification is made to medical, the Facility Manager are to begin services as required by policy. The policy prohibits residents from being disciplined for refusing to answer questions from the screening. Only those staff with appropriate credentials have access to this electronically maintained information. The agency 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 residents as a key factor. Upon intake, the resident and staff complete the PREA screening form and the Mental Health screening inventory. These tools identify all required components of the standard. From these 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 Facility Director and the PREA Compliance Manager. It is the responsibility for the designated staff to run these lists weekly to review for appropriate placement. During the on-site audit this auditor reviewed the residents on the HRA and HRV lists as well as changes made to ensure the safety of residents.

#### **Standard 115.242 Use of screening information**

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

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Policy F.3400, 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 residents. The policy requires a bi-annual review of housing for transgender and intersex residents. The policy also provides for all transgender and intersex residents to shower separately from all other residents, and are assessed for their own perception of risk at the facility. The facility conducts reviews of the High Risk Victimization (HRV) and the High Risk of Aggression (HRA) list on a weekly basis, or more often if needed, to ensure that residents are placed in educational, vocational, and housing that ensures their safety. Residents 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 during the on-site audit.

#### **Standard 115.251 Resident reporting**

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

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

The agency has numerous ways for a resident to internally report sexual abuse or sexual harassment. Methods of reporting include telling a staff, writing a letter to the PREA Director and third-party reporting. Externally, the agency provides information of the Rape, Abuse and Incest National Network (RAINN). It was confirmed through conversation with the administration that mail sent to the RAINN or the PREA Director is treated as legal correspondence and is not opened at the facility level. The posters in the facility provided the address for RAINN, and resident 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 Director if they do not wish to report through the Chain of Command.

#### **Standard 115.252 Exhaustion of administrative remedies**

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

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

The Resident Rule Book was reviewed. Interviews were also conducted.

The agency policy confirms that notes or letters 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 residents to deposit their notes/letters. The black box is emptied in their multi-purpose room 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. Emergency notifications, those defined as matters that present a substantial risk of physical injury or irreparable harm may be presented directly to the Facility Manager, are forwarded immediately to the appropriate person. In the interview with the Facility Director it was clarified that if a PREA allegation was presented in written form he immediately becomes a first responder.

#### **Standard 115.253 Resident access to outside confidential support services**

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

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

An agreement memo with Rape Crisis Center, SOP 4.54A, and PREA – The North Carolina Approach were reviewed. Resident interviews confirmed findings.

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

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

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

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

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 Director or send an e-mail through the link provided. Both options will result in the PREA Director receiving the complaint. The PREA Director will then generate an incident report and inform the Facility Director. This information is also available at the facility for visitors.

### **Standard 115.261 Staff and agency reporting duties**

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

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

Policy F.3400, 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 investigator(s) and the PREA Director. Agency staff training details the notification to the state agency regarding vulnerable adults.

### **Standard 115.262 Agency protection duties**

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

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

Policy F.3400 was reviewed. Interviews confirmed findings.

The agency requires immediate action to protect residents 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 115.263 Reporting to other confinement facilities**

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

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

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

The agency policy requires that any receipt of sexual abuse or sexual harassment that occurred at another facility be immediately reported to the appropriate Facility Director. This notification must be documented. An incident report is also generated, which flags investigators and the PREA Director. Allegations made by a resident at another facility are treated the same as a new allegation, and facility investigators are notified and begin their review of information.

### **Standard 115.264 Staff first responder duties**

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

- Does Not Meet Standard (requires corrective action)

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

Policy F.3400 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 115.265 Coordinated response**

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

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

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

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

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

This standard is Not Applicable as the (RCRVBMC) does not enter into collective bargaining agreements.

**Standard 115.267 Agency protection against retaliation**

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

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

Policy F.3400, Form OPA-I22 and Form OPA I24 were reviewed. Interviews confirmed findings. The agency policy addresses practices to protect both staff and residents from retaliation as a result of reporting sexual abuse or sexual harassment information. Various protection methods for residents 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.

**Standard 115.271 Criminal and administrative agency investigations**

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

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

Policy F.3400, and the Coordinated Response Overview were reviewed. Investigation files were reviewed. Staff interviews confirmed findings. The agency policy requires that criminal investigations are conducted by outside law enforcement, therefore the facility investigators only conduct an initial investigation to determine if outside law enforcement is to be notified and administrative investigations. All investigators identified at the facility have received appropriate investigator specialized training. All evidence is gathered, documented and preserved. Prior allegations involving the same perpetrator or victim are reviewed. The credibility of the victim or alleged abuser is determined on an individual bases. The agency does not use polygraph examinations in order to continue an investigation. Administrative investigations address staff actions, credibility and a review of fact and findings of the criminal investigation (if applicable). All interviews are conducted as approved by the Office of Special Investigations and Compliance. Both criminal and administrative investigations are documented.

**Standard 115.272 Evidentiary standard for administrative investigations**

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



relevant review period)

- Does Not Meet Standard (requires corrective action)

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

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

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

### **Standard 115.273 Reporting to residents**

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

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

Policy F.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 resident’s signature, signature of the staff making the notification, and the outcome of the investigation.

### **Standard 115.276 Disciplinary sanctions for staff**

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

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

Policy F.3400, Policy C. 1900, 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 115.277 Corrective action for contractors and volunteers**

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

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

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

The agency policy confirms that any contractor or volunteer who violate the zero-tolerance policy will be prohibited from contact with residents. 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 115.278 Disciplinary sanctions for residents**

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

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

Policy F.3400 and the Resident Rule and Policies Booklet were reviewed. Staff interviews confirmed findings.

The agency policy dictates disciplinary actions for residents who violate the zero-tolerance policy. The Resident 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. Residents are not disciplined for behaviors in which staff consent. There is no disciplinary action for residents 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 residents.

#### **Standard 115.282 Access to emergency medical and mental health services**

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

- Does Not Meet Standard (requires corrective action)

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

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 residents 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 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers**

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

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

Policy F.3400, Policy CP-18, Policy CC-8, and the Coordinated Response Overview were reviewed. Interviews confirm findings. The agency provides on-going medical and mental health services for victims of sexual abuse, whether the incident occurred within an institution or in the community. All care is provided 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 residents when information is present.

### **Standard 115.286 Sexual abuse incident reviews**

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

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

Policy F.3400, 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 that are 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.

### **Standard 115.287 Data collection**

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

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

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

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

### **Standard 115.288 Data review for corrective action**

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

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

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

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

### **Standard 115.289 Data storage, publication, and destruction**

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

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

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

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

### **AUDITOR CERTIFICATION**

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

G. Peter Zeegers

10-28-2016

Auditor Signature

Date