

**PREA AUDIT REPORT**     Interim     Final  
**ADULT PRISONS & JAILS**

**Date of report:** April 17, 2016

<b>Auditor Information</b>			
<b>Auditor name:</b> Bobbi Pohlman-Rodgers			
<b>Address:</b> PO Box 4068, Deerfield Beach, FL 33442-4068			
<b>Email:</b> <a href="mailto:bobbi.pohlman@us.g4s.com">bobbi.pohlman@us.g4s.com</a>			
<b>Telephone number:</b> 954-818-5131			
<b>Date of facility visit:</b> March 21 - 22, 2016			
<b>Facility Information</b>			
<b>Facility name:</b> Sanford Correctional Center			
<b>Facility physical address:</b> 417 Advancement Center Road, Sanford, NC 27330			
<b>Facility mailing address:</b> <i>(if different from above)</i> PO Box 2490, Sanford, NC 27331			
<b>Facility telephone number:</b> 919-776-4325			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input checked="" type="checkbox"/> Prison	<input type="checkbox"/> Jail	
<b>Name of facility's Chief Executive Officer:</b> Superintendent I John Godfrey			
<b>Number of staff assigned to the facility in the last 12 months:</b> 68			
<b>Designed facility capacity:</b> 298			
<b>Current population of facility:</b> 290			
<b>Facility security levels/inmate custody levels:</b> Minimum Custody			
<b>Age range of the population:</b> 20 and over			
<b>Name of PREA Compliance Manager:</b> Randall Turner		<b>Title:</b> Assistant Superintendent	
<b>Email address:</b> <a href="mailto:randall.turner@ncdps.gov">randall.turner@ncdps.gov</a>		<b>Telephone number:</b> 919-776-4325	
<b>Agency Information</b>			
<b>Name of agency:</b> North Carolina Department of Public Safety			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> <a href="#">Click here to enter text.</a>			
<b>Physical address:</b> 512 N Salisbury Street, Raleigh, NC 27604			
<b>Mailing address:</b> <i>(if different from above)</i> 4201 Mail Service Center, Raleigh, NC 27699-4201			
<b>Telephone number:</b> 919-825-2739			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> Frank L. Perry		<b>Title:</b> Secretary, NCDPS	
<b>Email address:</b> frank.perry@ncdps.gov		<b>Telephone number:</b> 919-733-2126	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Charlotte Williams		<b>Title:</b> PREA Director	
<b>Email address:</b> charlotte.williams@ncdps.gov		<b>Telephone number:</b> 919-825-2754	

## **AUDIT FINDINGS**

### **NARRATIVE**

Sanford Correctional Center received an on-site PREA audit on March 21 and March 22, 2016 by DOJ Certified PREA Auditor Bobbi Pohlman-Rodgers. Prior to the on-site visit, the facility provided a completed PREA Pre-audit Questionnaire and a flash drive with the requested and required documents. The auditor reviewed the same documents prior to the on-site visit. The auditor also made contact with the facility approximately one-week 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 current inmate rosters and staff assignments.

On March 21, the auditor met with Superintendent Godfrey, Assistant Superintendent/PREA Compliance Manager Turner, Program Director Grimes, Administrative Sergeant Ayers, Case Manager Price and Administrative Sergeant Smith. This brief meet focused on the audit process, the interim/final report, Corrective Action Plan periods, and additional documentation that would be needed. It was also discussed that there were three standards in which the agency had been working to come into compliance and that this facility had already implemented the changes as required by the agency PREA Coordinator. This meeting was followed by a tour of the facility.

The tour included nineteen buildings and all outside areas. It is noted that PREA audit notices, Zero Tolerance posters, and reporting methods were located throughout the facility in areas where both inmates and staff had access. Other facility specific PREA information was made available to inmates on the PREA boards located in each dormitory. Mail boxes were identified in each dormitory, as well as material to write a grievance. There were some areas that prevented staff viewing; however the facility was quick to remedy this through the use of mirrors. Additionally, the facility requires all staff to conduct 30-minute rounds to enhance supervision.

Interviewees were randomly selected through the use of inmate rosters and staff assignments. There were a total of 10 inmates interviewed – with at least one from each housing unit. These interviews included two inmates who reported a prior victimization and one with a disability (sight). There were eleven random staff interviewed – some from both shifts. An additional 12 interviews with specialized staff positions were conducted. The agency head and the Agency PREA Coordinator were interviewed prior to this audit by DOJ Certified Kevin Maurer, and the information was provided to this auditor.

Staffing includes two 12-hour shifts as well as 8-5 staff. There are 44 Correctional Officer I positions and 7 Correctional Sergeant I positions at the facility. These counts include housing non-facility posts, support services, operations, and supervisory staff.

In the past twelve months, there were two allegations of sexual harassment. Both received administrative investigations; neither required criminal investigations. There were no allegations of sexual abuse. Files indicated that both were unfounded and included notification to the victim of the outcome. A review was conducted of two additional investigations conducted in 2015. All files contained required documentation.

Both medical and mental health services are available at Sanford Correctional Center. Medical staff is on-site for 8 hours per day, 5 days per week. Triage services are available through the Randolph Correctional Center. Mental Health services are provided as needed through an off-site staff provider.

Sanford Correctional Center has a Sexual Assault Response Team (SART) that consists of the Superintendent, PREA Compliance Manager, Program Director, Investigator, Medical staff and PREA Support Persons (PSP). The PREA Support Person (PSP) has received training to assist a victim through all processes, including providing assistance in obtaining outside support services. Forensic sexual assault medical exams are conducted at Central Carolina Hospital. Haven in Lee County provides victim advocates and outside support services as needed. Interpreter services are provided by Linguistica International, Inc.

## **DESCRIPTION OF FACILITY CHARACTERISTICS**

Sanford Correctional Center is a minimum security prison for 298 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 Sanford and within the Lee County boundaries, Sanford Correctional Center was one of the first 61 field units renovated or built during the late 1930's to house inmates working to build roads. Later it was used as a training facility for officers and in the 1970's was then converted back to a prison field unit.

Sanford Correctional Center has nine housing units. The General Assembly provided two 50-bed dormitories at this location as a part of the \$28.5 million Emergency Prison Facilities Development program that was authorized in 1987. Additionally, lawmakers provided two additional 50-bed dormitories as a part of the \$87.5 million prison construction program authorized in 1993. The original dormitory is still in use.

A/B and C/D buildings once contained two housing unit. As a result of renovations including the removal of the separation wall, each building now contains a single housing unit. E/F, G/H, and I/J all contain two housing units. Each of these buildings hold 64 inmates. This facility does not contain restricted housing or protective custody.

Additional buildings include administration, medical, class room/multi-purpose room, barber shop, library/clothes house, kitchen/dining hall, maintenance shed, staff building, and 4 storage buildings/sheds. Visitation is held in the dining room, or during good weather at the outdoor visitation area with 12 picnic table and visitor bathrooms. The staff building contains program offices, employee lounge and the Sergeant's office. Inmate outdoor recreation includes a recreation yard, basketball courts, volley ball, weights and a walking track.

Sanford Correctional Center is primarily a work facility. Inmates are assigned to one of the many jobs available, including Department of Transportation squads in Lee, Harnett and Moore counties, litter crews for local and state agencies, Correctional Enterprise – Sign Recycling plant, labor contracts with local governments and work release jobs in Lee County. Sanford Correctional Center also provides inmate work force for the Office of Staff Development and Training located in Apex. All other inmates are able to work at facility jobs such as custodial work, groundskeepers or culinary workers.

Educational programs include adult basic education (ABE) and general Education Diploma (GED) testing through the Central Carolina Community College. Accredited post-secondary educational program are available through UNC Chapel Hill's Friday Center. Vocational opportunities are also offered through Central Carolina Community College and include Brick Masonry and Human Resource Development. Additionally, religious services and substance abuse services are made available to inmates.

## **SUMMARY OF AUDIT FINDINGS**

The Sanford Correctional Center was well prepared for their PREA Audit and provided all documents prior to or upon request during the audit. There were minor issues with orientation materials being provided (both verbal and written) which were immediately addressed. Outside support services were available, and the PREA Support Person (PSP) is aware of these; however inmates were not clear on what services are provided by Haven of Lee County.

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

Computerized Incident Reports are well written and files were organized and contained appropriate documentation.

The facility staff were very helpful, very professional, and well versed in PREA activities at the facility level. The administrative staff responded to all privacy concerns immediately upon identification during the tour. It was this auditor's pleasure to work with the Superintendent and his staff.

Number of standards exceeded: 1

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 4

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

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

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

Policy F3400, Policy A2000, SOP .4600, 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 reported sufficient time to attend to PREA duties. This person reports directly to the Superintendent, and indirectly to the Agency PREA Coordinator. Additionally, the facility has named a secondary PREA Compliance Manager. The interview noted that efforts to coordinate compliance is through weekly meetings with administration, program services, and the Officer-in-Charge (OIC).

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 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, SOP F.1900, Staffing Plan Report dated January 2015, Approved Facility Posting Chart/Staffing Plan approved 06/22/15, Shift Narratives noting both cross-gender announcements and 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 Post Chart for all staff was last reviewed on 6/22/15. Deviations from the staffing plan are documented on the Shift Narrative. The Superintendent confirms that the facility utilizes a pulled post system with hold over or call in when needed. Unannounced rounds are documented in the Shift Narrative. These are conducted by the Sergeants and documentation includes the date and time of the round. Interviews with the PREA Compliance Manager confirmed that upper level management conduct unannounced rounds weekly and the Office-in-Charge conducts multiple rounds during their shift.

#### **Standard 115.14 Youthful inmates**

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

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

This standards is Not Applicable as this facility does not house any inmates under 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, Policy TX I-13, SOP 5.19, Safe Search Practices Training, NCDPS New Employee Orientation (revised 1/1/15), Cross Gender Announcement & Acknowledgement for staff, Staff Training Log, and Cross Gender Bulletin Board Poster Memo (dated 4/22/13) were reviewed. Interviews were also conducted to assist with the determination of compliance.

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. Training documents reviewed indicated that staff have completed appropriate training. Staff interviewed confirmed training on searching transgender and intersex inmates. Agency policy and facility SOP require the announcement of cross-gender staff entering the housing units. This was seen during the tour and both inmates and staff report that these announcements are being made as required.

There were two areas identified during the tour that indicated additional privacy was needed. These areas included the bathrooms in C/D and E/F dorms. Prior to the auditor leaving the facility on the second day, a walk-thru confirmed hanging doors had been installed to ensure privacy from cross-gender staff viewing.

#### **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, SOP 4360, and World-Wide Interpreters Telephonic Interpreter Services Contract were reviewed. 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.

The agency has established policy to provide for educational services for inmates with disabilities to be provided information at intake and assistance on PREA allegations, including reporting. Case managers would arrange for education in formats for those inmates identified as disabled. Agency policy also addresses the provision of interpreters to those inmates with a non-English primary language. There is a contract 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. Additionally, this facility offers English as a Second Language (ESL) classes. Educators are responsible for assisting with language and disability barriers. One inmate interviewed identified that his eye sight is decreasing due to cataracts, and he was awaiting word from the state regarding further medical care. The facility is responsive to his needs and will provide verbal information or larger printed materials as requested by 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. There were thirteen background checks conducted in the past twelve months (Pre-Audit Questionnaire). Proof of background checks conducted within the last 5 years was reviewed for all staff interviewed. It was noted that employee background screenings every 5 years is a new process in place for all North Carolina facilities.

### **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. There is one camera at the facility and this is focused on the basketball court.

### **Standard 115.21 Evidence protocol and forensic medical examinations**

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

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

Policy F3400, Policy CP18, SOP 4600, 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, Correspondence between facility and Haven of Lee County, and NCCASA documentation were reviewed. Interviews also provided information in the determination of compliance.

The agency conducts only administrative investigations. Lee County Sheriff's Office would complete criminal investigations, and no criminal investigations were conducted in the past twelve months. The Clinical Practice Guidelines cover appropriate evidence collection. The Agency has one PREA Support Person (PSP) who is 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. The agency is currently working with the North Carolina Coalition Against Sexual Assault (NCCASA) to create a state-wide system for community based services and documents were provided.

The agency does not have an MOU with Haven of Lee County; however there is documented correspondence between Haven of Lee County and the facility showing the intent to work together to provide victim advocacy and support services. The PREA Support Person (PSP) will assist the victim in contacting Haven at Lee County if requested.

Forensic examinations are conducted at Central Carolina Hospital, where one Sexual Assault Nurse Examiner (SANE) is on call, as per interview with Emergency Room Charge Nurse. They are anticipating having another SANE certified through UNC Chapel Hill.

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.

### **Standard 115.22 Policies to ensure referrals of allegations for investigations**

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

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

Policy F3400 and SOP 05.09 was reviewed. Interviews were conducted.

All allegations of sexual abuse or sexual harassment are classified as a major incident. Policy requires that all major incidents receive an investigation. Policy requires that allegations be referred to an inhouse trained investigator for the administrative portion and to the local law enforcement (Lee County Sheriff's Office) for criminal investigations. Policies are available through the NCDPS website.

### **Standard 115.31 Employee training**

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

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

Policy F3400, Training Curriculum's SAH 101 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. Training documentation is kept in LMS (Learning

Management System). Employee training documentation found that all staff had completed their annual training.

### **Standard 115.32 Volunteer and contractor training**

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

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

Policy F3400, Policy F0604; Training Curriculum's SAH 101 2015, Staff and Offender Relations Training, New Employee Orientation, Form OPA-T10, "Ways to Report" Poster, Volunteer Brochure, 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 122 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.

### **Standard 115.33 Inmate education**

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

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

Policy F3400, Diagnostic Procedural Manual Section 201 & 417, PREA Inmate Brocher (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.

Sanford Correctional Center receives inmates from a reception and diagnostic center. Agency policy requires all inmates entering into the system to receive intake and comprehensive training at the reception and diagnostic center. Sanford 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. 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. On March 23, 2016, the facility conducted orientation training with the four staff who may conduct inmate orientation. All were instructed that all orientation material is to be read to the inmates upon intake.

### **Standard 115.34 Specialized training: Investigations**

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

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

Policy F3400, Training Curriculums: Investigator, PPT and Mock Interview; Investigator Understanding Sexual Violence & PPT; and Incident Reporting, OPUS (Offender Population Unified System) Incident Reporting Pamphlet, and the Investigator PREA training file was reviewed. Investigator Interview was also conducted.

The facility has two (2) designated investigators who have completed specialized training for this purpose. The training meets the requirements of the standard. Interview with an investigator found that they were well versed in administrative investigations. Only those who have completed this training have access to the electronic incident report system to allow for the review of investigations and updating the system with new information. The agency only completes administrative investigations. All criminal investigations are conducted by Lee County Sheriff’s Office. 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 F3400, and Training Curriculum: PPT, CE Nursing and OSDT Roster were reviewed. Training files for medical staff and mental health staff were reviewed. Interviews were completed.

The agency policy requires that all medical and mental health staff receive PREA 101 and specialized medical and mental health training. The specialized training meets all requirements of the standard. Both medical and mental health staff have completed the training. Interviews with medical staff confirmed knowledge of specialized training. A prior interaction with the mental health provider confirms his specialized training. Forensic examinations are not conducted at this facility and therefore no training was provided. All forensic examinations are conducted a Central Carolina 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 F3400, Diagnostic Procedural Manual 305, and memo dated 08/14/15 were reviewed. A selection of inmate files were also reviewed. Interviews were conducted.

The agency conducts a risk assessment at the reception and diagnostic center upon the initial intake of inmates into the state system. This is completed within 72 hours of arrival. The risk assessment contains all elements of the standard. 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 Abusive List (HRA) to ensure that all housing, work, and programming services are assigned with the protection of the inmates as a key factor. Upon intake at a reception center, the inmate and staff complete the Mental Health Screening Inventory. This tool identifies all required components of the standard. From this document, two lists are produced – the HRV and HRA (see above). These lists are protected from viewing by staff who do not have an immediate need to know and access is only provided to the Facility Head, PREA Compliance Manager, Asst. Superintendent for Custody and Operations, Asst. Superintendent for Programs, and the Inmate Assignment Coordinators, or IAC. It is the responsibility for the designated staff to run these lists weekly to review for appropriate placement. This facility was then required, and has completed as of March 23, 2016, a review of all inmates on the HRV and HRA list as well as changes made to ensure the safety of inmates.

#### **Standard 115.42 Use of screening information**

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

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

Policy F3400, Policy TX-I-13, Policy C.0100, Screening tool, Learning Management System (LMS) Material, and the Instructions to access the High Risk Abuse 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) list at the facility on a weekly basis, or more often if needed, to ensure that inmates are placed in educational, vocational, and housing that ensures their safety. Inmates who are identified as HRV are now placed in closer proximity to the staff in the housing units. This information was provided to the auditor to show that prior to March 21, 2016, the facility conducted a review of the HRV and HRA lists to ensure the safety of inmates.

#### **Standard 115.43 Protective custody**

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

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

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

There have been no instances where protective custody 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. It is noted that interviews confirm that this facility does not provide protective custody or restrictive housing for inmates. Those requiring such housing would be transferred to another, more appropriate facility.

#### **Standard 115.51 Inmate reporting**

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

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

Policy F3400, Policy D0300, Form OPA-T10, Fraud, 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). Each housing unit contains a mail drop box 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, and Abuse 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 F0300, Policy G0300, and the Inmate Rule Book were reviewed. Interviews were also conducted.

The agency policy confirms that grievances of sexual abuse or sexual harassment require an immediate notification to the North Carolina Department of Public Safety PREA office preventing a response from the subject of the complaint. 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 2 grievances in the past 12 months. Investigators and the agency PREA Coordinator were immediately notified of the grievance and all were resolved within 90 days. Both were sexual harassment grievances and determined to be unfounded.

### **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.**

E-mail correspondence with Haven at Lee County, SOP 4.45A, 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 Haven at Lee County. The facility does not yet have an MOU with Haven at Lee County; however, there is correspondence documenting that Haven at Lee County is committed to providing support to inmates. The PREA Support Persons (PSP) are aware of the services available through Haven at Lee County. 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. While the name and contact information for Haven at Lee County was made available to inmates on the PREA boards, there were no details as to the services that they would provide. On March 31, 2016, the facility conducted training with all inmates on the services of Haven at Lee County, the local rape crisis agency. Additionally information was posted for inmate needs.

### **Standard 115.54 Third-party reporting**

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

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

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

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

The North Carolina Department of Public Safety (NCDPS) offers opportunities for third party reporting and accepts third party reports. Information on how to report to the NCDPS is provided on their agency website. Those concerned will find two separate methods of reporting to the agency. They may write to the 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.

#### **Standard 115.61 Staff and agency reporting duties**

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

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

Policy F3400, SOP 4600, 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. Agency staff training 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 and Abuse 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 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 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 nor any outside reports alleging abuse at this 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 F3400 and PREA training curriculum were reviewed. Staff interviews confirmed findings.

The agency requires all staff to separate, protect physical evidence and the crime scene, and to report to administration when an allegation of sexual abuse is received. All staff interviewed could clearly articulate these steps. It is noted that staff PREA training identifies all staff as first responders. Contractors and volunteers are required to protect the victim and report the information to a security staff. There were no instances in this facility of allegations of sexual abuse in the past twelve months.

### Standard 115.65 Coordinated response

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

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance**

**determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

SOP 4600, Coordinated Reponse Plan and Coordinated Response Overview were reviewed. Interviews were conducted and confirm findings.

The NCDPS has created a template that includes all PREA related requirements for a proper Coordinated Response Plan. Each facility is provided this draft template, which directs that their facility specific information be included in the plan and thereafter published to facility staff. This plan addresses first responder duties, leadership duties, investigator duties, PREA manager duties, PREA Support Persons duties, SART (Sexual Assault Response Team) duties, Mental Health and aftercare duties, and retaliation duties. The plan reviewed was facility specific and included specific tasks for each member. The facility was updating contact information within the plan due to changes. Additionally, there is a flowchart that helps staff to comply with the plan.

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

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

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

This standard is Not Applicable as Sanford Correctional Center does not enter into collective bargaining agreements.

### **Standard 115.67 Agency protection against retaliation**

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

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

Policy F3400, Form OPA-I22 and Form OPA-I24 were reviewed. Interviews confirmed findings.

The agency policy addresses practices to protect both staff and inmates from retaliation as a result of reporting sexual abuse or sexual harassment information. Various protection methods for inmates are identified in policy. There is a form that is used to document the retaliation monitoring at the 90 day mark. The form also prompts and allows for the documentation of periodic status checks. There were no instances where retaliation monitoring was required due to an allegation of sexual misconduct. The PREA Support Person monitors

inmates and the PREA Compliance Manager will monitor staff. Staff interviews confirm that measures used to keep inmates safe may include the alleged perpetrator be transferred, or inmate transfers, if requested.

#### **Standard 115.68 Post-allegation protective custody**

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

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

Policy F3400 was reviewed. Staff interviews confirm findings.

The agency policy addresses the use of protective custody only if no other alternative means of protection is available, or if inmates request this level of protection. Inmates requesting this level of protection may completed the Request for Protective Custody and must document the reasons for the request. Once requested, an inmate would be transferred to another facility as this facility does not provide any protective or restricted custody. There were no instances of the use of protective custody as a result of a sexual abuse allegation in the past 12 months.

#### **Standard 115.71 Criminal and administrative agency investigations**

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

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

Policy F3400, SOP 4600, 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. Both 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. There were no allegations that were referred for prosecution since August 20, 2012.

#### **Standard 115.72 Evidentiary standard for administrative investigations**

- Exceeds Standard (substantially exceeds requirement of standard)

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

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

Policy F3400 and SOP 4600 were reviewed. Interview confirmed the findings.

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

### **Standard 115.73 Reporting to inmates**

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

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

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

The agency utilizes Form OPA-I30 to document notification to the victim of the outcome of the investigation, and Form OPA-I30A is used to document the status of the alleged offender. These forms were found in the 4 files reviewed along with the inmates signature, signature of the staff making the notification, and the outcome of the investigation.

### **Standard 115.76 Disciplinary sanctions for staff**

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

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

Policy F3400, Policy A200, New Employee Orientation, Investigation File, and NCDPS internal webpage were reviewed. Interviews confirmed findings.

The agency policy provides for disciplinary action towards staff who violate the zero-tolerance policy, up to and including termination. All disciplinary actions are reviewed individually based on the nature and circumstances of the allegation. Comparable offenses by other staff

are also considered in a final determination of disciplinary action. All staff terminations are required to be reported to the state licensing body. There were no instances where 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 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 F3400, Policy B0200 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 F3400, Policy CP-18, Diagnostic Manual 305, Memos dated 10/09/13 and 11/14/12, North Carolina Authorization for Release of Information, Mental Health Screening Referral system, and Learning Management System (LMS) were reviewed. Interviews confirmed findings.

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

#### **Standard 115.82 Access to emergency medical and mental health services**

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

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

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

The agency requires that all inmates who report sexual abuse shall be immediately taken for medical services. Mental Health professionals are notified by the 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 Haven at Lee County. 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 F3400, Policy CP-18, Policy CC-8, and the Coordinated Response Overview were reviewed. Interviews confirm findings.

The agency provides on-going medical and mental health services for victims of sexual abuse, whether the incident occurred within an institution or in the community. All care is provided 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 F3400, Form OPA-I10, Coordinated Response Overview, and four 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, including medical staff. There were no allegations of sexual abuse that were substantiated or unsubstantiated, and therefore there were no PIR's to review. Incident Review actions could include the need for further protection, policy change, and/or staffing plan review.

#### **Standard 115.87 Data collection**

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

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

Policy F3400, Incident Reporting – OPUS (Offender Population Unified System), and PREA Incident Reports were reviewed. Interviews confirmed findings.

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

**Standard 115.88 Data review for corrective action**

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

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

Policy F3400, Form OPA-I10, 2015 Sexual Abuse Annual Report, and Coordinated Repsonse Overview were reviewed. Interviews confirmed findings.

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

**Standard 115.89 Data storage, publication, and destruction**

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

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

Policy F3400 and the 2015 Sexual Abuse Annual Report were reviewed. Interviews confirmed findings.

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

**AUDITOR CERTIFICATION**

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any

inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Bobbi Pohlman-Rodgers

May 6, 2016

Auditor Signature

Date