PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

COMMUNITY CONFINEMENT FACILITIES

Date of report: Dec 21, 2016

Auditor Information			
Auditor name: Art Beeler			
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Email: afbjab@aol.com			
Telephone number: 919-986-9155			
Date of facility visit: June 20 – 21, 2016			
Facility Information			
Facility name: Calvalcorp, LTD			
Facility physical address: 312 Tryon Road, Raleigh, North Carolina 27603			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 919-773-1834			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☒ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Robert Calallaro			
Number of staff assigned to the facility in the last 12 months: 18			
Designed facility capacity: 56			
Current population of facility: 56			
Facility security levels/inmate custody levels: Community/Low			
Age range of the population: 18+			
Name of PREA Compliance Manager: Click here to enter text.	**Title:** Click here to enter text.		
Email address: Click here to enter text.	**Telephone number:** Click here to enter text.		
Agency Information			
Name of agency: Click here to enter text.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: Click here to enter text.			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: Click here to enter text.			
Agency Chief Executive Officer			
Name: Robert Cavallaro	**Title:** CEO		
Email address: rj@cavalcorp.com	**Telephone number:** 919-773-1834		
Agency-Wide PREA Coordinator			
Name: Dori Jones	**Title:** Office Manager/PREA Coordinator		
Email address: djones@cavalcorp.com	**Telephone number:** 919-773-1834		

AUDIT FINDINGS

NARRATIVE

There were several issues noted in the review. For ease of reference, I have listed the issues found. This list may not be all inclusive, but represents findings which were discussed at the closeout or came about from clarification through correspondence.

1. The male shower facilities are basically what would be categorized as a gang shower. The facility had installed curtains to provide some privacy, but it was not enough. To meet the standard it is suggested a checkerboard system of curtains be developed much like in the pattern of ceiling tile so that individuals would have private shower areas. By doing it in this fashion the standard is met and it can be done without significant cost to the facility. (The facility has agreed to complete this in the near future)
2. The facility has not completed a staffing plan to demonstrate staffing considerations in regards to PREA and the video monitoring which takes place. A cursuory review demonstates with male and female monitors on the second and third shifts there is sufficient staffing. However, this needs to be documented in a formal sense. I provided a template the facility may choose to use. I also indicated that the facility would need to find a way to make that document available to the public. (Completed)
3. It was suggested that the facility develop a webpage to assist them in documenting issues regarding to PREA and making them available to the public. A developed webpage can be used for so much more to include distribution of rules and regulations for the resident and their family. So the creation of a webpage would not simply be something for PREA, but could be used in a great many areas. (The facility agrees and will work on completion)
4. It was suggested that the facility purchase a laptop where PREA orientation for residents can be viewed. The PREA coordinator, who has a multiplicity of other assignments could place the resident(s) in eyesight of the monitor, have them watch the material and then come back to answer other questions. Again, there is no requirement for this, but in reviewing the facility, it seems logical to suggest this as a best practice. Having all of the material pre-loaded and available for review by incoming residents should obviate any longer than 72 hour lapse in residents receiving initial education and orientation. This laptop could also be used by any offender who might be deaf to either use the captioning service to communicate with loved ones or others or as in most cases these days lip read or read the sign language of the person on the other end with Skype of similar software. The facility will need to think of a contingency plan if the family of the offender does not have a computer or smartphone. (The facility has agreed with this suggestion and will implement in the future.)
5. There is no private space for the PREA coordinator or an investigator to conduct private conversations with a resident. The only private space is in back of the monitor's station which is a storeroom. This area is not conductive to professional conversations. The lack of this private space is not going to inhibit the audit; however, as the facility becomes more involved in PREA, it is absolutely essential that conversations regarding sexual safety, sexual harassment and sexual abuse are conducted in an area where confidential conversations can be held. (Unless there is major construction, the facility has no way to accomplish this. The facility has assured me that they will take steps to make certain confidential conversations are maintained in private. While this is not optimal, this is acceptable and I will mark this as completed.)
6. It will be required fot the facility to have all of their PREA policies and procedures translated into Spanish. During my review of the facility there was an English deficient resident, who needed this service. In a like manner it will be necessary for the facility to obtain the services of someone who could provide confidential translation services for residents, when necessary. It was suggested that the facility develop a contact with a language line to provide this service. (The facility is working on competing this process.)
7. In a review of Standard 217, it was found that staff had not been asked the "three questions relative to sexual abuse" prior to employment. A template of the three questions was provided for all the staff to certify. Additionally, there was not evidence that those with prior institutional experience had been vetted with their previous places of employ concerning if they had sustained cases of sexual abuse or harassment. The Bureau of Prisons does a background check on any employee who is to work at the facility, but there was no evidence that any vetting regarding sustained sexual abuse issues had been accomplished. Since it appears this will be a facility issue, it was suggested that the facility develop a letter to send to the previous institution asking the question as outlined in the standard with a date for it to be completed. If the RRC does not receive a response in that time frame, they may should they choose call the previous employer. However, it is my opinion as an auditor that due diligence has been completed by the sending of a letter which is return receipt requested. (The three questions have been asked to every employee. A letter template has been developed to ask questions should someone be hired who has previous institutional experience. If there are current employees who have previous institutional experience this letter needs to be forwarded.)
8. While it is evident that the PREA coordinator has worked diligently with INTERACT (crisis center) to develop an agreement as to what services would managed by them, there is no MOU or letter of agreement on file. It is required there is at minimum a letter of agreement demonstrating the services which INTERACT will manage. (As a sidebar, INTERACT has told the facility they will provide people to accompany victims of sexual abuse to the hospital if wished). (INTERACT has provided a letter regarding services they will render. The facility is waiting a letter from the mental health provider. Therefore this finding remains open.)
9. During the course of the review, two PREA "investigations" were reviewed. Neither investigation comported with a system of records which could be called upon to demonstrate a complete and through investigation. Upon a review of the documentation, it was believed that the RRC did not have the responsibility to complete the investigation, but rather it was the responsibility of the RRM's office. However, correspondence received suggest that the RRM is holding the RRC accountable for the investigation when they are empowered to complete. Tere a need for the identified RRC staff to complete relevant training regarding sexual

abuse investigations, and to develop a standardized investigatory packet. The policy practice of referring all allegations for review by the local police department is deemed appropriate. If this has not been codified into local written policy it should be so documented. Subsequent to the completion and approval of an administrative investigation, the resident is notified in writing of the outcome of the investigation. Any criminal investigation would be under the purview of the law enforcement agency conducting it. That the preponderance standard of evidence articulated as the standard used in conducting administrative investigations should be codified in local policy. (The standards regarding investigations and the completion of investigations have caused more consternation than any other. The RRC is acting as a contractor for the Bureau of Prisons. As such the RRM has indicated it is the responsibility of the RRC to ensure investigations are complete and comport to the requirements of the agency. As it appears the RRM's office is not inclined to provide a template for investigations, I have suggested the three centers in Central NC develop an investigatory template. Upon completion of this template, it will be reviewed to determine standard sufficiency. A larger issue, which is not going to be resolved at the facility level is the training of BOP personnel who would conduct staff investigations. There is no evidence that the RRMs office or other BOP offices empowered to conduct investigations have received the training as outlined in the standards. A telephone call to the Chief, OIA demonstrates that OIA agents have had some training. Since BOP indicates they will conduct staff investigations, and BOP is part of DOJ, it is clear there should be demonstration that those empowered to conduct PREA staff investigations have received the training requisite by PREA. Additionally, the records, according to the RRM would have to be requested for review via a FOIA request. This is counter to the standard as well. As indicated this is beyond the scope of the RRC. I have corresponded with the RRM regarding this and will be corresponding with NCCD. A second staff member will be trained at Calvacorp to conduct investigations. This has not occurred as yet. This remains open)

10. It is suggested because the program director makes all decisions concerning staff discipline, she be removed from the role of a staff investigator for PREA. It is suggested there be two staff investigators (people who have completed the training) so that the PREA coordinator has coverage when she is on vacation or otherwise not at the facility. The facility agrees witih this suggestion and this matter is competed.)
11. Currently, the PREA coordinator conducts the Risk Assessment and the 30-day follow-up. It is recommended to develop a system of checks and balances that the case managers complete the initial risk assessments and have them reviewed by the PREA coordinator. Additionally, the PREA coordinator should inform staff and document her discussion with staff regarding anyaccomodations made because of a Risk Assessment. The case managers should also complete the 30-day review and document not only the review but if the resident needs any follow-up education at that time. Toward this end case managers will need to receive specialized training on conducting risk assessments. (As soon as the case managers complete training to conduct risk assessments and follow up, this will be completed.)
12. That the program director be responsible for monitoring any allegations of retaliation. That this monitoring be documented and maintained in a systems of records as identified in local policy. Guidance is found in 115.267. (The center has agreed that the program director will monitor and document retaliation. This is deemed completed.)
13. The PREA coordinator has established good relationships with many in the community. They have all told her of their willingness to provide services in line with their mission. The PREA coordinator needs to obtain at a minimum a letter of agreement from each of these outside providers indicating what services they would provide. (This will be deemed completed as soon as the center receives letters of agreement from all parties. In the next three years, it is recommended that memorandums of understanding be completed with all outside agencies providing services.)
14. The practice of establishing a SART (Sexual Abuse Review Team) be codified in local policy and that local policy articulate the issues the review team will cover. As it is anticipated there will be few reviews, it is suggested a checksheet be developed on the requirements of this team and their responsibilities. (As soon as the template for review is completed and shared, this will be completed.)
15. That the PREA coordinator develop a list of topics covered in both inmate education and staff training. This list should be placed on some sort of record to document specific topics discussed. Upon completion of the training, the resident or employee initial each of the topics discussed, and the record be maintained in a systems of records. The annual training for staff be documented in much the same fashion. (As soon as the checklist for staff is complete to cover the topics staff received training on this will be complete.)
16. That at the next training session for staff on PREA significant time is spent discussing the concepts of sexual identity. While all staff had been so trained, it is clear this is a new issue for some and while all staff articulated they would be professional, some cited their uncomfortableness dealing with issues of sexual identity, especially as it related to transgendered residents. (This training will be conducted and documented. This matter is complete.)
17. That there be a procedure outlined in local policy as to the scope and nature of the types of data to be maintained. That policy documents how long such data is to be maintained. And that the policy indicates why they are maintaining the data. It is recognized there can be no analysis of data at this point and time, but after the first year, there is discussion had in the annual report on the data being analyze and if it provides turning points for local policy changes. (The data to be maintained needs to be articulated in policy. The policy does indicate the records will be maintained for 10 years. As soon as the center determines the type of data they are going to maintain in their policy, this matter will be deemed completed.)
18. That a time frame be established each year for the PREA annual report of the facility to be completed and made available to the public. This is where a webpage again would assist in not only meeting the standard but increasing program transperancy. (The center has agreed to a webpage so they can post information regarding PREA and other information. While the center has some flexibility regarding when their annual report is due, a annual report needs to be completed no later than June 30, 2017.)
19. The development of an emergency area for the temporary placement of a victim identified as being sexually abused needs to be established with staff trained as to the location of this temporary area. (The center understands the physical layout of the facility

does not provide for an way to separate any residents one from another. They have determined if there is a temporary need to maintain separation from other(s) until arrangements for transport are obtained, the resident needing separation will be maintained in a storage area which exists behind the monitors desk. While this is not optimal, it is better than not having that level of protection.

s the reader can tell, during the on-site review there were findings of approxoimately 20 deficiencies keeping the facility from obtaining PREA accreditation. Over the next several months the facility worked diligently in rectifying these deficiencies. A follow up on site review was conducted with the following found.

1. The facility created private shower areas in the shower by using curtains to provide separation. When construction becomes possible, separate shower stalls should be constructed; however the creative use of shower curtaining provides the privacy mandated by PREA. The downfall is not having an area to store clothing or a towel; however, it meets minimum standards.
2. Calvacorp has incorporated a staffing plan. It is important they remember to publish this staffing plan annually. It is suggested this become a part of their annual plan.
3. At the time of the on-site review, Calvacop did not have a methodology of sharing information publically. A suggestion was made they create a web page for this use among others. At my last on site review, they indicated they had hired an IT person to create a web page. This is not a requirement for PREA, but it certainly makes publication of issues and rules easier.
4. A laptop computer was purchased for the PREA coordinator. Part of the reason was for her to create training on the computer for PREA so that she did not have to do it in person each time except to answser questions. Additionally, this means if she is out of town and there are new arrivals, PREA training can occur within 72 hours. Another staff member (program director) can answer questions of new arrivals.
5. During the time of the on-site visit, the PREA coordinator did not have a private office, which in effect did not give her a private area to discuss sexual safety with residents or staff. During my follow-up visit I was told at the present time there were not plans for a private office, but I was told, the PREA coordinator would use the area behind the officer's station to conduct private discussions or the vacated dining facility. While it is not optimum, and I strongly advise the facility find a way to create private space for the PREA coordinator, nothing in the standard mandates a private office. It only mandates an area where confidential conversation may take place. Given the assurance of the PREA coordinator that she will maintain confidentiality, I reluctantly agreed.
6. Local PREA policies have been translated into Spanish. The training video has been translated into Spanish and the staff have contacted a language line to use in the case staff are not available to translate.
7. The questions to be answered by every staff member relative to PREA were completed by every staff member with the results placed in their personnel files. There were no cases where there was positive information reported.
8. The PREA coordinator received information from Interact regarding the scope of services this agency would provide to those involved in allegations of sexual safety. For the purposes of this review a letter is acceptable; however, a memorandum of understanding between the agency and the center would be preferred.
9. The PREA coordinator has completed investigator's training. In so far as the review is concerned as long as there is one trained staff member the facility is in compliance. If the facility has not already obtained the certification of another staff, it is suggested this occur. With the assistance of another center, an investigatory template has been developed for inmate investigations. The staff indicated they had a place to keep all inmate investigations under lock and key. At the end of this section, more will be said regarding staff administrative investigations.
10. The staff have an agreement with the Raleigh Police Department that any instances involving possible criminal conduct will be referred to them. The center has memoralized this agreement. Again, over the course of the next few years, it is recommended that this agreement be solidified in a memorandum of understanding or an memorandum of agreement.
11. During the on-site review, it was found that the PREA coordinator was conducting all of the initial assessments for newly arrived residents along with the thirty-day reviews. It was suggested during the on site review that case manager conduct the initial assessments and the thirty-day reviews with the PREA coordinator being the secondary reviewer. By the time of my follow-up review this had been initiated and in place. Case managers were appropriately trained.
12. The program director indicated she would be responsible for monitoring retaliation. This information was placed in local policy.
13. The PREA coordinator received information from the mental health provider of what services they would provide to include trauma services. This information has been memorialized. Again, it is recommended something more formal be provided to document what services and when the services would be provided. If the provider is the same provider chosen by the parent agency (FBOP), it is recommended in the SOW between the agency and the FBOP delineate the PREA mental health services to be provided.
14. A Sexual Abuse Review Team policy has been completed. A checklist developed and placed into policy to ensure that the team covered all requisite issues. At the time of my on-site review or follow-up review, there had been no reason for the team to meet. The development and memorialization of a checklist into local procedure will help guide the team when and if it does have to meet.
15. The PREA coordinator has done a good job in ensuring that all staff receive PREA training. It is recommended that a training record (list of topics relative to PREA) be reviewed and signed by every employee receiving any training. This information would be included in the employee's personnel file or other secure file to document the training.
16. The issue of sexual identify is ever evolving and requires a frank discussion by all staff to ensure that staff understand the significant cultural shift this entails. It is recommended that future training regarding sexual identify provide a much more involved review of this.

17. Local policy mandates that all documentation regarding PREA is maintained for a minimum of ten years.
18. A annual report will be prepared and published on the website being developed. If the website has not been operationalized, the annual PREA report will need to be completed by the end of December 2016, with the annual staffing plan included. The center must find a way to publish this information if the website is not operational.
19. Given the physical structure of the facility, there was not a place designated to house an alleged perpetrator and keep the person separated from the victim until arrangements were made to have the person transported. If this becomes necessary a place close to the officer would be used. In the converse, if it became necessary to protect the victim from others in the facility, the emergency placement of this person in the room behind the officer's station would be used. Extra staff would be on site during these times.

The largest concern found during the on-site review which continued without resolution for almost six months was the issue of staff administrative investigations. It became clear the staff at the residential reentry center would not be allowed by the parent agency (FBOP) to complete a staff administrative investigation. Over the course of several months, many emails and letters were forwarded in an attempt to develop clarity. While it was incumbent for the center's staff to resolve this issue, it was also clear since the parent agency paid their salaries, they were not able to "rock the boat" to obtain resolution. Only last week did this auditor receive an email from the Office of Internal affairs saying that all staff designated to conduct a staff administrative investigation would be appropriately trained by the Office of Internal Affairs. Since during this time there has not been a staff administrative investigation to the best of my knowledge, this minimal evidence was taken as compliance. If a staff member of the agency (BOP) conducts an investigation, a copy of the person's training record as well as the lesson plan of the training would need to be received as evidence. In a similar manner, a procedure for any auditor to review a completed staff administrative investigation needed to be developed. Initially, the auditor was not given any indication that a process could be established to review a completed investigation to ensure that the issues found in the standards were addressed. Again, as there had not been any staff administrative investigation conducted, the auditor wanted to make sure policy and practice was established. In the same email provided by the Chief of Internal Affairs, it was noted while an actual procedure was not established, the auditor would have access to a completed investigation. It was noted the Chief, OIA had asked that any investigation not be copied without permission. While this evidence (OIA's email) was accepted as minimally acceptable evidence of compliance, it is recommened that the Bureau establish a much better delineated process. If PREA standards have not become part of the monitoring instrument of the Bureau where the look at the policy and practice of the residential reentry center, it is recommended it become part of the yearly review.

DESCRIPTION OF FACILITY CHARACTERISTICS

Calalcorp is a for profit community confinement center located in south Raleigh. The house is located in what would best be described as an industrial neighborhood. The house enjoys a small footprint of approximately 6500 square feet for a capacity of 56 residents. It appears the facility maintains a population of male and female residents which approximates capacity much of the time.

The staff of 18 do an phenominal job of maintaining basic services for this population. There is limited space for all activities. Meals are catered and served in a dining room. There is a TV room for male and female offenders. The residents are allowed to comingle in the facility common areas. Residents are prohibited from entering opposite sex living quarters. There are three dormitory style living areas; two for males and one for females. Each resident has storage space and each area has a washer and dryer. Residents are responsible for their immediate living areas. There is suitable bathroom space for all offenders and with the exception of one recommendation concerning privacy, the bathroom areas meet PREA requirements. The staff have worked diligently to make sure the blend of security and privacy is matched.

Staff offices are maintained on a wing of the facility. In the staff offices, there is really no area affording an area where a private conversation could be held with an individual. Even the office area of the program director does not afford privacy, because of its location residents would be required to be viewed by staff before entering this area. For most operational issues such an arrangement is seen as fine, and in some cases preferable, but for PREA, there needs to be a place where privacy is maintained. One of the only areas for a private discussion at this time is a store room behind the monitor's station. While this may serve as a temporary area for private discussion, it is hope some alternative is developed as a long term solution.

The facility has cameras in all of its common areas. These cameras are monitored in the monitor's area. There are cameras which look out behind the facility where there is a small weight lifting area. These cameras provide a good review of the common areas of the facility. Cameras are not located in living areas or bathrooms.

The facility has phones located in the common areas for the residents to use. These phones do not require special codes and they are not recorded. During the scope of the review PREA information, especially crisis service information was placed next to the phones to allow residents to view the phone number to call without having to go to documents or the PREA bullentin board.

SUMMARY OF AUDIT FINDINGS

For ease of reference, I have listed the issues found. During the on-site review the following was found. All of the standard not met during the initial on-site review have been met. It is clear the staff of Calvacorp were dedicated to the resolution of all issues. This is significant given the number of issues unresolved at the end of the initial review. It is also significant as the center was thrust into PREA compliance by their parent agency indicating thy had to be audited and compliant by the end of FY 2016. While this did not occur, it was not viewed as the fault of the center. The two issues requiring clarity were the purview of the parent agency (FBOP) and not the residential reentry center.

Number of standards exceeded: 0

Number of standards met: 22 / final tally 36

Number of standards not met: 14/ final tally 0

Number of standards not applicable: 3/ final tally 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The policy of the center as well discussions with both staff and residents demonstrates that the center has and has taught to all that the center has a zero tolerance of sexual harassment and sexual abuse. The leadership of the center is committed to making sure this policy of zero tolerance is followed. This is demonstrated in their effort to bring to light two instances of alleged sexual misconduct between inmates. I appreciated the candor and efforts being made by the staff.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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 found as not applicable as the facility does not contract with others for the confinement of residents. For purposes of PREA, the contract with a food vendor is not found applicable.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

While the facility has taken staffing under consideration in making determinations regarding the safe housing of residents, they have not completed a staffing plan. This was discussed with center staff during the review. Additionally, it was discussed that anytime any circumstances changed as outlined in 213.C1 the center would make a conscious effort to review and document the plan. This plan needs to be a formal plan and requires making it available to the public. It was suggested the center consider putting up a webpage for this and other

PREA requirements. Additionally, the center could use a website for a plethora of other issues. A review of the population statistics for the center demonstrate that the center routinely maintains a population at its rated capacity of 56. A staffing plan has been completed and is deemed acceptable 7/20/2016.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

All staff have been trained as to the requirements of cross gender supervision, viewing and searches. There is no evidence found in policy or through interviews with staff and residents that any issue of cross gender viewing came to light. Cameras are only employed in common areas. Much discussion was had regarding the searches of an individual who professed to be the sexual identity other than what their anatomy might suggest. Ass staff indicated they would discharge their professional duties; however, it remains clear many staff have difficulty concerning the issues of sexual identity. All bathrooms except one have appropriate curtains, etc. to provide for security and maintaining privacy. A solution of developing cross curtains for this male restroom was discussed and once completed will meet the standard. Additionally, no resident described any occasion where a staff member watched them dress and undress, toilet or bathe. Curtains are being purchased to provide for individual shower compartments for male offenders. As soon as this is accomplished this standard will be met 7/20/2016.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

At the time of the review, none of the policies or procedures regarding PREA had been translated into Spanish. The facility had one resident who did not speak English proficiently. In this regard, it was recommended that the center procure a language line to allow for the communication of a resident and staff if necessary to determine if there was sexual misconduct. When having a discussion with staff regarding the use of inmate interpreters two said if they needed to do so they would use inmate interpreters. Appropriate education was had with both staff. In regards to other offenders with disabilities, the purchase of the aforementioned laptop computer with the ability of Skype would go a long way of providing a mechanism for others to communicate with deaf offenders. It is not anticipated that non sighted residents would be assigned to the center, but were they assigned material would be read to them. 7/20/2016 – The facilty needs to demonstrate that policies have been translated into Spanish and a agreement with a language line or other entity for confidential translation has been procured. This has been accomplished.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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 BOP conducts background investigations (NCIC) of those who are being considered for employ. Review demonstrates that if someone had previously been employed in an institutional setting there was no vetting of whether the employee had a sustained incident of sexual misconduct. This requirement has been placed in local employment procedures. Additionally all of the staff at the RRC have completed the three questions located in 115.217 and responses placed in their personnel files. No staff currently employed at Calvacorp has previous institution experience.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

While the owner of the facility has indicated there are plans to upgrade the facilities to include additional office space and another living unit, none of this has occurred as yet or since PREA can come into the discussion. The facility has updated its cameras to include cameras in all common areas which are monitored at the monitor's desk. This is live monitoring with record capability. The owner has indicated before any architecutual design was completed he would have the plans reviewed to ensure PREA was part of the discussion. In regards to facilities, there is no private space for the PREA coordinator or other staff to have a confidential discussion with a resident. The only space which might meet this need is a storeroom behind the monitor's station and that area really does not provide a good location. Because there is this storeroom, not having a more appropriate, professional space to conduct private conversations will not be considered in making a determination of standard compliance; however, it is strongly suggested an appropriate space for interviews and discussions should be persured.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

Any person requiring forensic examination would be taken by ambulance or vehicle to either INTERACT or Wake Med. Both have the pability of providing for SANE using nationally based protocol. It is clear that the PREA coordinator and INTERACT and Wake Med nave been in discussion. Before closing out this standard and finding compliance the PREA coordinator needs to obtain a letter of agreement from both Wake Med and INTERACT as to the services they woild provide to a person who had been allegedly sexually abused. As the facilty has received a letter of agreement from interact, this standard is found in compliance.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The facility has made a decision that all allegations of sexual abuse would be referred to the police department for review. Of the two incidents of PREA allegations, one was reviewed by police and one not. The center staff had made a decision in the future all allegations would be reviewed by the police to determine if a criminal investigation would be pursued. A letter of agreement should be obtained from the Raleigh Police Department in this regard. If the police department says there is not sufficient evidence to pursue a criminal vestigation, a determination will be made by the Bureau of Prisions an administrative investigation is to be conducted and who will be npowered to conduct the investigation. Trying to obtain a clear understanding of how this standard is being managed by the Bureau of Prisons and its RRC's has been difficult. Standard 115.403 makes it the auditor's responsibility to be clear as to how a standard is being met. The facility being audited has the responsibility to satisfy the auditor subject to appeal that there is enough information to make a determination. When initially reviewing this standard and others involving investigations, it was believed that the actual investigations were not being conducted at the RRC but rather by the RRM's office. Yet, correspondence reviewed during this week suggests that the RRC is to conduct administrative investigations when it involves inmates. It is clear that any staff administrative investigation is conducted not by center staff but by BOP/DOJ staff. At a minimum for each allegation, the RRC shall receive from either the Office of Internal Affairs or the RRM a notification authorizing the RRC to conduct inmate administrative investigations. During the week of December 12th, the auditor received an email from the Chief, Office of Internal Affairs indicating that all staff designated to conduct staff administrative investigations would be appropriated trained as mandated by the standards.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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 PREA coordinator has done a great job in meeting the employee training needs of staff. In discussing staff education, all staff spoke highly of the training they had received. It was clear all of the components of required training were touched upon during training. It is suggested that the staff initial off of a training checklist the topics of discussion for training. The checklist of training subjects for employees

could be taken directly from 115.231 a1. As it appears the training has been given and the staff have signed indicating they have received PREA training, this suggestion will not result in a finding of non-compliance. The suggestion made will provide an ongoing record of compliance. In the area of specialized training, it is recommended an additional person receive training to conduct administrative investigations. The program director had been slated to conduct administrative investigations; however, since the program director makes all hiring and staff discipline decisions, it was not deemed appropriate she be charged with conducting an administrative decision and then be called to make the decision regarding a staff member's continued employment or discipline. Should case managers be charged with conducting the risk assessments and thirty-day reviews as is being suggested, then they will require specialized training to demonstrate competence in conducting these assessments.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

At the present point and time this standard is not applicable as the facility has no one who falls under its requirements. On occasion the facility does use student interns. If the facility decides to use student interns, it is suggested they undergo the same training as all other staff.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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 PREA coordinator has taken on the onus of resident education on her shoulders. She has done a great job in this regard. When a resident arrives at the facility the monitor makes sure they receive PREA information, but generally the next day the resident meets either collectively or individually with the coordinator to go over all PREA related information pertinent to the facility. The video she uses is closed captioned and provides a Spanish translation. Like for employee training, it is suggested that a checksheet be developed where the resident initials for each area of eduction they receive. It is also recommended that at the 30- day risk assessment review, case managers ask and document if residents have any educational questions. All residents, except for the one which was not English proficient, indicated they had received adequate education regarding PREA.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

As has been alluded to previously, the area of administrative staff investigations is in need of clarification. First, it is recommended the center assign an additional staff member to to the responsibility of completing staff investigations. The program director was initially designated; however, it is recommended that she not conduct these investigations as she makes all personnel related decisions. It is recommended that the RRC and the BOP develop some sort of documentation designating who is responsible for conducting an administrative investigation. At the time of this writing, the PREA coordinator has received specialized training and the second staff member has been designated. This person has yet to receive training. Upon the completion of the training for this second staff member, specialized training for investigations at the center will be completed. However, if the BOP/DOJ staff are conducting the administrative investigation, there is no documentation to satisfy that the investigator meets the standard. Since this is a DOJ initiative, and all BOP and for that matter OIG employees are DOJ employees, it is opined some clarification is necessary. Correspondence has been sent to the RRM and before making a final determination correspondence will be intiated with NCCD. The center staff has no control over the BOP, but as a result of all staff investigations being conducted by a DOJ entity, it is opined some clarification is necessary. A telephone call to the Chief of the Office of Internal Affairs provided enough evidence that the agents assigned to that office have received some training; however it is not known if it meets the training requisite in the standard. As soon as I receive documentation that the center staff have been trained, I hope this standard will be deemed closed. Again, during the week of December 12th, this auditor received an email from the Chief of the Office of Internal Affairs indicating that all persons conducting staff administrative investigations were appropriately or would be appropriately trained.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

All medical care and mental health care for residents who have reported or otherwise need such services will be completed by INTERACT. Interact has SANE capability and provides mental health services. The PREA cooridinator has a good releationship with staff at INTERACT. At a minimum a letter of agreement needs to be obtained from INTERACT outlining the services they will provide to residents where an allegation of sexual abuse has been made. All staff have been trained and have been empowered to call 911 for ambulance service if at any time they believe someone needs medical treatment. It is suggested that a specified referral form be created to formally document a referral of an alleged victim or perpetrator to a mental health provider. This formal referral should be maintained in a system of records. Until such time as a letter of agreement is obtained from the mental health provider outlining what services they will provide, this standard remains open. During my follow up in person review, the PREA coordinator had received a letter from the mental health provider indicating servicres to be provided. While for the purposes of this review this meets minimum requirements, it is recommended that the Bureau of Prisons' articulate the provison of "PREA" treatment in a more demonstrative fashion either through the SOW with the provider or some other mechanism.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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 PREA coordinator has developed a risk instrument to measure for potential aggressiveness and victiminization. It appears adequate for the clientle the house serves. It is completed within 72 hours of the resident's arrival at the center. Currently, the PREA Coordinator is completing the risk assessment herself. It is suggested that case managers complete the assessment, that the PREA coordinator review it and that case managers conduct the 30 day review. In this way there is a system of checks and balances. The PREA coordinator will notify any staff necessary should the risk assessment reveal that accomodations need to be made. The PREA coordinator needs to develop some mechanism to document this notification. As soon as it is documented the two case managers have been trained to complete these assessments and follow ups, this standard will be found in compliance.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

As stated in 115.241, the PREA coordinator needs to develop a mechanism to inform staff as necessary if there is a finding requiring action from the risk assessment and a method to document this in the record. This requirement needs to be placed in local policy. As soon as it is demonstrated that the PREA coordinator has developed this practice and it is codified in policy, this standard will be complete. The case managers are now completing the assessment. The PREA coordinator is the secondary reviewer. If information needs to be confidentially conveyed to staff regarding an assessment, the PREA coordinator has the responsibility of adlvising appropriate staff and documenting the conversation.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ 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.

All English speaking residents were able to articulate the ways to report sexual abuse and/or harassment. All residents acknowledged an ability to have a third party report as well as to report in anonymously.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

There is no time limit for the submission of any formal administrative remedy to report allegations of sexual misconduct. There were a number of ways residents were advised they could report. A check with the RRMs office indicated that office would accept an administrative remedy without a time limit as generally prescribed. While the house hopes that any grievance would not result in a formal report but rather the report would be done by an offender to any staff member, there are clear steps where the resident could rest assured if staff were involved in the allegation they would be removed from any action regarding the allegation. If necessary, the staff member would be removed from resident contact until such time as the allegation was investigated and a decision made.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The staff at the house have done a very good job in educating staff and residents of the availability of having access to confidential support services. INTERACT will provide the services. During the review, I requested information concerning INTERACT be moved in immediate access to the phones. This was done. A call to INTERACT connected without difficulty.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Again the staff and specifically the PREA coordinator has done a very good job in advising both staff and residents of the methods where third-party reporting was available.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

All staff stated that they had a responsibility to report any and all allegations of sexual misconduct. When pressed, all continued to state a responsibility to report even if they knew it was very unlikely for any action to have occurred. They said to a person it was not their responsibility to make that determination, they would report to the PREA Coordinator or the Program Director.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

As the agency and the house are one in the same, every staff member indicated they clearly understood of their responsibility of protecting any offender who it is alleged is a victim of sexual abuse. Further, every employee was able to clearly indicate how they would protect a resident where there was possible victimization. Finally, the house, because of the physical layout, has developed a plan where an alleged victim would be housed in the storage room behind the monitor's station until the PREA coordinator or the Program Director could make further arrangements.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

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

.iere have been no instances of having to report to other confinement centers allegations of sexual misconduct made by residents against other facilities; however Calvicorp has develop policy to forward to the named institution a letter, return receipt requested, indicating what allegations had been made.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Every staff member at the house is a first responder. With only eighteen staff, there is not a bifurcation of responsibilities. The staff all knew and were able to articulate their responsibilities of keeping the alleged victim safe first and foremost, to obtain needed medical attention if necessary, and to ensure that the forensic evidence was maintained. I was impressed of the way each of the staff responded to these series of questions. This is universally the case at community confinement facilities. All staff have to have the training and have to be empowered to take the initial first steps both to protect the alleged victim and to preserve evidence. Having only 18 staff staggered through ' watches there can be no bifurcation of duties in this regard.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

This standard is generally written to make certain that collective bargaining enties do not interrupt the standards to ensure that sexual safety of all involved, staff and resident are managed appropriately. Because Cavalcorp does not have a bargaining unit, this standard is really non applicable, but because the coordinated response for a community confinement facility is totally different mixing the center's resources with community resources in a much more demonstrative manner than in an institutional setting, I have determined Cavalcorp meets this standard because of the working relationships developed with outside partners.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

As indicated previously, the physical structure of the center does not lend itself to physical separation of a resident from another resident. This is not unusual given the role of community confinement centers. In much discussion regarding this, Cavalcorp has established a safe zone for alleged victims not needing immediate transport to hospital to a storage area which is directly behind the monitor's station until the PREA coordinator or Program Director can arrive at the center.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The center understands it responsibility to make sure all who report are safe from retaliation. The Program Director has taken on the responsibility of monitoring the issue of retaliation. Her responsibility needs to be codified in local policy. Additionally, some method of docunmenting a routine check of monitoring for at least ninety days of for as long as the resident remains at the facility is maintained. Additionally, this standard also is to ensure that staff are free from retaliation. There have been no reported instances of retaliaton.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☒ Does Not Meet Standard (requires corrective action)

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

We have spoken of investigations and the conduct of investigations needing clarification. The center has made a decision that all allegations of sexual abuse will be reviewed by police. This needs to be codified into policy. If the police turns the matter over to the house, there must be some determination of whom is empowered to conduct the investigation. If the center staff is empowered to conduct the investigation, the standard is clear that the investigation must be complete and what it must contain. The investigations I reviewed during my on-site visit did not meet these standards. The Bureau of Prisons has indicated that as contractors, it is the responsibility for center staff to ensure that any investigation meets standards. As the Bureau has indicated this (the documentation and maintence of an investigation is the center's responsibility, I am recommending that center staff in concert with other center staff in close proximity develop a template of what would be

included in an investigatory file. This investigation should be reviewed to ensure that the standards articulated in 115.271 are met. Simply having staff trained to conduct administrative investigations does not provide for a format which outlines the requirements of a completed administrative investigation. More significantly, the auditor who is conducting any PREA review has to have access to any investigation to termine if the requirements of the standard are met. When asking this question, the RRM indicated that any request to review staff investigations would need to be made via FOIA. This is not acceptable. Some commumity confinement centers will have the luxury of having someone on staff who has completed administrative investigations previously which can meet standard and the level of evidence required. Cavalcorp is not one. Correspondence is to be had with NCCD staff to obtain more information regarding this matter. A template for a local investigation has been accomplished. Additionally, while there has not been a review as there has not been one to review, the auditor has been advised that review of completed staff investigations will be possible. While an actual process will need to be established, the Chief of the Office of Internal Affairs has indicated review is possible. The one cavate is the Chief requested the review not be copied without permission.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ 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 house understands and needs to put into policy that the standard of evidence required is preponderance. All staff need to understand what this evidentiary standard means. As soon as an explaination of this standard is placed in local policy, this standard will be met. The PREA coordinator has ensured that the issue of preponderance has been placed in local policy and has trained staff.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

In the case of the two cases which were treated like PREA cases, the resident's were informed of the outcome of the investigations. A form has been developed subsequent to these cases to inform all in writing of the findings of the investigation.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The Program Director has the responsibility of disciplining staff for misconduct. It is written into policy that allegations of sexual misconduct sustained will result in discipline up to an including termination. At this point this is a policy determination as there has been no cases of staff discipline. The owner of the facility was also interviewed. He had no issue with appropriately disciplining any staff member with a sustained finding of sexual misconduct. A cautionary note to those making staff discipline decisions. Any action requiring termination, demotion or suspension of more than fourteen days, which in labor law known as an adverse action, requires a need to document and articulate the rationale and reason for the action taken by the deciding official.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

This standard is deemed as not applicable as there are currently no volunteers or contractors at the facility. If in the future interns or other volunteers are part of the activity of the center, then policy will need to ensure that these staff are trained. Additionally, there needs to be an explicit statement concerning the dismissal of any contractor or volunteer where an allegation of sexual misconduct is sustained. This same statement should explicity indicate the volunteer or contractor may be released from service without renumeration during an active investigation.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

It is clear the center, whose rules for inmate discipline falls under the purview of the Bureau of Prisons, ensures that the rules for inmate discipline are followed. The cases where there were allegations of sexual misconduct received incident reports for their behaviors. They were appropriately sanctioned according to policy. All issues meet the requirements of Wolff. It is clear that any alleged victim will not be disciplined for making a report. Only a resident where it is proven they have fabricated their allegation will there be a consideration of discipline. It is clear that any such a decision will be made only by the Program Director in consultation with the PREA coordinator.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

As indicated every staff member at the facility has been empowered to obtain emergency medical treatment for any victim. Additionally, all staff have been trained that their first responsibility is to make certain the medical care of the resident is quickly provided if appropriate. The center has arrangements with both Wake Med and INTERACT to provide necessary and appropriate care to include services to be provided by SANE at either of the facilities. Mental health services are to be provided within twenty four hours to any alleged victim. It is recommended that a formal mental health referral be developed to send to transitional services as soon as an allegation is made and a letter of agreement is obtained from transitional services demonstrating the level of mental health services. As soon as this letter of agreement is obtained, this standard will be viewed as in compliance. This has been accomplished. Staff have been trained if they have any concerns regarding the health and/or safety of a resident they are to call 911.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Again, the center staff were able to articulate that appropriate medical care to include pregnancy testing and care, emergency contraception and protection against sexually transmitted diseases is provided. Local policy articulates that this care is provided without cost to the resident. As with many other areas, how this care is to be provided should be articulated in letters of agreement with the agencies providing care. The letter of agreement should articulate specifically the issues of ongoing medical care described. Additionally any letter of agreement with mental health services should include that the provider is qualified to provide trauma care. This standard will be closed as soon as there is a letter of agreement received from the mental health provider. The PREA coordinator has secured letters of agreement from the medical and mental health provider.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

After the two incidents which have been described, there was a SART review. It is recommended a policy be developed which clearly outlines the issues the SART will review. It is anticipated there will be very few reviews. And as such, a developed template will be of great assistance to the leadership of the facility. The facility indicates they will put in place a SART template.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

As this is a new endeavor, the facility has been keeping data as required by the Bureau and BJS. They are developing a standard template of information which they will maintain in a system of records. The issue with data collection is without analysis of data, data is simply a bunch of numbers. The staff at the facility understands this and understands the necessity of maintaining data in a method where it is not only numbers, but data which can be analyzed over time. As soon as the facility articulates the data which is to be maintained, this standard will be closed. The facility will maintain all PREA related data for a period of 10 years.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

At this time, this is a policy determination. The need for a yearly analysis of data is needed to be articulated in local policy as well as the objective of what the center wishes for the data to reveal. It is necessary that the center develop an annual report to be available to the community which provides a picture to anyone who reviews as to not only the trends over time of PREA allegations and findings, but as to issues which to speak to amelioration. As indicated some sort of data template needs to be developed so that it can be maintained on a routine and not retrospective manner. Additionally it is suggested the staff determine when an annual report is to be completed. In no case shall this first annual report extend past June 30, 2017. As soon as a determination is made as to when the annual report is to be completed and a proposed outline of what is to be discussed in the annual report, this standard will deemed to be complete. The staff will include a review of data on a yearly basis and will incorporated it into their annual review which will be completed by the end of December.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The data which is collected is to be maintained in a secure fashion in the PREA coordinator's officer. This data is to be maintained for a period of at least ten years. Any additional data storage requirements the Bureau requires shall be addressed in local policy.

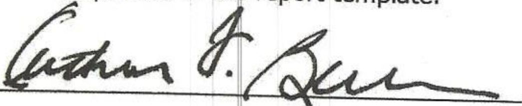
AUDITOR CERTIFICATION

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.



Auditor Signature Arthur F. Beeler

_December 19, 2016__________

Date