

PREA AUDIT REPORT Interim Final
ADULT PRISONS & JAILS

Date of report: October 27, 2016

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: October 13 – 14, 2016			
Facility Information			
Facility name: Rutherford Correctional Center			
Facility physical address: 549 Ledbetter Road, Spindale, NC 28160			
Facility mailing address: <i>(if different from above)</i> PO Box 127, Spindale, NC 28160			
Facility telephone number: 828-286-4121			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Prison	<input type="checkbox"/> Jail	
Name of facility's Chief Executive Officer: Superintendent Richard Elingburg			
Number of staff assigned to the facility in the last 12 months: 52			
Designed facility capacity: 236			
Current population of facility: 228			
Facility security levels/inmate custody levels: Minimum Custody			
Age range of the population: 18-99			
Name of PREA Compliance Manager: Larry Godwin		Title: Assistant Superintendent	
Email address: larry.godwin@ncdps.gov		Telephone number: 828-286-4121	
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: 919-825-2739			
Agency Chief Executive Officer			
Name: Frank L. Perry		Title: Secretary, NCDPS	
Email address: frank.perry@ncdps.gov		Telephone number: 919-733-2126	
Agency-Wide PREA Coordinator			
Name: Charlotte Williams		Title: PREA Director	
Email address: charlotte.williams@ncdps.gov		Telephone number: 919-825-2754	

AUDIT FINDINGS

NARRATIVE

The Rutherford Correctional Center received a PREA audit beginning September 1, 2015. PREA Notices were sent to the facility for display to all inmates and staff, and were posted by the appropriate date. The facility provided a flash drive with all documentation required and requested to the auditor by September 15, 2016. After a review of the documents, the on-site audit began on October 13, 2016 and was completed on October 14, 2016

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

On October 13, 2016, the auditor met with Superintendent Richard Elingburg Jr., Assistant Superintendent/PREA Compliance Manager Larry Godwin, Program Director Cassandra Howell, Administrative Assistant Shayne Dotson, and Correctional Sergeant Dale Hunt. This brief entrance meeting focused on the audit process, the interim/final report, Corrective Action Plan periods, and additional documentation that would be needed. This meeting was followed by a tour of the facility.

The tour included all 15 buildings and all outside areas. The auditor observed PREA related materials posted throughout the facility for inmate and staff viewing. These included the PREA Audit Notice, Zero Tolerance posters, and information on how to report sexual abuse or sexual harassment. Other facility specific information was also posted for inmate viewing. Phones were observed in each housing unit for inmate use.

Interviewees were selected through the use of the inmate rosters and staff assignment/posts. There were a total of 11 inmates selected for interview, and this included two inmates who self-identified as LGBTI. There were no reported LGBTI inmates, disabled inmates, inmates who reported a prior victimization, or an inmate with limited English. There were 10 random staff selected for interview; these staff were selected from both shifts. Additionally, 14 specialized positions were selected for interview. This included the PREA Manager, Superintendent, Upper Level Management, Medical Staff, Mental Health Staff, Human Resources, 2 Volunteers, Investigator, Intake, Risk Screening, Incident Review, Retaliation Monitor, and First Responder Staff. The Agency head and Agency PREA Coordinator were interviewed prior to this audit by DOJ Certified Auditor Pete Zeegers, and the information was provided to this auditor.

Staffing includes two 12-hour shifts, as well as 8-5 staff. There are 42 employees with direct contact with inmates, which includes 37 Correctional Officer I and 6 Sergeants. There is one trained PREA Investigators and 338 volunteers. There is no camera system at this facility.

In the past twelve months, there were 2 allegations of sexual abuse and 1 allegation of sexual harassment. Each was investigated and all three were closed as unsubstantiated. A review of the files indicates that the facility does notify inmates and conducts a PREA Incident Review at the conclusion of the investigation.

Basic medical services are available at Rutherford Correctional Center. There is a medical staff available during the days and a mental Health staff is available by request as there is a staff Psychologist that is located off-site and services multiple facilities. Carolinas HealthCare System – Blue Ridges Morganton (former Grace Hospital) is the local hospital where services are provided that cannot be handled at the facility, including forensic examinations required for sexual abuse investigations.

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

In the interim, The Path Shelter, Family Resources of Rutherford County, is providing services to inmates through an MOU dated August 12, 2016. The center has agreed to provide counseling services to survivors of sexual abuse and harassment who are incarcerated at Rutherford Correctional Center, work with facility staff for security clearance and policy compliance, PREA Audit Report

maintain confidentiality, provide training to the facility staff, and to communicate with the facility. Rutherford Correctional Center has agreed to make the certified rape crisis counselors a component of their Coordinated Response Plan, provide for phone counseling, ensure reasonable communication between the counselor and inmate, follow-up and on-going contact, provide training to crisis counselors, and to provide inmates the mailing address and phone number of the center for reporting purposes.

DESCRIPTION OF FACILITY CHARACTERISTICS

Rutherford Correctional Center is a minimum security prison for 236 adult male inmates run under the North Carolina Department of Public Safety (NCDPS). The NCDPS Mission is to promote the elimination of undue familiarity and sexual abuse amongst the offender population.

Located in the City of Spindale and with the Rutherford County boundaries, Rutherford Correctional Center was one of the 51 county prisons established in 1931. It was dedicated to serve the citizens of North Carolina on August 18, 1932 under the direction of Rutherford's first Superintendent and previous Sheriff of Rutherford County, W.C. Hardin. The original facility, which is still in use today, consists of an administrative office, kitchen, and dormitory with a total construction cost of \$25,000.00.

The General Assembly provided two 50-bed dormitories in the \$28.5 million Emergency Prison Facilities Development program authorized in 1987. Both dormitories opened in 1988. Lawmakers approved another 50-bed dormitory in the \$87.5 million prison construction program authorized in 1993.

Rutherford Correctional Center has provided inmates to work on North Carolina highways since 1932. Following recent expansions, the prison began providing additional inmate highway labor in Cleveland, Polk and Rutherford counties. Currently there are 70 inmates on highway labor. Additionally, Rutherford Correctional Center provides 40 inmates to the community through the community work program. In an effort to enhance skills within the public, there are 20 selected inmates assigned to private industry jobs.

Rutherford Correctional Center has 4 open-bay housing units (dormitory style). The facility offers no Restrictive Housing Unit. Each housing unit has information posted for inmate viewing that include the PREA Audit Notice, information on how to report sexual abuse or sexual harassment, and contact information for the local rape crisis center, The Path Shelter. Each dormitory provides inmate privacy while showering, toileting or changing clothing through doors or curtains.

The remaining buildings on the property house Administration, Human Resources, Accounting, Canteen, Supervisors, Medical, Kitchen/Dining, Chapel, Barber shop, tool shed, chemicals, 2 clothes houses, education, and Sgt. Offices. There is an outdoor recreation yard that provides horse shoes, weights, basketball, and Corn Hole. An outside Visitation area is also available, with a bulletin board for visitor information. Visitation is held weekly.

Education is provided by Isothermal College. Twice a week inmates receive instruction on preparing for the High School Equivalency test. New Lease on Life is a program that allows state prisoners to partner with local animal shelters, animal welfare agencies, and/or private non-profit agencies to train dogs in preparation for their adoption. In turn, inmates are given a chance to serve the community by training dogs to be well-behaved pets. Once an inmate has completed the appropriate training, he is provided a dog for the next 8-12 weeks. Inmates teach basic obedience, house training, and socialization through positive reinforcement and repetition. Dogs are taught to walk on and off the leash and to respond to basic commands. The facility also offers a Veteran's only group "Continuing the Mission".

Inmates may work a variety of jobs. Externally, work release programs are available, as well as 3 Department of Transportation work squads and 6 labor contracts. Internally, they may work in maintenance, groundskeeper, kitchen, and custodial.

Religious services are provided through a community-funded Pastor. This facility addresses all religious beliefs as evidence by the sample calendar and interview with the Pastor.

SUMMARY OF AUDIT FINDINGS

The Rutherford Correctional Center was well prepared for their PREA Audit. The facility had requested documents available on the first day of the audit, and supplied additional documents/information as requested. There were a few sight areas that were immediately addressed by the administrative staff.

The facility has a Sexual Assault Response Team (SART) and PREA Support Person (PSP). The SART is activated when there is an allegation of sexual assault. The PSP plays an important role in assisting the victim through the various activities associated with an allegations (investigation, medical exam, interviews, and support services). There is one (1) PREA Support Person identified.

The facility staff were helpful, very professional, and well versed in PREA activities at the facility level.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 4

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

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

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

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

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

The PREA Compliance Manager/Assistant Superintendent has been employed for 20 years and assumed the role as the PCM in June 2015. He reports that approximately 10% of his time is related to PREA duties. His efforts toward compliance include reviewing policies and procedures, implementing change as needed, unannounced rounds, addressing blind areas as identified, and the training of staff. Upon the identification of an issue with PREA compliance, he updates procedures, reviews the staffing plan, provides training for staff, and re-checks to ensure continued compliance with new guidelines.

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

Standard 115.12 Contracting with other entities for the confinement of inmates

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

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

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

Standard 115.13 Supervision and monitoring

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

- Does Not Meet Standard (requires corrective action)

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

Policy F.1600, Policy F.1601, Staffing Plan Report dated January 2015, Post Chart Summary Review dated August 8, 2016, OIC Narratives noting unannounced rounds, and North Carolina General Statute 143B-709 were reviewed. Additionally, interviews were conducted to further determine compliance.

While North Carolina General Statute requires a staffing analysis every 3 years, the agency policy requires an annual review of the staffing plan, including a review of all required components of the standard, which was completed in January 2015. The facility has a Post Chart that details positions and was last reviewed on August 8, 2016.

Deviations from the staffing plan are noted on the Shift Narrative. The facility uses a star system for holdover coverage as needed, or until additional staff is available. Unannounced rounds are documented in the Officer-in-Charge Narrative. These rounds are conducted by upper and middle level staff and are conducted on all shifts on random days.

Standard 115.14 Youthful inmates

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

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

This standard 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 .1500, 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 strip or visual body cavity searches conducted. Training documents reviewed indicated that staff have completed appropriate training. Agency policy requires the announcement of cross-gender staff entering the housing units. While both inmate and staff confirmed that an announcement is made of female staff on duty at the beginning of each shift, the announcement of when female staff re-enter a housing unit is not consistent. Prior to this report, the facility conducted training on cross gender announcements with all staff through a signed staff PREA training roster.

Each housing unit allows for inmate privacy while showering, toileting, or changing clothing through the installation of doors and/or curtains. Inmate interviews confirmed that they do feel they have privacy.

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

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

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

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

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

Information is available in both English and Spanish (the most common non-English language at this facility). It was unclear during the audit if there is a system to ensure that inmates with learning disabilities are identified upon intake and when providing information on the facility and PREA reporting. While there is a policy to address this, there appeared to be no system in place to ensure that inmates are provided the information in a manner that they can understand. Inmate interviews stated that they are provided a document to read and sign. Prior to this report, the facility provided case manager training that requires all newly arrived inmates to be asked if they can read or if they have any problems with comprehension. If an inmate answers yes, the case manager will meet individually with the inmate.

Standard 115.17 Hiring and promotion decisions

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

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

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

The agency policy prohibits the hiring or promotion of individuals who have engaged in sexual abuse, or attempting to engage in sexual abuse in a detention facility or in the community, or who have been civilly or administratively adjudicated for the same. The agency requires all staff to annually sign a statement that they have not engaged in the aforementioned activities (PREA Hiring & Promotion Prohibitions and HR005). This information was reviewed through the LMS (Learning Management System) and copies were provided to the auditor for review. All staff are documented as having completed this step of their training. The agency also requires all employees to self-report any such misconduct. Criminal background check are required for contractors and employees, and material omissions regarding misconduct or false information are grounds for termination. The agency does respond to requests from other institutions where a former employee has applied to work. The agency conducts background checks at hiring. Proof of background checks conducted within the last 5 years was reviewed for all staff interviewed. Of the 24 files reviewed, all had received a background screening within the past 5 years.

Standard 115.18 Upgrades to facilities and technologies

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

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

Standard 115.21 Evidence protocol and forensic medical examinations

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

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 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 Spindale Police Department would complete criminal investigations, and no criminal investigations were conducted in the past 12 months. The agency has sent a letter to all law enforcement agencies in the state on March 16, 2016 requesting their compliance with PREA standards in the event a criminal investigation is conducted.

The Clinical Practice Guidelines cover appropriate evidence collection. The facility has two PREA Support Person (PSP) who are trained for victim advocacy services, and acts as the link to assist victims with the investigative process, professional resources, community based advocates, and mental health professionals. Training records confirm the training. 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 Carolinas HealthCare System – Blue Ridges Morganton (former Grace Hospital). The facility provides forensic examinations. There is no cost incurred by an inmate for these services. The agency is currently working with the North Carolina Coalition Against Sexual Assault (NCCASA) to create a state-wide system for community based services and documents were provided. In the interim, the facility has an MOU with The Path Shelter, Family Resources for Rutherford County, Inc. who has agreed to provide services for inmates upon request. The PREA Support Person (PSP) provides assistance to the victim in contacting the agency.

Standard 115.22 Policies to ensure referrals of allegations for investigations

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

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

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

All allegations of sexual abuse or sexual harassment are classified as a major incident. Policy requires that all major incidents receive an investigation. Policy requires that allegations be referred to an inhouse trained investigator for the administrative portion and to the local law enforcement (Spindale Police Department) 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 annual training and understand the material presented, with the exception of Elder Abuse laws and the searching of transgender or intersex inmates. Training documentation is kept in LMS (Learning Management System). Employee training documentation found that all staff had completed their annual training. Of the 22 staff files reviewed who are required to complete this training, all 22 have completed PREA training as required. Prior to the writing of this report, the facility conducted staff training on Elder Abuse laws and appropriate searches for transgender and intersex inmates.

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

The agency requires all volunteers to complete the same PREA training as staff, with minor deviations. There is also a Volunteer Brochure specifically for volunteers to receive PREA information. This facility reports 338 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. Two interviews were conducted. The community funded Pastor who runs the volunteer program conducts annual PREA training with volunteers and utilizes a Power Point Presentation and scenarios. Each volunteer is required to sign a training acknowledgement form. The volunteer interviewed reported that she has completed both the background check and the PREA training in the past year and feels comfortable with the inmates.

The community funded Chaplain was interviewed. It is this position that ensures all volunteers received NCDPS PREA training. He confirmed that they conduct annual training for all volunteers in both 2015 and 2016.

Standard 115.33 Inmate education

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

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

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

Rutherford Correctional Center receives inmates from a reception and diagnostic center, or through a transfer. Agency policy requires all inmates entering into the system to receive intake and comprehensive training at the reception and diagnostic center. Rutherford Correctional Center inmates arrive at the facility having already received comprehensive education, and therefore receive facility specific information. The comprehensive education was reviewed at Craven Correctional Center and meets the criteria of the standard regarding content. Inmate education is maintained in OPUS (Offender Population Unified System) and copies were provided to the auditor for review.

Interviews with inmates confirmed the receipt of facility specific information at intake and transfer. The facility conducts inmate Orientation upon arrival of inmates. Informational posters were observed around the facility on the PREA boards in the dorms. Staff interviews also confirm Orientation material is appropriate to inmates needs and clear copies of all written material is provided to inmates. Inmates were not familiar with The Path Shelter and the services that are available during the interview, although information was available in the units. Of the 12 inmates files reviewed, 11 have received PREA education upon intake and typically within 72 hours.

Prior to the writing of this report, the facility provided each inmate with a memo that details the services of The Path Shelter. Inmates were required to sign the form. A copy of the roster was provided to the auditor along with a sample of the memo.

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 one (1) designated investigator who has 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 Spindale Police Department. The auditor reviewed training documentation of identified investigator, as well as the training provided by the agency to investigators. The Investigator has 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 PREA 101 and specialized medical and mental health training. The specialized training meets all requirements of the standard. The agency staff Psychologist who provides Mental Health services has completed the standard PREA training and the specialized training. This was confirmed with documentation and through interview. The medical staff has completed the standard PREA training and the specialized training. This was confirmed with documentation and through

interview.

Forensic examinations are not conducted at this facility and therefore no training was provided. All forensic examinations are conducted at the Carolinas HealthCare System – Blue Ridges Morganton (former Grace Hospital).

Standard 115.41 Screening for risk of victimization and abusiveness

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

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

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

The agency conducts a risk assessment at the reception and diagnostic center upon the initial intake of inmates into the state system. This is completed within 72 hours of arrival. The risk assessment contains all elements of the standard. The agency recently changed their processes to ensure that both inmates at risk of victimization or being aggressive are appropriately identified. This system went into effect March 2016. The agency PREA Coordinator provided to this auditor documentation that the agency now produces a High Risk for Victimization List (HRV) that is reviewed alongside the High Risk for Abusiveness List (HRA) to ensure that all housing, work, and programming services are assigned with the protection of the inmates as a key factor. Upon intake at a reception center, the inmate and staff complete the Mental Health Screening Inventory. This tool identifies all required components of the standard. From this document, two lists are produced – the HRV and 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 Superintendent, Assistant Superintendent/PREA Compliance Manager, and Case Manager Supervisor. It is the responsibility of the Assistant Superintendent/PREA Compliance Manager to ensure these lists are reviewed weekly for appropriate placement. This was confirmed during the interview. A review of 12 files found that this screening is not always completed within 72 hours. Of the 12 files: 1 inmate arrived prior to the screening implementation, 5 were screened within 72 hours, and 5 were screened after 72 hours.

Prior to the writing of this report, the facility provided a new procedure for case managers that will require the risk screening to be completed within 72 hours. This procedure was provided to the auditor along with staff signatures that they have received the training.

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 Abusiveness Report were reviewed. Interviews were conducted.

The policies address 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 Abusiveness (HRA) lists 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 the results of the screening are used to determine housing and bed assignment. Interviews confirmed that the Assistant Superintendent/PREA Compliance Manager or Case Manager Supervisor 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 restricted housing/protective custody is not utilized at this facility. The Superintendent confirmed that protective custody would not be used except in an emergency situation and would require a transfer.

Standard 115.51 Inmate reporting

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

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

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

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

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

Standard 115.52 Exhaustion of administrative remedies

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

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

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

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

Standard 115.53 Inmate access to outside confidential support services

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

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

The Path Shelter Brochure, The Path Shelter MOU, 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 The Path Shelter. In August 2016, the facility and The Path Shelter entered into an MOU for the provision of services.

The PREA Support Persons (PSP) is aware of the services available and is expected to assist victims in contacting them. Inmates are provided identification of the PREA Support Services through Form OPA-I30, which documents the PREA Support Persons role during the investigation and thereafter to assist in providing support services to the victim. A copy of the Brochure was in each housing unit for inmate viewing which identifies services available and contact information.

Standard 115.54 Third-party reporting

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

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

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

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

Standard 115.61 Staff and agency reporting duties

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

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

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

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

Standard 115.62 Agency protection duties

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

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

Policy F.3400 was reviewed. Interviews confirmed findings.

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

Standard 115.63 Reporting to other confinement facilities

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

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

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

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

Standard 115.64 Staff first responder duties

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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

The agency requires all staff to separate the alleged victim and alleged abuser, 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. While there were 2 allegations of sexual abuse at the facility, neither was reported within a time frame for the collection of evidence and neither identified the alleged perpetrator. Both investigative report identify immediate notification to the appropriate parties as identified in the Coordinated Response Plan.

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

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

An interview with the PREA Support Person (PSP) found that they are not notified immediately when there is an allegation of sexual abuse or sexual harassment, and therefore services and monitoring as required are not initiated. Of the three files reviewed, only one had retaliation monitoring. Additional staff interviews confirm that measures used to keep inmates safe may include housing changes, the alleged perpetrator be transferred, or inmate transfers, if requested.

Prior to this report, the facility conducted training with all management staff to include the duties and responsibilities of the PREA Support Person, retaliation monitoring, and the Coordinated Response Plan. Proof of the training was provided by staff signature.

Standard 115.68 Post-allegation protective custody

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

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

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

The agency policy addresses the use of protective custody only if no other alternative means of protection is available, or if inmates request this level of protection. Inmates requesting this level of protection may completed the Request for Protective Custody and must document the reasons for the request. Interviews confirm that while protective custody is available, it is not used at this facility. There were no instances of the use of protective custody as a result of a sexual abuse allegation in the past 12 months.

Standard 115.71 Criminal and administrative agency investigations

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

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

Policy F.3400, 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. 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. A review of the 3 investigation files found that all were closed as unsubstantiated.

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.

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.

reviewed. Investigation files were reviewed. Interviews confirm findings.

The agency policy requires that an inmate be notified of the outcome of an investigation. 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. A review of the files indicates that only one file contained victim notification. In the remaining 2 files, one inmate had been released and there was no indication that the last victim was notified. An interview with the staff indicates that the PSP, who is responsible for making the victim notification, may not always be advised of the outcome of the investigation.

Prior to this report, the facility conducted training with all management staff to include the duties and responsibilities of the PREA Support Person, victim notification, and agency policy. Proof of the training was provided by staff signature.

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. One investigation alleged inappropriate contact by a staff member; however the investigation was closed as unsubstantiated. There were no instances where a staff violated agency sexual abuse or sexual harassment policies.

Standard 115.77 Corrective action for contractors and volunteers

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

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

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

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

Standard 115.78 Disciplinary sanctions for inmates

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

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

Policy F.3400, Policy B.0200, and the 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 two inmate-on-inmate sexual abuse incidents that were reported in the program in the past 12 months; however, the alleged perpetrator was never identified and the investigations were closed as unsubstantiated. 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 his response to the facility. Additional counseling services are available as identified and as requested by the victim through the PSP (PREA Support Person) and The Path Shelter. Medical staff interviewed provided the Sexual Abuse Nursing Protocol and reported that 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.

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 one 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 Manager and SART members, who are comprised of upper level management and input from other staffing positions. Medical or Mental Health is not included in the facility team.

Of the three allegations, one was a sexual harassment allegation that was not required to have an Incident Review. However the facility did conduct one at the conclusion of the investigation. Of the remaining two allegations of sexual abuse, the facility did conduct an Incident Review. Recommendations were made; however there was no follow-up to show compliance with the recommendation or documentation to show why the recommendation could not be implemented. All were documented on the OPA-I10 form as required by the agency policy. None of the reviews conducted included a member from the medical or mental health staff.

Prior to this report, the facility conducted training with all management staff on PREA Incident Reviews. Proof of the training was provided by staff signature.

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

December 8, 2016

Auditor Signature

Date