

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

**Date of report:** April 24, 2016

<b>Auditor Information</b>			
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<b>Date of facility visit:</b> February 8, 2016 & February 9, 2016			
<b>Facility Information</b>			
<b>Facility name:</b> Avery-Mitchell Correctional Institution			
<b>Facility physical address:</b> 600 Amity Park Road, Spruce Pine, NC 28777			
<b>Facility mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>			
<b>Facility telephone number:</b> 828-765-0229			
<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> Administrator I Mike Ball			
<b>Number of staff assigned to the facility in the last 12 months:</b> 315			
<b>Designed facility capacity:</b> 860			
<b>Current population of facility:</b> 856			
<b>Facility security levels/inmate custody levels:</b> Medium Custody			
<b>Age range of the population:</b> 20 and over			
<b>Name of PREA Compliance Manager:</b> Brian Watson		<b>Title:</b> Special Affairs Captain	
<b>Email address:</b> brian.watson@ncdps.gov		<b>Telephone number:</b> 828-765-0229 Ext 505	
<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> N/A			
<b>Physical address:</b> 512 N Salisbury Street, Raleigh, NC 27604			
<b>Mailing address:</b> <i>(if different from above)</i> NC Department of Public Safety, 4201 Mail Service Center, Raleigh, NC 27699-4201			
<b>Telephone number:</b> 919-825-2739			
<b>Agency Chief Executive Officer</b>			
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<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Charlotte Jordan-Williams		<b>Title:</b> PREA Director	
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## AUDIT FINDINGS

### *NARRATIVE*

Avery-Mitchell Correctional Institution received an on-site PREA audit on February 8 and February 9, 2016 by DOJ Certified PREA Auditor Walter J. Krauss, Psy.D. The review of policies, procedures and most documentation as well as the written report was completed by Peter Plant, DOJ Certified PREA Auditor, in collaboration with W. J. Krauss. During the Pre-Audit phase, the auditors reviewed a variety of documents provided by the agency and facility. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with PREA Standards. Dr. Krauss contacted the agency PREA Director prior to the site visits to discuss the agenda and to provide information on how best to facilitate the on-site auditing process. The auditor provided an agenda for the site visit and requested additional information be made available on the first day of the audit. This additional information included inmate rosters with housing unit assignments and staff rosters broken down by job title and shift.

The on-site audit began with a meeting between the PREA Auditor, Regional Security Coordinator, Assistant Superintendent of Custody, Assistant Superintendent of Programs, and the PREA Compliance Manager/Special Affairs Captain. The Administrator I was on Medical leave at the time of the audit and the Assistant Superintendent of Custody assumed that role in the interim in his absence. The discussion focused on the audit process, the interim/final 30-day report, Corrective Action Plan period, and the final report. It was also noted that two of the standards were currently being discussed with the NC Agency PREA Director and G4S Youth Services, Inc., in collaboration with the PREA Resource Center. The meeting was followed by a comprehensive tour of the facility.

During the tour, the auditor observed PREA audit notices and Zero Tolerance posters throughout the facility where both inmates and staff had access to the information. The tour included administration, visitation, programming offices, inmate receiving, medical/dental, the gymnasium, the clothes house, education, the chapel, the dining hall, kitchen/food service, maintenance, vocational classrooms, the warehouse, the canteen, twenty-four housing units, and four restrictive housing units.

Interviewees were randomly selected for both inmates and staff by the auditor. There were a total of seventeen random inmates interviewed, including inmates who were developmentally disabled and/or who spoke English as a second language. There were no inmates at the facility at the time of the audit who had current PREA allegations, reported prior victimization, or who had identified themselves as gay, bisexual, transgender, or intersex.

Staff interviews included the Assistant Superintendent of Custody, PREA Compliance Manager (Special Affairs Captain), Human Resources staff, Medical and Mental Health staff, a volunteer who has contact with inmates, intake and screening staff (Case Manager and Receiving Officer), investigative staff, an intermediate or upper level staff (Lieutenant) responsible for conducting unannounced rounds, staff who supervise inmates in restrictive housing, a member of the Incident Review Team (a PREA Support Person who was also responsible for monitoring retaliation against inmates), and a correctional officer who acted as a first responder. Additionally, ten security staff, five from each of the two shifts, were randomly selected and interviewed. The Agency head and Agency-wide PREA Director were interviewed prior to this audit by DOJ Certified PREA Auditor Kevin Maurer, and the information was provided to this auditor.

There was one allegation of sexual abuse that was received from another facility in the past 12 months, which was investigated and determined not to have been a form of sexual abuse. There were three allegations of sexual abuse in 2015, one of which was referenced above and found to be unsubstantiated. The inmate was notified of the results of the investigation at the notifying facility. The other two allegations were investigated and determined to be unfounded. No reports involved a criminal investigation.

## DESCRIPTION OF FACILITY CHARACTERISTICS

Avery-Mitchell Correctional Institution is a medium level security facility for male inmates age 20 and above and is managed by the North Carolina Department of Public Safety (NCDPS). The NCDPS Mission, as it relates to the Prison Rape Elimination Act, is to promote the elimination of undue familiarity and sexual abuse amongst the offender population.

Avery-Mitchell Correctional Institution is situated on 100 acres of land beside the Avery and Mitchell County line and can house up to 860 inmates. There are twenty four individual housing units located within three buildings and one restrictive housing unit. On the first day of the onsite PREA audit, there were reportedly 856 inmates at the facility, thirty six of which were housed within the restrictive housing unit. The facility is operated under the Unit Management concept which allows the facility to break down a large inmate population into smaller, more manageable groups. This concept provides more individualized correctional services to inmates, while maintaining safe and humane living conditions. There are approximately 315 staff with Custody staff operating in a two shift staffing rotation system rather than the traditional three. First shift Custody staff work from 5:45 AM to 6:00 PM while second shift staff work from 5:45 PM to 6:00 AM.

There are three main housing buildings, named Avery, Watauga, and Yancey due to their historical significance in the area. Each building contains eight pods, and each pod contains thirty two or thirty six inmates. There is also a 40 person restrictive housing unit. At the entrance of each building, there are posters that provide information regarding the agency's zero-tolerance information, including "Ways to Report", "Break the Silence", and the general announcement for the on-site visits in both English and Spanish. Inmates pass these posters multiple times during a 24-hour period moving from the dorms to meals, education, vocation, and recreation. Very few Spanish posters were noted otherwise and staff were asked to address that concern. Keeping with the Unit Management concept, each housing building contains a canteen, library, barbershop, recreation room and access to the recreation yard.

All housing units contain toilets and showers that have been modified to provide privacy. Some inmates did report during the random inmate interviews that they could be seen from the control room. A review from the control room confirmed that privacy is provided in both the bathroom and showers by the addition of what was referred to as "cracked ice" Plexiglas that was added to the control room windows where the toilets and showers could be viewed. This allows for privacy, but provides security staff with the ability to supervise the area as well. The shower curtains provided some privacy, but as reported by staff, they were designed specifically for female offenders and not males. The PREA Compliance Manager indicated the new shower curtains have been requested, but are currently awaiting purchasing authorization.

In the Receiving Area, there are four bays used for inmate strip searches with cement walls that do not allow for privacy between them. In response to this concern, the PREA Compliance Manager informed this auditor that the Masonry Department would be increasing the height of the walls between the bays to allow for privacy. The PREA Compliance Manager also emphasized that there are no cameras in that area, female staff never conduct strip searches of male staff, and female staff are never in the area during that time.

Avery-Mitchell Correctional Institution provides educational and vocational programming to inmates. These include Adult Basic Education (ABE), General Equivalency Diploma (GED), Commercial Cleaning, Computer Application, Masonry, Horticulture, and Heating, Ventilation and Air Conditioning (HVAC) classes. Upon completion of the HVAC program inmates have the opportunity to obtain national licensure prior to release. Other programming offered includes religious services, Thinking for a Change, Father Accountability, Life Skills, and Human Rights Defenders (HRD) Focus on Freedom.

Job assignments include both internal and external opportunities. Externally, some inmates work with the North Carolina Department of Transportation on road squads. Internally, inmates are provided jobs as dorm janitors, barbers, grounds keepers, Maintenance, loading dock workers, and kitchen workers.

Both medical and mental health staff are available at the facility. Medical staff are available twenty four hours per day/seven days per week. Mental Health staff provide daily coverage; however, coverage on the weekends is only available through an on-call system whereby staff will come to the facility once contacted and if necessary. In the event of a sexual assault, inmates would be transferred to Blue Ridge Regional Hospital in Spruce Pine, NC, which does not have Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) on staff, but are reportedly scheduled to receive the necessary training in early Spring. If it is determined that SAFE or SANE staff are needed, the inmate would be transferred to a sister hospital in Asheville, NC to do so. Discussions are reportedly in progress with GRACE Hospital in Morganton, NC as well.

The facility also has a Sexual Assault Response Team (SART) which includes the Facility Superintendent/Administrator, Assistant Superintendent of Custody/Operations, Assistant Superintendent of Programs, PREA Compliance Manager, PREA Investigators, and Medical Supervisor or Mental Health practitioners. There are currently seven investigators and seven PREA Support Persons (PSP). Although currently there is no contract with a local rape crisis center, there is a pending MOA with Mitchell County SafePlace in Spruce Pine, North Carolina. In the meantime, PREA Support Persons are staff who have been trained to assist the victim through all processes, including providing assistance in obtaining outside support services.

## SUMMARY OF AUDIT FINDINGS

It was clear that Avery-Mitchell CI and the NCDPS have a firm commitment to meeting the requirements as set forth in the PREA Standards, not only in policy, but in practice as well. Throughout the process, facility staff were professional, organized, and knowledgeable of the PREA requirements as well as most resources available at the facility level. Administration was responsive to concerns, open to suggestions, and encouraged the auditor to provide feedback on how the facility could improve where applicable. The facility's choice of staff to fill the PREA Compliance Manager position was excellent as staff and inmates alike offered only the most complimentary feedback, which was often unsolicited. Overall, it was an absolute pleasure to work with the Administrator and staff during this process, and this auditor was appreciative of the facility's hospitality and ability to facilitate this process as requested.

Communication and its value in the effective implementation of the PREA requirements were evident throughout this process via documentation and staff interactions with this auditor. Communication efforts were enhanced through the use of information technology, including the presence of emergency call buttons in each of the RHU cells and NCDPS's impressive development of the Electronic Rounds Tracking System, which employs a tablet device in the process of completing rounds with greater staff accountability. Surveillance camera coverage within the facility is impressive as well. Staff report there are 108 cameras, 98 of which are integrated into the network. Furthermore, the facility has installed motion sensors in all closets or smaller rooms that have blind areas when observing through the window. During rounds, any light on indicates that someone is in the room and thus requires further investigation. Ten of the aforementioned cameras are older fixed position cameras that only provide real time monitoring and do not allow for recorded coverage. It is recommended these cameras are upgraded to allow for network coverage when possible.

Despite the use of such technological advancements, a significant number of blind spots remain where surveillance is not available. These blind spots, in addition to the loss of key security posts throughout the facility, have made security efforts more challenging. The posts included positions in the Programs Department, Receiving Control, Medical Office, and within the RHU. Specific concerns related to blind spots were addressed in the interim report and shared with Administration, including those identified at the Foothills Minimum Custody Unit.

Prior to this auditor's involvement in the process, G4S Youth Services, Inc., had already expressed concern that the agency is only identifying inmates who are sexually aggressive based on the completed Risk Assessment. While they are gathering all the information necessary for identifying those inmates Vulnerable to Victimization, this information is not tracked nor used to determine housing, work, and programming assignments. The agency's current system is to provide appropriate protections for all inmates from those identified as sexually aggressive. Per a prior conversation between G4S Youth Services, Inc. staff, the agency-wide PREA Director, and e-mail correspondence with the PREA Resource Center (PRC), it was confirmed that the standards require both populations to be identified in order to provide appropriate protections. The agency has been responsive to this information and is currently working towards the creation of an objective tool to be implemented in the next six months as well as systems for identification and inclusion into the housing, programming, and work assignment determination process.

Related to this concern is the facility-based PREA Compliance Manager's inability to identify or track those inmates determined to be at risk for victimization and an inability to access specific OPUS (Offender Population Unified System) screens that would allow them to review that information and their reported lack of authorization / involvement in administrative PREA-related investigations until they have been completed. In essence, the PREA Compliance Manager in all likelihood would not have awareness of potential victims at his or respective facility until a problem had arisen. Although PREA Compliance Managers are not given the profile to read an investigation report in OPUS, the agency PREA Coordinator states that the PREA Compliance Managers have sufficient involvement or awareness of facility-based PREA-related administrative investigations through communication within the Sexual Assault Response Team and their role in monitoring staff retaliation. The facility-based PREA Compliance Manager; therefore, does have sufficient time, but does not have sufficient information to comply with the PREA standards at the time of the site visit.

G4S Youth Services has also contacted the PREA Resource Center to determine if the current system in place, specifically the annual LMS system (Employee Statements) and requirement to report any offenses, is enough to satisfy requirement 115.17 (e). It is this auditor's interpretation of the standards that it is not because a staff member would likely not report anything that they know would result in their termination. A formal criminal background check every five years would be an appropriate check and balance. Compliance will be determined based on the PRC response.

When inmates arrive at the facility, policy and staff and random inmate interviews confirm that inmates are immediately provided with a comprehensive facility-based orientation booklet that provides an excellent overview of the facility's zero tolerance policy along with specific instructions on how to report sexual abuse or harassment, both within the facility and to an outside agency. Currently, the facility is in the process of working out an agreement with a local rape crisis center, Mitchell County SafePlace, per an e-mail dated 5-18-15. In the meantime, the facility trains select employees to serve as PREA Support Persons (PSP) to meet the requirements of this standard, which is excellent. The PSP plays an important role in assisting the victim through the various activities associated with an allegation (investigation, medical exam, interview, support services). Currently, Avery-Mitchell has seven trained PREA Support Persons. The day after arrival inmates receive an orientation regarding the facility's PREA program, which far exceeds the thirty day requirement. A review of eighteen inmate records revealed that all had been oriented within the thirty day requirement; thirteen of those had been oriented the following day and the longest delay was eight days after admission.

Seven of the fourteen records reviewed indicated the inmates had been screened for risk more than seventy two hours after admission as required per the standards. Upon review, it was found that the facility-based policy indicated screenings are conducted within three business days rather than seventy two hours. The PREA Compliance Manager indicated that oversight would be corrected immediately.

Two letters were received from inmates in advance of the audit and a third was received after the on-site audit had been completed. This auditor met with the two inmates whose letters had already been received to discuss their concerns. As a result of the conversations, a corrective action was added to remind staff on how to communicate with gay, bisexual, transgender, or intersex inmates in a professional manner. The third letter reflected a concern that had already been identified by this auditor. More specifically, the shower curtains were not designed to provide privacy for men. The PREA Compliance Manager is in the process of addressing this concern.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 4

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

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

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

Policy F3400, Policy A2000, SOP 05.09 (a-g), Form OPA-A16, NCDPS Organizational Chart, NC State Statute 14-27.7, and NCDPS Memo dated 10/27/15, that identified the PREA Compliance Manager, were reviewed. The Administrator and PREA Compliance Manager were interviewed.

The agency has a policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy, along with additional policies 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 for Programs reported sufficient time to attend to PREA duties. Although PREA Compliance Managers are not given the profile to read an investigation report in OPUS, the agency PREA Coordinator states that the PREA Compliance Managers have sufficient involvement and awareness of facility-based PREA-related administrative investigations through communication within the Sexual Assault Response Team and their role in monitoring staff retaliation. The PREA Compliance Manager reports directly to the Administrator, and indirectly to the Agency PREA Coordinator. The agency PREA Coordinator reports to general counsel, sufficient time to attend to PREA duties, and currently has 140 PREA Compliance Managers that report to her indirectly.

**CORRECTIVE ACTION:** The PREA Compliance Manager has sufficient time, but does not have authorization to view OPUS (Offender Population Unified System) screens that would help him identify inmates considered to be at risk for victimization. This item was corrected on March 17, 2016 when the agency PREA Coordinator provided documentation that the agency now produces a High Risk for Victimization (HRV) list that is reviewed in addition to the High Risk for Abusiveness (HRA) list to ensure that all housing, work, and programming services are assigned with the protection of the inmates as a key factor.

### 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)

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

### Standard 115.13 Supervision and monitoring

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

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Policy F1600, SOP 5.32, Staffing Plan Report dated January 2015, Approved Facility Posting Chart/Staffing Plan approved 06/08/15, OIC Round Documentation, Unannounced staff rounds documentation for 3 housing buildings, and North Carolina State Statute 143B-709 were reviewed. Additionally, interviews were conducted to further determine compliance.

While state statute requires a staffing analysis every 3 years, the agency policy requires an annual review of the staffing plan, including a review of all required components of the standard, which was completed in January 2015. Deviations from the staffing plan are documented on the Daily Shift Report as per policy. Unannounced rounds are conducted by the Officer in Charge. Interviews with the PREA Compliance Manager confirmed that upper level management conducts unannounced regularly; however, a review of several log books indicated that staff need to more clearly indicate when the rounds conducted are "unannounced rounds." This issue was addressed during the thirty-day post-audit period. Documentation (scans of three unit log books) was provided that clearly reflected that this issue was corrected. Further, documentation (shift narratives and signed review sheets) was provided that this issue was covered in line up.

### **Standard 115.14 Youthful inmates**

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

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This standard is Not Applicable as this facility does not house any inmates under 20 years of age.

### **Standard 115.15 Limits to cross-gender viewing and searches**

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

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Policy F1600, Policy F0100, Policy TX I-13, SOP 5.19, Safe Search Practices Training, NCDPS New Employee Orientation (revised 1/1/15), Cross Gender Announcement & Acknowledgement for staff, Staff Training Log, and Cross Gender Bulletin Board Poster Memo (dated 4/22/13) were reviewed. Interviews were also conducted to assist with the determination of compliance.

The agency has trained all staff on cross-gender viewing and searches. Cross gender staff entering the housing areas are required by policy to announce their presence, as observed during the tour. Policy requires documentation of any cross gender searches. There were no reported cross gender searches conducted. Training documents reviewed indicated that staff have completed appropriate training.

Staff interviews indicated that while the staff have received training, they were unable to articulate the agency policy, regarding transgender/intersex searches. During the tour, it was discovered certain areas did not contain privacy to inmates using toilets. These areas were addressed with the PREA Manager.

Prior to the 30-day report, the facility met with all staff regarding transgender/intersex searches and provided refresher training. This is documented on Shift Security Rosters for February 24, 26, and 28, 2016, to cover all three shifts.

### **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)

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Policy E1800, Policy E2600 and World-Wide Interpreters Telephonic Interpreter Services Contract were reviewed. Facility documents in both English and Spanish were observed during the tour. The agency has established policy to provide for educational services for inmates with disabilities to be provided information 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 in effect with World-Wide Interpreters Telephonic Interpreter Services Company that was signed on 5/21/2014 and is in effect for a 1 year period, with 2-1 year extensions, for a total of 3 years. Policy prohibits the use of inmate interpreters except in emergent circumstances.

That said, this facility is not designated by DPS Population Management as a facility approved to house Spanish speaking inmates. Inmates housed at this facility speak English sufficiently, as determined during the admission process, to function in an English-only speaking environment. Subsequently, this facility does not offer English as a Second Language (ESL) classes, as is the case in facilities where Spanish speaking inmates are housed.

### **Standard 115.17 Hiring and promotion decisions**

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

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

The agency policy prohibits the hiring or promotion of individuals who have engaged in sexual abuse, or attempting to engage in sexual abuse in a detention facility or in the community, or who have been civilly or administratively adjudicated for the same. The agency requires all staff to annually sign a statement that they have not engaged in the aforementioned activities (PREA Hiring & Promotion Prohibitions and HR005). This information was reviewed through the LMS (Learning Management System) and copies were provided to the auditor. The agency also requires all employees to self-report any such misconduct. Criminal background check are required for contractors, and material omissions regarding misconduct or false information are grounds for termination. The agency does respond to requests from other institutions where a former employee has applied to work.

**CORRECTIVE ACTION:** During the site visit, it became clear that the facility and agency did not conduct background checks at least every five years. A memo dated February 25, 2016, from the facility's Administrative Officer stated that the agency is in the process of conducting a background screening of all facility employees hired prior to 2012. In March 2016, the agency updated their systems to

include a 5-year background screening for all staff. Proof of these screenings was provided to this auditor by the Agency PREA Coordinator.

### **Standard 115.18 Upgrades to facilities and technologies**

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

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

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

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

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Policy F3400, Policy CP18, Form OPA-A18, Form OPA – 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, and NCCASA were reviewed. Interviews also provided information in the determination of compliance.

The agency conducts only administrative investigations. The Mitchell County Police Department completes all criminal investigations. Uniform Evidence Protocols are in policy and are appropriate. The Agency has seven PREA Support Persons (PSP) who are trained for victim advocacy services, and acts as the link to assist victims with the investigative process, professional resources, community based advocates, and mental health professionals. There is an Incident Scene Tracking Log for documenting persons who may enter a possible crime scene before investigators are on-site, as well as a Chain of Custody form for documenting any evidence. 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. Forensic examinations are conducted at the Stanly Regional Medical Center.

The facility is in the process of developing a relationship and MOU with the Mitchell County SafePlace rape crisis center.

### **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 in-house trained investigator for the administrative portion and to the local 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 F3400, Training Curriculum's SAH 101 04/08/13 and 07/01/15, Staff and Offender Relations Training, New Employee Orientation, Form OPA-T10, Employee Training Files, brochures, handbooks, and other documents were reviewed. Interviews with staff were also conducted. The agency policies require annual training for all staff in all areas identified within the standard. Interviews with staff confirmed they complete annual training and understand the material presented. Training documentation is kept in LMS (Learning Management System). Employee training documentation found that all staff had completed their annual training (PREA: Sexual Abuse and Sexual Harassment 101). Staff were able to articulate the training they had received.

During the on-site audit an inmate who identified himself as gay and another that said he was not, but was perceived to be, reported frequent related inappropriate comments by a limited few staff. During the 30-day post audit period the facility addressed this issue during shift change meetings. Documentation (signed shift narratives and review sheets) was provided.

### **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 04/08/13 and 07/01/15, Staff and Offender Relations Training, New Employee Orientation, Form OPA-T10, "Ways to Report" Poster, Volunteer Brochure, and other documents were reviewed. Volunteer interview also confirmed training.

The agency requires all volunteers to complete the same training as a staff, with minor deviations. There is also a "Ways to Report" poster to remind volunteers and contractors of the various ways to report. An interview with one of the contractors confirmed that the training was completed and the volunteer understood how to report. The file review 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 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. Agency policy requires all inmates entering into the system to receive intake and comprehensive training at the reception and diagnostic center. Facility 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 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 housing building. Although the facility does not admit inmates that speak only Spanish, it provided pictures of bulletin boards in several units that held PREA information in Spanish.

### **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. The facility has seven designated investigators who have completed specialized training for this purpose. The training meets the requirements of the standard. An interview with an investigator found that they were well versed in the administrative investigation process. 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 Mitchell County Police Department. The auditor reviewed training documentation of identified investigators.

### **Standard 115.35 Specialized training: Medical and mental health care**

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

***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. Interviews with medical staff confirmed knowledge of specialized training; however, the medical staff interviewed had not yet completed the specialized training. During the 30 day review, the medical staff member completed the training and a training roster was provided to the auditor. Forensic examinations are not conducted at this facility and therefore no training was provided.

#### **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. However, the current system allows only for the identification of sexually aggressive inmates (High Risk Abuse Report). While information is obtained regarding vulnerability, there is not an objective tool for the identification of inmates who are vulnerable to victimization. This assessment is required to be reviewed within 30 days of intake. If the inmate reports a history of victimization or is identified as being sexually aggressive, notification is made to medical, the Administrator and the PREA Compliance Manager to initiate services as required by policy. The policy prohibits inmates from being disciplined for refusing to answer questions from the screening. Only those staff with appropriate credentials have access to this electronically maintained information.

Seven of the fourteen records reviewed indicated the inmates had been screened for risk more than seventy two hours after admission to Avery-Mitchell as required per the standards. Upon review, it was found that the facility-based policy indicated screenings are conducted within three business days rather than seventy two hours.

**CORRECTIVE ACTION:** The agency must update the screening tool to include an objective method of identification of those inmates who are vulnerable to victimization. This must be implemented at Avery-Mitchell for all new inmates, as well as all standing inmates reassessed for vulnerability. This tool shall be provided to the auditor for review, along with a sample of those inmates at Avery-Mitchell who may now be identified as vulnerable to victimization. There must also be a plan to complete the remaining standing inmate population. Within the thirty day period following the on-site visit, Avery-Mitchell corrected the policy requiring new admissions to the facility to be re-screened within seventy two hours of arrival rather than three business days.

In response to the aforementioned Corrective Action Plan, on March 17, 2016, the agency PREA Coordinator provided to Bobbi Pohlman-Rodgers, DOJ Certified PREA Auditor, documentation that the agency now produces a High Risk for Victimization (HRV) that is reviewed in addition the High Risk for Abusiveness (HRA) list to ensure that all housing, work, and programming services are assigned with the protection of the inmates as a key factor. This information was subsequently forwarded to this auditor for review. 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 lists. These lists are protected from view by staff who do not have an immediate need to know and access is only provided to the Facility Head, the PREA Compliance Manager, Assistant Superintendent for Custody and Operations, Assistant Superintendent for Programs, and the Inmate Assignment Coordinators (IAC). It is the responsibility for designated staff to run these lists weekly to review for appropriate placement. This facility was then required, and has completed as of March 18, 2016, a review of all inmates on the HRV and HRA lists 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, Screening tool, Learning Management System (LMS) Material, and the Instructions to access the High Risk Abuse Report were reviewed. Interviews were conducted.

The policy addresses clear guidelines, including limits, for housing and work assignments based on the safety of all inmates. The policy requires a bi-annual review of housing for transgender and intersex inmates. The policy also provides for all transgender and intersex inmates to shower separately from all other inmates, and are assessed for their own perception of risk at the facility. While the agency has identified those inmates deemed at high risk for sexual aggression, and have implemented methods of reviewing all housing, programs, and work assignments to ensure the safety of all other inmates, the agency does not currently have a system in place for those inmates who are identified as vulnerable to victimization.

**CORRECTIVE ACTION:** Once the agency has updated their current screening system to include the identification of vulnerable to victimization inmates, the facility will need to review the housing, work assignments and programming to ensure provisions for a safe environment from those inmates identified as sexually aggressive. Proof of this review must be provided to the auditor.

In response to the corrective action plan, on March 17, 2016, the agency updated their current system to now include a review of the High Risk Victimization (HRV) and High Risk of Aggressive (HRA) list at the facility on a weekly basis, or more often if necessary, to ensure that inmates are placed in educational, vocational, and housing that ensures their safety. Inmates that are identified as HRV are now placed in a closer proximity to the staff in the housing units. This information was provided to the auditor to show that on March 24, 2016, Avery-Mitchell CI initiated this new system and made changes in order to protect 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.

Agency policy prohibits the involuntary placement of inmates in segregated housing unless there are no available alternatives. Policy and interviews confirm that services for an inmate who may be placed in protective custody are continued as normal unless there is a specific documented reason for restriction. Policy dictates documentation of the use of protective custody when necessary and 30 day reviews of such placement. During the on-site audit some staff stated they do not discuss alternatives prior to placing inmates in segregated housing. The facility addressed this during the 30 day post audit period and provided documentation that this issue had been addressed during line ups.

### **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). It was confirmed through conversation with the administration that mail sent to the PSL or the PREA Coordinator is treated as legal correspondence and is not opened at the facility level. The posters in the facility provided the address for PLS, 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 Hotline or through email with the PREA Coordinator if they do not wish to report through the Chain of Command.

Department policy requires that a "toll free PREA telephone number for reporting directly to the PREA office incidents of sexual abuse and sexual harassment where applicable" be made available; however, the agency stated that this is only available in facilities that hold female inmates.

#### **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. A box is used by inmates to submit grievances and those boxes are checked daily by supervisory staff. There is no requirement to use a less formal method of reporting prior to a written grievance. There is no disciplinary action if the report is made in good faith. A final response is due within 90 days, as well as notification to the inmate that it has been accepted within 5 days. Grievances are allowed to be prepared by the victim or other third party person who assists the victim. Emergency grievances, those defined as matters that present a substantial risk of physical injury or irreparable harm may be presented directly to the 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.

#### **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.***

SOP 4.54A and PREA – The North Carolina Approach were reviewed. Inmate interviews confirmed findings.

The facility has a MOU pending for the provision of outside support services for inmates. In the meantime, inmates are provided notification of the PREA Support Services through Form 130, which documents the PREA Support Persons role during the investigation and thereafter to assist in providing support services to the victim. Currently, the facility has seven staff trained as PREA Support Persons. The facility is in the process of developing a relationship and MOU with the Mitchell County SafePlace rape crisis center.

**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 PREA Coordinator or send an e-mail through the link provided. Both options will result in the PREA Coordinator receiving the complaint. The PREA Coordinator will then generate an incident report and inform the Superintendent. 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 4.54, SOP 4.54A, and PREA 101 Staff Training were reviewed. Staff interviews confirmed findings.

The agency policy requires all staff, volunteers and contractors to immediately report any knowledge, information or suspicion of sexual abuse or sexual harassment, and any violation or neglect of responsibility, to administration. Contractor contracts include a requirement for reporting any information regarding sexual abuse. Policy and interviews confirmed that staff are not allowed to share information with anyone who does not have a need to know. All allegations are reported to both the facility investigators and the PREA Coordinator. Agency staff training details the notification to the state agency regarding vulnerable adults.

**Standard 115.62 Agency protection duties**

- Exceeds Standard (substantially exceeds requirement of standard)

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

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

Policy 3400 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 this to the facility investigators who will assist with taking appropriate steps for protection. Staff were able to articulate this requirement during the interviews. There were no allegations of this type in the past 12 months.

### **Standard 115.63 Reporting to other confinement facilities**

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

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

Policy 3400 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 PREA Coordinator. Allegations made by an inmate at another facility are treated the same as a new allegation, and facility investigators are notified and begin their review of information. There was one incident that was reported by another facility. Notification was made to the facility after the inmate made the allegation. As per policy, this was investigated.

### **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 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 4 instances in this facility where the first responder was first on the scene. A document review shows that appropriate steps were taken, including appropriate notifications.

### 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 05.09, Coordinated Response Plan and Coordinated Response Overview were reviewed. Interviews were conducted and confirm findings.

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

### Standard 115.66 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 Avery-Mitchell 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 agency updated their form to include spaces for documenting the date and information of

these status checks and has implemented this agency wide. It is noted that there were no cases of substantiated or unsubstantiated sexual abuse at Avery-Mitchell CI or of instances of reported or of retaliation at this facility.

#### **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 complete the Request for Protective Custody and must document the reasons for the request. Inmates who are placed in involuntary protective custody are seen every seven days by a counselor who documents this check. Unless documented, all inmates are provided the same programs and services as prior to their placement. Additionally, the Classification team reviews all placements of Protective 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, 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 basis. 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 after 8/20/12.

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

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

- Does Not Meet Standard (requires corrective action)

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

Policy F3400 was reviewed. 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 include specific mention of the status of the alleged offender. These forms were found in the files reviewed along with the inmates signature, signature of the staff making the notification, and the outcome of the investigation.

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

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

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

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

The agency policy provides for disciplinary action towards staff who violate the zero-tolerance policy, up to and including termination. All disciplinary actions are reviewed individually based on the nature and circumstances of the allegation. Comparable offenses by other staff are also considered in a final determination of disciplinary action. All staff terminations are required to be reported to the state licensing body. There were no instances where staff required such discipline in the past 12 months.

### **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 violates 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. 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 referrals to medical and mental health services after information of prior sexual victimization or sexual aggressive behaviors is discovered during the screening process. Services are provided within 14 days by facility medical and mental health staff. Interviews confirmed informed consent is obtained 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 mental health social worker or PREA Support Person (PSP). Mental Health staff confirm notification. Additional counseling services are available as identified and as requested by the victim through the PSP (PREA Support Person). Provisions for STD testing and treatment are provided at the facility level based on physician orders and/or victim request. All treatment related to sexual abuse is offered without financial cost to the victim regardless if they name the perpetrator or not.

### **Standard 115.83 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 and consistent with the community level of care. Follow-up care is provided within two weeks, as well as can be requested by the victim. STD testing and treatment is offered. Again, all services are provided to the victim without financial compensation. The agency also offers evaluations to sexual aggressive inmates when information is present.

### **Standard 115.86 Sexual abuse incident reviews**

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

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

Policy F3400, Form OPA-I10, and Coordinated Response Overview were reviewed. Completed OPA-I10 forms were reviewed. Interviews confirmed findings.

The agency requires a Post Incident Review (PIR) at the conclusion of any investigations of sexual abuse determined to be substantiated or unsubstantiated. Form OPA-I10 is completed. This is a standardized form that contains all elements of the standard. Participants include the PREA Compliance Manager and SART members, who are comprised of upper level management and input from other staffing positions, including medical staff. There were no Post Incident Reviews completed in the past 12 months.

### **Standard 115.87 Data collection**

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

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

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

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

### **Standard 115.88 Data review for corrective action**

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

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

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

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

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

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

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

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

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

**AUDITOR CERTIFICATION**

I certify that:

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

Walter J. Krauss, Psy.D., USDOJ Certified PREA Auditor  
Auditor Signature

April 24, 2016  
Date