PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 8/30/2016

Auditor Information			
Auditor name: Tina Sallee			
Address: P. O. Box 373, Campbellsville, Kentucky 42718			
Email: r.fields44@ymail.com			
Telephone number: 270-980-2430			
Date of facility visit: 8/11/16			
Facility Information			
Facility name: Dismas Charities Greensboro			
Facility physical address: 307 N. Church Street, Greensboro, NC 27401			
Facility mailing address: *(if different from above)*			
Facility telephone number: 336-370-4357			
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: Dale Cauble, Director			
Number of staff assigned to the facility in the last 12 months: Redacted			
Designed facility capacity: Redacted			
Current population of facility: Redacted			
Facility security levels/inmate custody levels: Community			
Age range of the population: Adults 19 to 70 years of age			
Name of PREA Compliance Manager: Dale Cauble		**Title:** Director	
Email address: dcauble@dismas.com		**Telephone number:** 336-370-4357	
Agency Information			
Name of agency: Dismas Charities, Inc.			
Governing authority or parent agency: *(if applicable)*			
Physical address: 2500 7th Street, Louisville, Kentucky 40208			
Mailing address: *(if different from above)*			
Telephone number: 502-636-2033			
Agency Chief Executive Officer			
Name: Jan Kempf		**Title:** Executive Vice-President/COO	
Email address: jkempf@dismas.com		**Telephone number:** 502-636-2033	
Agency-Wide PREA Coordinator			
Name: Joseph Theriot		**Title:** Regional Vice-President	
Email address: jtheriot@dismas.com		**Telephone number:** 502-636-2033 x1305	

AUDIT FINDINGS

NARRATIVE

Dismas Charities Greensboro located at 307 N. Church Street, Greensboro, NC is a (Redacted)-bed community confinement facility (halfway house) for men and women used to provide quality, community-based services and programs to individuals in the criminal justice system and assist them in becoming positive productive members of their community. The average length of stay is approximately (Redacted) days. The facility currently has (Redacted) Federal offender residents (age 19 years and over). The facility currently employs (Redacted) staff (Redacted). The agency/facility has the responsibility for the overall well-being of federal residents (male and female) who are in the process of one of the most difficult transitions of their lifes returning to society after a period of confinement. The mission of Dismas Charities, Inc., Healing the Human Spirit since 1964, and Dismas Charities Greensboro, to support community safety and the future well-being of released federal offenders. A typical day at Dismas Charities Greensboro includes but is not limited to montoring movements and behavioral signs of residents; conducting urine drug test; training classes for residents (providing residents with proper tools for job search and for release); assisting residents to find employment (research and visit employers); increasing personal responsibility and personal accountability of each resident; conduct home/employment site visits; monitor visitation and family relationships; monitoring those residents on home detention; and counseling residents when they have issues and/or concerns.

This audit was conducted by DOJ Certified PREA Auditor Tina Sallee. During the Pre-Audit phase the auditor reviewed a variety of documents provided by the agency. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with the PREA Community Confinement Standards. The auditor did not receive any correspondence or requests from staff or residents prior to the on-site audit (a notice was posted with contact information for the PREA Auditor/audit date six weeks prior to the on-site audit).

An on-site PREA Audit was conducted on Thursday, August 11, 2016. An entrance meeting was held with Facility Director Dale Cauble and Regional Vice-President Cathy Bellew. The on-site audit work plan was discussed, samples of residents and staff were selected, and specialized staff were identified. Also, additional pre-audit information was obtained. Following the entrance meeting a tour of the facility was led by Facility Director Dale Cauble and Regional Vice-President Cathy Bellew. All areas of the facility were viewed (Redacted). PREA-related informational posters and the PREA audit notice were observed posted throughout the facility. Additionally, informational pamphlets and posters regarding PREA and Crisis Services were found in areas where staff and residents had access. Pamphlets and posters are printed in English and Spanish. No SAFE or SANE staff are employed at the facility; however, these professionals are provided at Moses H. Cone Hospital Emergency Room where forensic examinations would be conducted at no cost to the resident and/or their families.

Interviews were conducted with the Executive Vice-President/COO, the Regional Vice-President/Agency-Wide PREA Coordinator, the Regional Vice-President, the Facility Director, the Social Services Coordinator, one Resident Monitor (intake staff that provides PREA education/information and staff that performs screening for risk of victimization and abusiveness), and 4 residents (3 male and 1 female).

During the past 12 months Dismas Charities Greensboro reported zero (0) allegations/investigations of sexual harassment/sexual abuse. But the agencies with authority to conduct criminal investigations would be the Federal Bureau of Prisons/U.S. Probation/Greensboro Police Department/Guilford County Sheriff's Office and/or North Carolina State Highway Patrol. Mental Health services can be provided by Community Treatment Services, Federal Bureau of Prisons Reentry Services Division, Residential Reentry Management Branch and/or local Monarch Behavior Health if needed.

The residents interviewed had been located in another adult correctional facility before coming to Dismas Charities Greensboro and had reportedly heard about/knew of PREA and they were very complimentary of their personal feelings about the safety and the security of this facility. There were no residents identified as hearing or visually impaired, or who had limited English proficiency to interview.

All residents confirmed during interviews that they do receive information on PREA and their right to not be sexually abused/harassed, how to report sexual abuse/harassment, their right not to be punished for reporting such immediately upon arriving at the facility. Residents confirmed during interviews that they are assessed to ascertain risk of being sexually victimized and/or abusive. Additionally, after residents are admitted into the facility they are provided additional information about sexual abuse/harassment. Residents who have experienced trauma, abuse, or victimization are provided services, as needed.

DESCRIPTION OF FACILITY CHARACTERISTICS

Dismas Charities Greensboro, is located at 307 N. Church Street, Greensboro, NC. The tour of the facility was conducted by Facility Director Dale Cauble and Regional Vice-President Cathy Bellew. The facility was housed in one main building with two floors. The facility was clean, in good repair, and well maintained. The building is spacious enough for the staff and the residents, with open hallways and good lighting. There are currently (Redacted) cameras monitoring facility and all cameras can be viewed at the Central Monitoring Office (CMO) by resident monitoring staff and also by the Facility Director in his office. (Redacted). Cameras cover inside of building/outside of building with monitors located in the Central Monitoring Office (CMO) and in the Facility Director's office.

The PREA Audit notice and posters containing PREA information including the PREA hotline number are prominently posted on bulletin boards, dining area, hallways, and dorms.

There has been no significant modifications made to this facility since August 20, 2012. Interviews confirmed that any modifications/updating to the facility in future would be based on the practice of considering the effect upon the facilities ability to protect residents and staff from sexual harassment/sexual abuse and/or allegations of sexual harassment/sexual abuse.

** All Information redacted is considered proprietary as it relates to contractual properties

SUMMARY OF AUDIT FINDINGS

The first PREA community confinement facility audit of the Dismas Charities Greensboro in North Carolina was conducted on August 11, 2016. The audit consisted of data review, staff and resident interviews and facility tour and observations. Staff members were interviewed including the Executive Vice-President/COO; Regional Vice-President/Agency-Wide PREA Coordinator; Regional Vice-President, Facility Director; Social Service Coordinator; and one Resident Monitor. A number of residents were interviewed. Documents were timely and complete and included resident assessment forms, resident education acknowledgment forms completed during intake process, as well as staff PREA training records. Staff and resident interviews occurred efficiently. The entire facility was toured. Overall, the facility was well prepared for the audit and performed well in all areas.

Number of standards exceeded: 2

Number of standards met: 33

Number of standards not met: 0

Number of standards not applicable: 4

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 agency and facility has a written policy mandating zero tolerance toward all forms of sexual harassment and/or sexual abuse in the Dismas Charities Greensboro facility. The policy details the approaches it uses to prevent, detect and respond to sexual harassment and/or sexual abuse in the facility. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate the policy. Policy is thorough and mirrors the PREA language. Policy is in use and staff were able to explain it to the auditor when asked.

The agency has designated an Agency-Wide PREA Coordinator, Joseph Theriot, Regional Vice-President. He is very knowledgeable of PREA requirements/standards, and reports that he has sufficient time and authority in assisting agency/facility staff and to coordinate the agency's/facility's compliance with PREA-related topics and/or PREA standards.

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.

NOT-APPLICABLE – this facility does not contract for the confinement of its residents.

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)

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In the past 12 months there have been zero (0) reports/investigations of sexual harassment/sexual abuse at the Dismas Charities Greensboro

facility. Staff interviewed voiced that the physical layout of the facility, the composition of the resident population, and other relevant factors are used to calculate adequate staffing levels and to determine needs for further technologies, on an ongoing basis for the safety of the residents and the staff. There is a current camera/video monitoring system. The facility policy meets all the elements of the standard. The staffing plan has been completed and meets all the elements of the standard. Staff and resident interviews and documentation confirmed the practice of supervision and monitoring.

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.

Agency/facility policy states that staff are trained in cross gender pat down searches. All staff at time of audit had been trained in cross gender searches. Agency/facility policy prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. This was confirmed during staff and resident interviews.

All toilet stalls have doors and all showers have curtains. Both review of policies and interviews with staff and residents confirmed that opposite gender staff announce their presence when entering into the dorm area. Staff and resident interviews confirmed this is the practice. None of the cameras field of view included toilet/shower areas.

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.

Policy has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual harassment/sexual abuse but there were no residents with disabilities or LEP to interview at this time. If it is determined that residents have limited reading skills, intake and/or screening staff will read the written materials to the residents.

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 facility conducts extensive background and reference checks. There is a facility policy to conduct background checks verified through documentation and staff interviews. The facility policy addresses all of the elements of this standard. The Federal Bureau of Prisons must give written approval for employees before Dismas Corporate Office can approve a potential employee, the following paperwork is submitted to the Bureau of Prison Residential Reentry Office including but not limited to the Employment Application, Educational Verification, Reference Verifications, Authorization for Release of Information (Bureau of Prison Form), complete set of fingerprints for NCIC/NLETS Request Form (Bureau of Prison Form).

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.

There has been no significant modifications made to this facility since August 20, 2012. Interviews with the Executive Vice-President/COO, the Regional Vice-President/Agency-Wide PREA Coordinator, the Regional Vice-President, and the Facility Director confirmed that any and all modifications/updating to the facility in future will be based on the practice of considering the effect upon the facilities ability to protect residents and staff from sexual harressment/abuse and/or allegations of sexual harassment/abuse.

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.

(a)-(b) The facility does not conduct administrative or criminal investigations. The name of the agencies that have responsibility would be United States Parole Office/Bureau of Prisons and/or local Greensboro Police Department/Guilford County Sheriff's Office and/or North Carolina State Highway Patrol. (c)-(g) The facility offers contact information for mental health services both Community Treatment Services, Federal Bureau of Prisons Reentry Services Division, Residential Reentry Management Branch and/or local Monarch Behavior Health but forensic medical exams, when needed, would be conducted at Moses H. Cone Hospital Emergency Room, at no cost to the resident or to their family.

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 agency/facility policy ensures that an administrative/criminal investigation is completed on all allegations of sexual harassment/abuse. The agency/facility policy requires that all allegations that are criminal in nature are reported to the United States Parole Office/Bureau of Prisons and/or local Greensboro Police Department/Guilford County Sheriff's Office and/or North Carolina State Highway Patrol, agencies with the legal authority to conduct criminal investigations.

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.

Documentation and staff interviews indicated that all current staff have completed PREA Training (training included all 10 elements of the subsection) and staff have signed acknowledgment forms (documentation through employee signature that employees received the training). That training is tailored to the gender of the residents and that staff can receive additional training if needed, that all employees are made aware of the agency's/facility's no tolerance for sexual harassment/abuse policies and procedures.

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.

Policy meets the requirements of the standard. The facility does utilize volunteers, vendors, and contractors, and they are required to complete the PREA training. The facility maintains documentation/acknowledgement forms confirming that volunteers, vendors and contractors sign stating that they understand the PREA training that they have received on their responsibilities under the facility's sexual harassment/abuse prevention, detection, and response policies and procedures.

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 agency/facility policy is thorough and mirrors the PREA language. PREA education is conducted during intake/assessment process with videos, pamphlets, posters on bulletin boards and documentation of the residents participation in these education sessions with resident signatures verifying they understand the facility's zero-tolerance policy regarding sexual harassment/abuse. Residents acknowledged during interviews they do receive the education upon entering the facility, that they understood their rights to be free from sexual harassment/abuse and their right to be free from retaliation for reporting such incidents. Residents were able to discuss various ways they can report an allegation and/or receive services if needed. The agency/facility does provide residents education in formats accessible to all, including those who are limited English proficient or handicapped (but there were no residents to interview at this time with either).

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.

This standard is NOT-APPLICABLE. This facility does NOT conduct administrative or criminal investigations. The name of the agencies that have responsibility would be United States Parole Office/Bureau of Prisons and/or local Greensboro Police Department/Guilford County Sheriff's Office and/or North Carolina State Highway Patrol.

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)

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This standard is NOT-APPLICABLE. The facility does not employ full or part-time medical or mental health practitioners.

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.

Residents are screened during intake for risk of sexual victimization and sexually abusive behavior. The screening instrument contains all 9 criteria to assess residents for risk of sexual victimization and sexually abusive behavior. Documentation of the screening instrument is maintained in each resident file and the facility reassesses the resident's risk of victimization or abusiveness based upon any additional relevant information received by the facility since the intake screening. No resident reported to the auditor that their personal information was used in any exploitative or inappropriate way. The facility policy strictly controls the dissemination of information gathered from the screening.

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)

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Documentation and staff interviews indicate that the facility policy reflects PREA language. The facility does use information from the risk screening required by PREA Standard number 115.241 to decide housing and program assignments with the goal of keeping all residents safe. To date there have been NO transgender or intersex residents admitted to the facility but staff have received training for the possibility in future if the need should arise regarding separate shower/housing/and programming assignments.

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)

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Documentation, staff interviews and resident interviews indicate that the facility policy mirrors PREA language. Residents have multiple internal and external ways to privately report sexual harassment/abuse, retaliation by other residents or staff for reporting sexual harassment/abuse and/or staff neglect or violation of responsibilities that may have contributed to such reports. Staff interviews confirmed that staff can privately report sexual harassment/abuse of residents also. The facility policy is that all staff will accept reports made verbally, in writing, anonymously, and from third parties and promptly document any/all reports.

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)

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The facility has an administrative procedure for dealing with resident grievances regarding sexual harassment/abuse. Documentation and staff interviews confirm the facility policy is in line with expectations in subsections: the facility does not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual harassment/abuse; the facility does not require a resident to use informal grievance processes with the staff of an alleged incident of sexual abuse; the facility ensures that all residents may submit grievance/grievance processes; the facility allows third parties, including family members, parole officers, and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse; the facility policy states that the facility may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

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 facility utilizes the Federal Bureau of Prisons Reentry Services Division, Community Treatment Services to provide confidential emotional support for providing mental health assessment and counseling for those residents that fall under PREA while the resident resides in the Residential Reentry Center and/or on home confinement through the local Monarch Behavior Health to provide victim advocate and supportive services to residents upon request. Posters/pamphlets containing contact information are given out during intake process and posted throughout the building for resident and staff information/utilization. Resident interviews confirmed that residents are aware of these services and their right to make contact for services. Residents also have access to family members and probation/parole officers.

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.

Documentation and interviews confirmed that the facility provides methods to receive third-party reports of resident sexual harassment/abuse and publicly distributes the information on how to report sexual harassment/abuse on behalf of others. PREA pamplets/posters are given to residents during intake/assessment process and posted throughout the building for resident and staff information. Residents have access to family members and probation/parole officers.

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.

(a)-(e) The facility policy requires all staff to report/document immediately any knowledge, suspicion, or information regarding an incident of sexual harassment/sexual abuse that occurred in the facility; to report any retaliation against resident or staff for reporting such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident and/or retaliation.

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.

Documentation and staff interviews confirm that when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, the staff have been trained to take immediate action to protect the resident, including but not limited to separating the resident from potential abuser; notifying their supervisor, and completing documentation. All staff expressed that their primary responsibility at all times is the safety of all residents and staff in the facility.

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)

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The facility policy and staff interviews confirm that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director must notify the head of the facility/appropriate office at the agency where the sexual abuse is alleged to have occurred and requires notifying the appropriate investigative agency immediately.

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.

The facility policy and staff interviews confirm that policy does cover all required elements of staff first responder duties/training and staff could articulate the steps they are to take when responding to an incident of sexual abuse.

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.

The facility's detailed coordinated response plan and staff interviews confirm facility policy/training for actions required in response to an incident of sexual abuse among staff first responders, investigators, and facility leadership.

Standard 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.

NOT-APPLICABLE. The facility does not participate in any collective bargaining agreements.

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 facility documentation and staff interviews confirm agency protection against retaliation and zero-tolerance for retaliation.

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.

Documentation and staff interviews confirm agency/facility policy is in line with the PREA Standard subsection language. The agency/facility policy requires that all allegations of sexual harassment or sexual abuse be referred for investigation to an agency with the legal authority to conduct criminal investigations United States Parole Office/Bureau of Prisons and local Greensboro Police Department/Guilford County Sheriff's Office and/or North Carolina State Highway Patrol, and/or administrative investigations (United States Parole Office/Bureau of Prisons). Investigations are conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; the credibility of an alleged victim, suspect or witness would be assessed on an individual basis and shall not be determined by the person's status as resident or staff; investigations include an effort to determine whether staff actions/failures to act contributed to the abuse; documentation is immediate and includes a description of the physical and testimonial evidence, investigative facts and findings; the facility retains all written reports; the departure of the alleged abuser or victim from the employment or control of the facility does not provide a basis for terminating an investigation; the facility cooperates with outside investigators and remains informed about the progress of any investigation until its conclusion/finding and is notified in writing.

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.

Documentation and staff interviews confirm facility policy is in line with the PREA Standard language. The facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated for administrative investigations.

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.

Documentation and staff interviews confirm facility policy is in line with the PREA Standard language, including but not limited to, the facility, following an investigation into a resident's allegation of sexual harassment/abuse suffered in the facility, shall inform the resident as to whether the allegation has been determined to be "substantiated, "unsubstantiated", or "unfounded". If the agency did not conduct the

investigation, it shall request the relevant information from the investigative agency in order to inform the resident. All such notifications and/or attempted notifications shall be documented.

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.

Documentation and staff interviews confirm facility policy that staff who violate agency/facility zero tolerance sexual harassment/abuse policies are subject to disciplinary action. Disciplinary actions include but are not limited to a variety of sanctions, including termination. The agency/facility policy requires all allegations of sexual abuse to be reported to the United States Parole Office/Bureau of Prisons and the local Greensboro Police Department/Guilford County Sheriff's Office and/or North Carolina State Highway Patrol regardless of whether the staff resigns or is terminated.

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.

Documentation and staff interviews confirm facility policy that all volunteers, vendors, and contractors are trained/sign an acknowledgment form stating they understand the zero tolerance policy for sexual contact with residents and informed how to report any knowledge, suspicion, or information regarding sexual harassment/abuse that occurred in the facility directly to the Facility Director. Any volunteer, vendor and/or contractor who were to engage in sexual abuse would be prohibited from contact with residents and reported to law enforcement immediately.

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.

Documentation and staff interviews confirm facility policy that all residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse including but not limited to a referral for criminal investigations/possibility of criminal charges. Administrative sanctions are commensurate with the nature and circumstances of the abuse committed; the resident's disciplinary history, whether a resident's mental disabilities and/or mental illness contributed to the behavior; whether or not the resident is on probation/parole (placement could be terminated).

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.

Documentation and staff interviews confirmed facility policy requires that all residents shall have access to unconditional, immediate emergency medical and mental health services at no cost to the resident and/or the resident's family.

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.

Documentation and staff interviews confirmed facility policy requires that all residents shall have access to unconditional ongoing medical and mental heath care for sexual abuse victims (evaluation and treatment shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for contined care (consistent with the community level of care) at no cost to the resident and/or the resident's family.

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.

Documentation and staff interviews confirmed facility policy identifies staff that serve on an Incident Review Team that includes upper-level management officials, with input from line supervisors, and others. The review team considerations of all allegations include but are not limited to the following: whether the allegation or investigation indicated a need to change policy or practice to better prevent, detect, or respond to sexual abuse; whether the incident or allegation was motivated by race, ethnicity, gender identity, status or perceived status, or whether it was motivated or otherwise caused by other group dynamics in the facility. The review team examines the area where the incident allegedly occurred to assess physical layout; assess the adequacy of staffing levels in that area during different shifts; and assess whether monitoring technology should be improved/upgraded. The review team documents its findings.

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.

Documentation and staff interviews confirmed facility policy requires facility collect accurate, uniform data for every allegation of sexual harassment/abuse at the facility using a standardized instrument and set of definitions provided by Agency/Corporate. The facility does maintain, review and collect data as needed from all available incident-based documents and provides annually for Bureau of Prisons (Dismas Charities Greensboro residents are all Federal offenders) and at least annually at the corporate level (also upon request when necessary).

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.

Documentation and staff interviews confirmed facility policy to review data collected pursuant to PREA Standard 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training including but not limited to identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings to United States Federal Bureau of Prisons and the Agency/Corporate level Dismas Charities, Inc. The facililty report is approved by the agency head.

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.

Documentation and staff interviews confirmed agency/facility policy that ensures data collected pursuant to PREA Standard 115.287 are securely retained. The facility removes all personal identifiers and maintains sexual abuse data collected for at least 10 years after the date of the initial collection.

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.

Tina Sallee 8/30/16

Auditor Signature Date