

PREA AUDIT REPORT Interim Final
ADULT PRISONS & JAILS

Date of report: April 12, 2017

Auditor Information			
Auditor name: Bobbi Pohlman-Rodgers			
Address: PO Box 4068, Deerfield Beach, FL 33442-4068			
Email: bobbi.pohlman@us.g4s.com			
Telephone number: 954-818-5131			
Date of facility visit: March 8 – 9, 2017			
Facility Information			
Facility name: Central Prison			
Facility physical address: 1300 Western Boulevard, Raleigh, NC 27606			
Facility mailing address: <i>(if different from above)</i> 4285 MSC, Raleigh, NC 27699-4285			
Facility telephone number: 919-733-0800			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Prison	<input type="checkbox"/> Jail	
Name of facility's Chief Executive Officer: Warden Edward Thomas			
Number of staff assigned to the facility in the last 12 months: 156			
Designed facility capacity: 1104			
Current population of facility: 900			
Facility security levels/inmate custody levels: Close Custody			
Age range of the population: 20+			
Name of PREA Compliance Manager: Brenda Corbett-Moore		Title: Correctional Captain	
Email address: Brenda.corbett-moore@ncdps.gov		Telephone number: 919-733-0800	
Agency Information			
Name of agency: North Carolina Department of Public Safety			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 512 N Salisbury Street, Raleigh, NC 27604			
Mailing address: <i>(if different from above)</i> 4201 Mail Service Center, Raleigh, NC 27699-4201			
Telephone number: 919-733-2126			
Agency Chief Executive Officer			
Name: Erik A. Hooks		Title: Secretary, NCDPS	
Email address: erik.hooks@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

Central Prison received a PREA audit beginning January 25, 2017. PREA notices were sent to the facility for posting and display to all inmates and staff, and were posted by the appropriate date. The facility provided a flash drive with all documentation required and requested to the PREA auditor by February 8, 2017. After a review of the documents, the on-site audit began on March 8, 2017 and was completed on March 9, 2017.

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

On March 8, 2017, the auditor met with Warden Edward Thomas, Administrative Captain/PREA Compliance Manager Brenda Corbett-Moore, Deputy Warden Stephen Waddell, and Associate Warden for Operations Richard Monroe. This brief entrance meeting was focused on the audit process, the interim/final report, Corrective Action Plan periods, and additional documentation that would be needed. The facility staff also provided all requested documents that were previously requested by the auditor. This meeting was followed by a tour of the facility.

The tour included all inside areas and outside areas. The auditor was able to view PREA Audit notices, Zero Tolerance posters, and Sexual Abuse/Sexual Harassment reporting methods that were located throughout the facility where both inmates and staff have access. Other facility specific information was present throughout the inmate housing areas. Phones were observed in each housing unit for inmate use. Throughout the tour, the auditor observed staff announcing a female in the area. During the tour, the auditor was provided an opportunity to speak with inmates and staff.

Interviewees were selected through the use of the inmate rosters and staff assignment/posts. There were a total of 40 inmates selected for interview, and this included one inmate with a current allegations. There were no inmates identified as LGBTI, disabled, Limited English Proficient, or who reported a prior victimization. There were 10 random staff selected for interview; these staff were selected from both shifts. Additionally, fifteen specialized positions were selected for interview. This included the PREA Compliance Manager, Warden, Upper Level Management, Medical Staff, Mental Health Staff, Human Resource staff, Volunteer Coordinator, Investigator, Intake/Orientation Staff, Risk Screening Staff, Restricted Housing Staff, Staff who supervise Segregation, Staff who conducted Incident Reviews, PREA Support Person who monitors for Retaliation, First Responder Staff, and staff who handle inmate Grievances. The Agency head and Agency PREA Director were interviewed prior to this audit by DOJ Certified Auditor Pete Zeegers, and the information was provided to this auditor.

Staffing includes two 12-hour shifts, as well as 8-5 staff. Central Prison correctional staff is comprised of 449 Correctional Officer III, 84 Correctional Sergeant III, 21 Correctional Lieutenant III, 6 Correctional Captain III, 4 Correctional Housing Unit Manager II, and 5 Correctional Housing Unit Manager III. Central Prison Health Care Facility staff is comprised of 173 Correctional Officer III, 11 Correctional Sergeant III, 2 Correctional Housing Unit Manager II, and 1 Correctional Housing Unit Manager III. There are a total of 679 cameras at the facility. These cameras cover the majority of the areas enhancing the supervision of the facility.

In the past twelve months, there were 28 allegations of sexual abuse/sexual harassment received, and 25 allegations received through the grievance system. Each allegation received either an administrative or criminal investigation. The facility works with Capitol State Police for criminal investigations. A copy of a sample of these investigations were received that included 1 grievance, 1 inmate report, and 2 staff reports. Each of these files contained a PREA Support Services document, a retaliation report that included periodic status checks, a Post Incident Review, and notification to the victim of the outcome of the investigation.

Medical services are provided on-site at the state-of-the-art Central Prison Health Care Facility. Medical staff is available 24 hours per day, 7 days per week. Mental Health staff is present of the facility. Inmates would be transported to the Wake Medical Center for forensic sexual assault medical exams.

This facility has 4 PREA Support Persons (PSP) who have received training to assist victims through all steps of an investigation, including providing assistance in obtaining outside support services. The agency is currently working with the North Carolina Coalition Against Sexual Assault (NCCASA) to create a state-wide system for community based services. In the interim, the facility has begun communication with InterAct of Raleigh, a local family violence prevention center. The draft MOU suggests that InterAct of Raleigh will provide as an outside resource for victims of sexual assault who are in the custody of Central Prison and will include accompaniment during forensic examinations, emotional support, information/referrals, crisis intervention services, and follow-up services through the hotline, in-person and/or through mail correspondence. This draft MOU includes provisions for consent and authorized release of information. The facility duties in this draft MOU include making inmate's aware of services available, contact information (including phone and mailing address), and ensure that information is included in all inmate educational materials. The facility is also required in this draft MOU to provide appropriate training to InterAct staff on PREA standards, "Understanding the Correctional Environment", "Maintaining Professional Boundaries with Inmates", NCDPS policies, procedures, and facility guidelines, and other trainings on working in the facility with inmates as necessary.

DESCRIPTION OF FACILITY CHARACTERISTICS

Central Prison is a close custody facility and serves as the admission point of adult male felons sentenced to 20 years or more and to the main medical and mental health center for males. Located in the City of Raleigh and within Wake County boundaries, Central Prison was opened in 1884 and provides housing for specialized populations, including death row, felon safe keepers, mental health and medical care.

With a maximum capacity of 1104 inmates, included in this is 216 mental health beds and 130 medical beds. Inpatient mental health services include a therapeutic diversion unit focusing on progressing inmates from long term segregation to regular population. The medical unit provides numerous specialty clinics that include radiology, MRI, CAT scan, podiatry, ophthalmology, infectious disease, physical therapy, occupational therapy, dental, oral surgery, in house laboratory, urgent care and two surgical suites for minor surgery and colonoscopy services. Each hospital room provides a tubing tower that is secure and allows for medical care as prescribed. There is an older mental health unit that is currently under renovation that will provide approximately 90 additional medical beds.

While security measures require that certain inmates remain in their cells, there are more than 260 inmate job assignments that include working in the kitchen, laundry, or canteen. Inmates may also work as barbers, janitors, and clerks. Substance abuse group therapy meetings are available, as well as bible studies and worship services.

The facility is laid out in an L shape internally, with two long hallways that provide access to each housing or service area. The entrance of the facility houses the administration area which contains the Warden, Deputy Warden, Accounting, Support Services, Administrative Officer, Kitchen, Personnel and Mail room. These areas are cleaned by inmates from Wake Correctional Center. Other offices include the Program Director's office, Classrooms, Chaplains Office, Assistant Managers Office, Associate Warden of Custody, IA offices, and Sergeants Offices. Many of these offices had film on the windows that restrict supervision and a recommendation to reduce the height of the film was made by the auditor.

The five towers that surround the property and provide supervision of the grounds are manned 24 hours per day/7 days per week. There are 679 cameras about the property, and viewing is limited to certain designated staff. Outside recreational areas include basketball and volleyball. Inside recreation includes a gym, foosball, pool tables, and weight room. Canteen areas are available for all inmates.

The Kitchen is open and easy to supervise with the exception of the canned goods area which will be added to the unannounced rounds as a specific area to check. The four dining rooms are all open areas with 3 cameras per room. Chemical storage, canteen storage and the laundry area are open areas where sight supervision is easy to maintain.

The Health Care Facility has a basement which is used for warehousing and access to the area is controlled from the control center. Additionally, there are maintenance offices, medical storage and electrical rooms that require key card access. The Health Care Facility and the Mental Health Unit share both the basement and first floor, however, floors 2-5 are individual.

Visitation is by appointment only and is limited to 2 adults and either 2 adults and 1 child, or 1 adult and 2 children. The visitation center offers 23-booth facilities where inmates are separated from their visitors. Inmates are allowed one visit per week that does not include legal, law enforcement or clergy visits.

Central Prison has 31 housing areas.

1A - Closed

1B – Restricted Housing

1C - Closed

1D – General Population

1E – General Population

1F – General Population

2A – Restricted Housing

2B – Restricted Housing

2C – ICP (Construction Workers – medium custody)

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2D – General Population/Safe keepers
2E – General Population/Safe keepers
2F – General Population
3 – Death Row
4N & S – Hospital – short term care
5N & S – Hospital – long term care
G1-3 – General Housing
G1-4 – General Housing
1100-1200 - Closed
1300-1400 – Crisis Intake
2100-3100 – Mental Health
2200-3200 – Mental Health
2300-3300 – Mental Health
2400-3400 – Mental Health
4200-5200 - Safe keepers
4300-5300 – Mental Health

All housing is provided as single occupancy, wet cells. While the majority of the housing areas contain a general shower area with doors or shower curtains to provide privacy, the hospital units contain showers within the cell. Information on how to report sexual abuse or sexual harassment was found in each unit, as well as the notice of the upcoming PREA audit and auditor contact information. None of the units had information on available outside emotional support services. This was immediately addressed and the facility resolved this before the auditor left the facility.

SUMMARY OF AUDIT FINDINGS

Central Prison staff were well prepared for their PREA Audit. All documentation requested by the auditor was provided in a timely and organized manner. Information provided prior to the on-site was also well organized. There were a few areas where sight supervision was hindered, and administration immediately made adjustments.

The facility has a Sexual Assault Response Team (SART) and 4 PREA Support Persons (PSP). The SART is activated when there is an allegation of sexual assault and includes the Warden, PREA Compliance Manager, Investigator, assigned PSP, and medical or mental health practitioners. The PSP plays an important role in assisting the victim through the various activities associated with an allegations (investigation, medical exam, interviews, and support services).

Facility staff were very helpful, professional, and open to the audit process. During the audit, administrative staff allowed the PREA Compliance Manager to focus on the audit and continued with normal daily operations. This practice prevented any delays during the process. In light of the size of the facility and the size of the grounds in which the facility sits, this facility has done an exceptional job of implementing PREA standards. Captain Corbett-Moore is extremely capable and well organized as the PREA Compliance Manager, and is committed to ensuring full compliance with all standards. Michelle Hartley, a Correctional Housing Unit Manager and backup PREA Compliance Manager was also organized and extremely helpful to both the auditor and to the PREA Compliance Manager with her knowledge of the facility and records. Both were a pleasure to work with through this audit process.

Number of standards exceeded: 4

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 4

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

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

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

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

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

The facility has a PREA Compliance Manager and a secondary PREA Compliance Manager. The PREA Compliance Manager/Correctional Captain feels that she has enough time to attend to the PREA related duties at the facility. She had adjusted her schedule to meet the needs of PREA requirements. She coordinates the facility's efforts through informing staff, making herself accessible, addressing any vulnerabilities, and monthly briefings with both staff and administration. Addressing issues with PREA compliance begin with notification to the Warden and other Department Heads. Clarifying the issues and addressing changes, she is able to make great strides through the level of command. Additionally, the secondary PREA Compliance Manager is identified and assists the PREA Compliance Manager. She is very knowledgeable of the facility, record keeping systems, and PREA Standards.

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

Standard 115.12 Contracting with other entities for the confinement of inmates

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

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

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

Standard 115.13 Supervision and monitoring

- Exceeds Standard (substantially exceeds requirement of standard)

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

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Policy F.1600, Policy F.1601, Staffing Plan Report dated March 2017, Shift Narratives noting unannounced rounds, Pull Post List, and North Carolina General Statute 143B-709 were reviewed. Additionally, interviews were conducted to further determine compliance.

While North Carolina General Statute requires a staffing analysis every 3 years, the agency policy requires an annual review of the staffing plan, including a review of all required components of the standard, which was completed in November 2015. The facility has two Prison Post Charts, Central Prison and Central Prison HCF, that details positions and staff that was last reviewed by the management team on March 20, 2017.

Deviations from the staffing plan are noted on the Shift Narrative, and in the pull post daily list. Per the PREA Compliance Manager, the facility uses a pull post system for coverage as needed, or until additional staff is available. The Warden daily checks both the shift narrative and pull post daily list. Samples of the shift narrative and pull post list were reviewed by the auditor.

Unannounced rounds are documented in the Shift Narrative and in the activity log, which is maintained in the Sgt’s office. These are conducted by the Sergeant or PREA Compliance Manager at random times throughout each month and on all shifts. Documentation includes the day, time, and location of the rounds. Samples of shift reports show that unannounced rounds are made on varying shifts and in a variety of areas. Staff are advised not to alert other staff during unannounced rounds, and a memo from November 19, 2015 clarifies that control staff and housing post staff will not alert other staff.

Standard 115.14 Youthful inmates

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

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

Standard 115.15 Limits to cross-gender viewing and searches

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion

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

Policy F.1600, Policy F.0100, SOP .0103, SOP .3200, Policy TX I-13, Safe Search Practices Training, NCDPS New Employee Orientation (revised 1/1/15), Cross Gender Announcement & Acknowledgement for staff, Training Curriculum: Safe Search Practices, Form OPA-T30 – Cross Gender Acknowledgement, Staff Training Log, and Cross Gender Bulletin Board Poster Memo (dated 4/22/13) were reviewed. Interviews were also conducted to assist with the determination of compliance.

Training on safe search practices that include cross gender searches was confirmed. Policy requires documentation of any cross gender searches. There were no reported cross gender searches conducted. Interviews with inmates confirm that they have not been searched by female staff. Training documents reviewed indicated that staff have completed appropriate training.

Each unit within the facility has provided for inmate privacy through doors or curtains while showering. All individual cells contain a toilet and sink. Inmate interviews confirm that they feel they are afforded privacy to handle hygiene needs.

Agency policy and facility SOP require the announcement of cross-gender staff entering the housing units. Additionally, in April 2013, the PREA Coordinator sent out a memo to this effect. Staff were required to sign Form OPA-T30 that clearly delineates the responsibility of announcing cross-gender presence in the housing units. Interviews with female staff found that they do not always announce themselves each time they enter the housing unit, especially at night when inmates are sleeping. Interviews with inmates reported not hearing the announcements each time female staff enter the units. Prior to the writing of this report, the facility conducted instruction to all staff about the necessity of announcing female staff each time they enter a housing unit. The facility provided narrative and signed staff rosters of this training.

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

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

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

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

Agency policy requires that Limited English Proficient inmate are provided information in their main language. It is the responsibility of the Case Manager to ensure that an inmate is provided information in an appropriate language. There is a contract that went into effect on March 1, 2016 with Linguistica International, Inc. for the provision of interpreter services by telephone and covered 250 different languages. This contract expires on March 4, 2017 with options for three additional one year renewal periods. Policy prohibits the use of inmate interpreters except in emergent circumstances. There is PREA material in both English and Spanish available at the facility. Staff clearly knew that there were resources available for non-English speaking inmates. There were no reported instances where an interpreter/translator was needed in the past 12 months.

Agency policy requires the provision of services for inmates with physical or mental impairments. The Facility ADA Coordinator is to ensure that services are provided as needed. There were no inmates reported who were blind, deaf, or had reading or learning disabilities. To ensure that inmates have a clear understanding of the PREA material, the facility updated the orientation documentation to include a form to be signed that states the inmate read or had the information read to them.

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, SOP .3200, Memo regarding PREA Hiring and Promotions (dated October 2013), Addendum to the Memorandum, List of Disqualifying Factors, 2013 Employee Statement, sample of employee background screenings, and PREA Employee Statement were reviewed. Interviews were conducted to assist with determining compliance.

The agency policy prohibits the hiring or promotion of individuals who have engaged in sexual abuse, or attempting to engage in sexual abuse in a detention facility or in the community, or who have been civilly or administratively adjudicated for the same. The agency requires all staff to annually sign a statement that they have not engaged in the aforementioned activities (PREA Hiring & Promotion Prohibitions and HR005). This information was reviewed through the LMS (Learning Management System) and copies were provided to the auditor for review. All staff are documented as having completed this step of their training. The agency also requires all employees to self-report any such misconduct. Criminal background checks are required for contractors and employees, and material omissions regarding misconduct or false information are grounds for termination. The agency does respond to requests from other institutions where a former employee has applied to work. The agency conducts background checks at hiring. The facility was forthcoming in that 5-year background screenings had not yet been completed for some staff. Prior to the writing of this report, the facility completed all required background screenings and a copy of the background screening dates for all staff was provided to the auditor. At this time, the facility has no staff working that has not had a background screening with the past five years. Additionally the facility updated its standard operating procedure to include this as a requirement.

Standard 115.18 Upgrades to facilities and technologies

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

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

Standard 115.21 Evidence protocol and forensic medical examinations

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

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

The agency conducts only administrative investigations. The State Capital Police would complete criminal investigations. The agency sent a letter to all law enforcement agencies in the state on March 16, 2016 requesting their compliance with PREA standards in the event a criminal investigation is conducted.

The Clinical Practice Guidelines cover appropriate evidence collection. The facility has four 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, 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.

Inmates who experience sexual assault are taken to Wake Medical Center. Wake Medical Center charge nurse reported that they currently have 2-3 nurses who are completing the SANE certification. InterAct of Raleigh will send a victim advocate once notified. There is no cost incurred by an inmate for these services. The agency is currently working with the North Carolina Coalition Against Sexual Assault (NCCASA) to create a state-wide system for community based services and documents were provided. In the interim, the facility is in the process of obtaining a signed MOU with InterAct of Raleigh. Once signed, the understanding will provide services for inmates, including accompaniment during a forensic examination, emotional support, information/referrals, crisis intervention, follow-up services via the hotline, in-person and through mail correspondence.

During an interview with one PSP, it was reported that they were not aware of the available services of InterAct of Raleigh. Prior to the writing of this report, the facility provided the PSP's with services available, and instructed all investigators to notify the PSP when a PREA allegation is made so that the PSP can begin providing support services.

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)

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Policy F.3400 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 promptly, thoroughly, and objectively. Policy requires that allegations be referred to an in-house trained investigator for the administrative portion and to the local law enforcement (State Capital Police) for criminal investigations. Policies are available through the NCDPS website.

Standard 115.31 Employee training

- Exceeds Standard (substantially exceeds requirement of standard)

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

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

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

The agency policy requires annual training for all staff in topics identified within the standard, including the zero-tolerance policy, staff responsibilities, inmate’s rights, retaliation, dynamics, common reactions of victims, detection and response to allegations, inappropriate staff relationships, identifying inappropriate staff relationships, communication and mandatory reporting laws. Interviews with staff confirmed they complete this training annually. Interviews also found that staff were unfamiliar with Vulnerable Adult laws. Training documentation is kept in LMS (Learning Management System). Employee training documentation found that all staff had completed their annual training. Of the 19 staff files reviewed, all but one have completed the training in the past year.

Prior to the writing of this report, the facility trained all staff on NC Vulnerable Adult Laws and how these are handled at the facility. A copy of the signed staff acknowledgement of training was received.

Standard 115.32 Volunteer and contractor training

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

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

Policy F.3400, Policy F.0604; SOP .3400, Training Curriculum’s SAH 101 2013 and SAH 101 2015, Staff and Offender Relations Training, New Employee Orientation, Form OPA-T10, “Ways to Report” Poster, Volunteer Brochure, Visitation Reporting Poster, and other documents were reviewed.

The agency requires all volunteers to complete the same PREA training as a staff, with minor deviations. There is also a Volunteer Brochure specifically for volunteers to receive PREA information. This facility reports 228 volunteers that provide services to inmates. There is also a “Ways to Report” poster to remind volunteers and contractors of the various ways to report. The files reviewed contained a signed Acknowledgement form. A volunteer from AA was interviewed and he reported that he completes an annual PREA training and background check.

Standard 115.33 Inmate education

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

- Does Not Meet Standard (requires corrective action)

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

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

Central Prison receives inmates directly into the NCDPS system, or through a transfer due to medical or mental health conditions. Agency policy requires all inmates entering into the system to receive intake and comprehensive training at the reception and diagnostic center. All inmates are provided PREA general education at the time of intake at Central Prison along with a copy of the PREA Inmate Brochure and they sign a form indicating that they have received appropriate information. However, there is sometimes a delay to emergent mental health or medical crisis when inmates are taken directly to the appropriate departments.

Comprehensive PREA education is typically conducted within 15 day of intake at the facility. Inmate education is maintained in OPUS (Offender Population Unified System) and copies were provided to the auditor for review. Interviews with inmates confirmed that they received PREA information at intake. Some inmates reported not having viewed the PREA video, as they were admitted to the facility prior to the implementation of the video. However a review of documentation indicated that the facility conducted facility-wide PREA training in 2007. Informational posters were observed around the facility on the PREA boards in the housing areas. Staff interviews also confirmed Orientation and Comprehensive Education is provided to inmates. Of the 36 files reviewed, all inmates have received some PREA education. 14 inmates who arrived in or after 2015 were provided the Comprehensive PREA education within 30 days, 9 inmates who arrived prior to 2015 have received PREA education prior to 2016, and 13 inmates who arrived prior to 2015 have all last received PREA education in 2007. In order to ensure that all inmates have received the same education, the facility presented the PREA video to all inmates who arrived prior to 2015 and provided a roster which all inmates signed.

Standard 115.34 Specialized training: Investigations

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

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

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

The facility has designated investigators who have completed specialized training for this purpose. The training meets the requirements of the standard to include interviewing techniques, Miranda and Garrity warnings, evidence collection, and criteria and evidence required to substantiate a case for administrative or prosecution referral. Interview with an investigator found that they were well versed in administrative investigations and reported having taken the PREA Investigators training through NCDPS. 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 State Capital Police. The auditor reviewed training documentation of identified investigators, as well as the training provided by the agency to the investigators. Investigators have also completed the annual PREA training.

Standard 115.35 Specialized training: Medical and mental health care

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

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

Policy 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 Sexual Abuse and Sexual Harassment 101 and specialized medical and mental health training. The specialized training meets all requirements of the standard. A review of the medical and mental health staff training indicates that not all have completed this specialized training. An interview with mental health provide indicates no specialized training was provided to him. The facility was notified and immediately sought to rectify. Prior to the writing of this report, the facility found that there was an error in the online Learning Management System (LMS) where a large number of medical staff have not completed the appropriate classes during new hire or in-service training. The facility immediately changed their new hire curriculum and are in the process of resolving software issues with the technical services section. In the interim, the majority of medical and mental health staff have completed the required training and all others have been scheduled to complete the class before the end of April 2017. Documents of training were provided to the auditor for review.

Forensic examinations are not conducted at this facility and therefore no training was provided. All forensic examinations are conducted at the Wake Medical Center.

Standard 115.41 Screening for risk of victimization and abusiveness

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

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

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

The agency conducts a risk assessment within 30 days of intake. The risk assessment contains all elements of the standard. The agency recently changed their processes to ensure that both inmates at risk of victimization or being aggressive are appropriately identified. This system went into effect March 2016. The Agency PREA Director 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 Warden, Correctional Captain/PREA Compliance Manager and the Program Director. It is the

responsibility of the Correctional Captain/PREA Compliance Manager to ensure these lists are reviewed weekly for appropriate placement. Screening was confirmed through interviews with both staff and inmates. Of the 36 files reviewed, 13 were admitted after the process went into effect. Of these 13 files, 3 were completed on the same day as intake, 5 were completed within 1 day, 1 was completed within 4 days, 1 was completed within 5 days, 1 was completed within 6 days, 1 was completed within 13 days, and 1 was completed within 20 days.

Standard 115.42 Use of screening information

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

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

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

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

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

Standard 115.43 Protective custody

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

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

Policy F.3400 was reviewed. Interviews were conducted.

There have been no instances where protective custody for an inmate requiring protection due to a sexual misconduct has been used at this facility in the past 12 months. Agency policy prohibits the involuntary placement of inmates in restricted housing unless there are no

available alternatives. Policy and interviews confirm that services for an inmate who may be placed in protective custody are continued as normal unless there is a specific documented reason for restriction. Policy dictates documentation of the use of protective custody when necessary and 30 day reviews of such placement. Those requiring such housing would be transferred to another, more appropriate facility.

Interviews confirmed that there has not been a case where an inmate was placed in Restricted Housing for protection from sexual abuse or after having been sexually abused nor would this be used for these purposes.

Standard 115.51 Inmate reporting

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

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

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

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

Interviews confirmed that staff at the program were not aware that they may report privately through the Fraud, Waste, Abuse, and Misconduct Hotline or through e-mail to the PREA Coordinator if they do not wish to report through the Chain of Command. Prior to the writing of this report, the facility conducted training with all staff on their ability to report privately to the Fraud, Waste, Abuse and Misconduct Hotline. The facility provided signed staff rosters to show training.

Standard 115.52 Exhaustion of administrative remedies

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

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

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

The agency policy confirms that grievances of sexual abuse or sexual harassment require an immediate notification to the North Carolina Department of Public Safety PREA office preventing a response from the subject of the complaint. Inmates can hand their grievance

directly to security staff or to any administrator. There is no disciplinary action if the report is made in good faith. A final response is due within 90 days, as well as notification to the inmate that it has been accepted within 5 days. Grievances are allowed to be prepared by the victim or other third party person who assists the victim. Emergency grievances, those defined as matters that present a substantial risk of physical injury or irreparable harm may be presented directly to the Officer in Charge, are forwarded immediately to the appropriate person, and require an initial response from the facility within 48 hours and a final determination within 5 days.

Inmates request a grievance form from staff and return the form to the staff. These are then filed with the Grievance Officer who logs the grievances. If the grievance alleges sexual abuse or sexual harassment, it is also logged into the Incident Report system and identified as a PREA allegation. There were 25 grievances in the past 12 months alleging sexual abuse. Of these, 25 reached a final decision within 90 days of being filed. One of the grievances filed was reviewed. The file contained the grievance dated April 21, 2016, an incident report dated within 8 hours of the grievance being written, a statement from the receiving officer of the grievance indicating the inmate was taken directly to the medical department, a statement by the medical department showing the inmate was seen the same day as the incident, a statement of facts, and key interviews from witnesses (both staff and inmate). The report shows the investigation was completed on May 26, 2016 and found to be unsubstantiated. The file also contains the PREA Support Person Services Form and Victim Notification form signed by the inmate. Additionally, retaliation monitoring, and a PREA Post Incident Review form were present. The victim did not appeal the outcome of the grievance.

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.

InterAct of Raleigh Poster, Draft MOU with InterAct of Raleigh, and PREA – The North Carolina Approach were reviewed. Inmate interviews confirmed findings.

The Agency is in the process of working with the North Carolina CASA for the provision of services under this standard. While this is in progress, the facility has reached out to InterAct of Raleigh, a local domestic violence center. While there is no signed MOU, the facility provided communication with InterAct of Raleigh of the intent to provide services.

The PREA Support Persons (PSP) are aware of the services available and is expected to assist victims in contacting them. Inmates are provided identification of the PREA Support Services through Form OPA-I30, which documents the PREA Support Persons role during the investigation and thereafter to assist in providing support services to the victim.

The facility has a plan to provide inmates with specific information for InterAct of Raleigh upon signing of the MOU. Posters have been created and are ready to post in units and provide to inmates.

Standard 115.54 Third-party reporting

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion

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

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

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

Standard 115.61 Staff and agency reporting duties

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

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

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

The agency policy requires all staff, volunteers and contractors to immediately report any knowledge, information or suspicion of sexual abuse or sexual harassment, and any violation or neglect of responsibility, to administration. Contractor contracts include a requirement for reporting any information regarding sexual misconduct. Policy and interviews confirmed that staff are not allowed to share information with anyone who does not have a need to know. All allegations are reported to both the facility investigators and the Agency PREA Director. The Coordinated Response Plan details the notification to the state agency regarding vulnerable adults. Interviews with staff confirmed their knowledge of how to report internally (chain of command, other administrative staff, or to Agency PREA Director) and externally (Fraud, Waste, Abuse, and Misconduct Hotline).

Standard 115.62 Agency protection duties

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

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

Policy F.3400 was reviewed. Interviews confirmed findings.

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

Standard 115.63 Reporting to other confinement facilities

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

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

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

The agency policy requires that any receipt of sexual abuse or sexual harassment that occurred at another facility be immediately reported to the Warden. This notification must be documented. An incident report is also generated, which flags investigators and the Agency PREA Director. Allegations made by an inmate at another facility are treated the same as a new allegation, and facility investigators are notified and begin their review of information. There were 11 allegations that required reporting to another facility. These were reported immediately through the Incident Reporting system and verbally to the Warden of the facility where the allegation occurred. There were no reports received by other facilities that an inmate alleged sexual abuse or sexual harassment at Central Prison.

Standard 115.64 Staff first responder duties

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

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

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

The agency requires all staff to separate, protect physical evidence and the crime scene, and to report to administration when an allegation of sexual abuse is received. All persons interviewed who have contact with inmates could clearly articulate the required steps. 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. There were 28 allegations of sexual abuse in the past 12 months, but none that were reported within the time to collect DNA evidence.

Standard 115.65 Coordinated response

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

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

Coordinated 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, Medical duties, leadership duties, investigator duties, PREA Compliance Manager duties, PREA Support Persons duties, SART (Sexual Abuse Response Team) duties, Mental Health and aftercare duties, and retaliation duties. There is also a Coordinated Response Overview (flowchart) that clearly details the many steps that the agency expects to be completed.

The Coordinated Response Plan provided to the auditor on-site was not facility specific. Prior to the writing of this report, the facility updated the plan and made it facility specific through the inclusion of the facility specific information, including the name of the medical center where forensic examinations will be performed. Interviews confirmed that the majority of staff were aware of a plan that is to be followed when there is an allegation of sexual abuse.

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

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

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

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

Standard 115.67 Agency protection against retaliation

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

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

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

The agency policy addresses practices to protect both staff and inmates from retaliation as a result of reporting sexual abuse or sexual harassment information. Various protection methods for inmates are identified in policy. The PREA Support Person monitors inmates and the PREA Compliance Manager will monitor staff. There is a form that is used to document the retaliation monitoring at the 90 day mark. The form also prompts and allows for the documentation of periodic status checks.

Of the five investigation files reviewed, each contained documentation of retaliation monitoring and periodic status checks for a minimum of 90 days. Staff interviews confirm that measures used to keep inmates safe may include housing changes, the alleged perpetrator be transferred, or inmate transfers, if requested. Inmate interviews found that no inmate reported retaliation.

Standard 115.68 Post-allegation protective custody

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

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

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

The agency policy addresses the use of protective custody only if no other alternative means of protection is available, or if inmates request this level of protection. Inmates requesting this level of protection may complete the Request for Protective Custody and must document the reasons for the request. Interviews confirm that while protective custody could be provided at this facility, they have never restricted housing for victims. There were no instances of the use of protective custody as a result of a sexual abuse allegation in the past 12 months.

Standard 115.71 Criminal and administrative agency investigations

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

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

Policy F.3400, Coordinated Response Plan, 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. Administrative investigation activities include interviews, medical screening, video review, phone review, and a determination of the evidence for a criminal investigation. 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 alleged staff interviews are conducted as approved by the Office of Special Investigations and Compliance. The facility would forward any criminal investigations to the State Capital Police, who would consult with a magistrate. The facility would remain in contact with the State Capital Police regarding any criminal investigations as well as monitor progress and the disposition of the case.

The facility reported no criminal investigations in the past 12 months. A review of the five files found no indication of an allegation that

would require a criminal investigation. Two of the files were of undue familiarity by staff with two different inmates and the staff resigned prior to the conclusion of the investigation. Documentation show that she is not eligible for rehire.

Standard 115.72 Evidentiary standard for administrative investigations

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

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

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

The agency policy imposes no standard greater than a preponderance of the evidence in determining the outcome of an investigation. This was confirmed during an interview with an investigator.

Standard 115.73 Reporting to inmates

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

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

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

The agency policy requires that an inmate be notified of the outcome of an investigations. The agency utilizes Form OPA-I30 to document notification to the victim of the outcome of the investigation, and Form OPA-I30A is used to document the status of the alleged offender. Of the five files reviewed, all five contain a completed Form OPA-I30 showing the victim was notified of 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 F.3400, Policy A.0200, New Employee Orientation, Investigation File, and NCDPS internal webpage were reviewed. Interviews confirmed findings.

The agency policy provides for disciplinary action towards staff who violate the zero-tolerance policy, up to and including termination. All disciplinary actions are reviewed individually based on the nature and circumstances of the allegation. Comparable offenses by other staff are also considered in a final determination of disciplinary action. All staff terminations are required to be reported to the state licensing body. In two files reviewed, an officer resigned her position during the investigation. Documentation shows that she is not eligible for rehire.

Standard 115.77 Corrective action for contractors and volunteers

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

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

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

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

Standard 115.78 Disciplinary sanctions for inmates

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

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

Policy F.3400, Policy B.0200, and the Inmate Rule and Policies Booklet were reviewed. Staff interviews confirmed findings.

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

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

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

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

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

The agency policy requires immediate referral to medical and mental health services after information of prior sexual victimization or sexual aggressive behaviors is discovered during the screening process. Services are provided within 14 days by facility medical and mental health staff. As mental health staff are not located on site, the mental health referral would be forwarded to the staff who moves between multiple facilities. An interview with mental health staff confirm that he receives referrals and responds within the required time frame. Interviews confirmed informed consent is obtained before information is shared regarding a victimization that may have occurred prior to incarceration.

Standard 115.82 Access to emergency medical and mental health services

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

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

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

The agency requires that all inmates who report sexual abuse shall be immediately taken for medical services. Mental Health professionals are notified by the medical staff. Mental Health staff confirm notification and staff who are available on-call 24 hours per day/7 days per week. Further counseling services are available as identified and as requested by the victim, based on a treatment plan, and 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. All medical services provided follow the physician authorized nursing protocols. The Nursing Protocol for sexual abuse includes follow-up care and physician orders for STD testing and treatment. Nursing Protocol “Sexual Abuse” was reviewed and requires immediate medical attention for any life threatening injuries, preservation of any evidence if treatment necessary, and an assessment for injuries. Standing orders indicates that medical staff are required to notify a mental health referral. Nursing Protocol for “Sexually Transmitted Diseases” requires testing and referral to the primary care physician. Any prophylaxis treatment would be by physician order. All follow-up for medical services would be at the request of the inmate or as scheduled by the physician.

A review of one file where the inmate alleged sexual abuse shows that the inmate was seen by medical staff on the same day it was reported. The allegation did not indicate a need for STD testing and treatment.

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

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

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

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

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

Standard 115.86 Sexual abuse incident reviews

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

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

Policy F.3400, Form OPA-I10, Coordinated Response Plan, Coordinated Response Overview, and five investigation files were reviewed. Interviews confirmed findings.

The agency requires a Post Incident Review (PIR) at the conclusion of any investigations of sexual abuse where the allegation was determined to be substantiated or unsubstantiated. Form OPA-I10 is completed. This is a standardized form that contains all elements of the standard. Participants include PREA Compliance Manager and SART members, who are comprised of upper level management and input from other staffing positions. Five files were selected for review. Each contained a PREA Post Incident Review (PIR) completed within 30 days of the conclusion of the investigation.

Standard 115.87 Data collection

- Exceeds Standard (substantially exceeds requirement of standard)

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

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

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

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

Standard 115.88 Data review for corrective action

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

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

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

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

Standard 115.89 Data storage, publication, and destruction

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

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

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

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

AUDITOR CERTIFICATION

I certify that:

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

Bobbi Pohlman-Rodgers

April 14, 2017

Auditor Signature

Date