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

ADULT PRISONS & JAILS

Date of report: January 17, 2017

Auditor Information			
Auditor name: Todd Butler			
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Telephone number: 517-373-3966			
Date of facility visit: June 13-14, 2016			
Facility Information			
Facility name: Ironwood State Prison			
Facility physical address: 19005 Wiley's Well Rd.			
Facility mailing address: *(if different from above)* PO Box 2229, Blythe, CA			
Facility telephone number: (661) 758-8400			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Prison	☐ Jail	
Name of facility's Chief Executive Officer: Scott Keman			
Number of staff assigned to the facility in the last 12 months: 66			
Designed facility capacity: 3200			
Current population of facility: 3378			
Facility security levels/inmate custody levels: Level III GP, Special Needs Yard and Level I			
Age range of the population: 18+			
Name of PREA Compliance Manager: R. W. Smith		**Title:** Associate Warden of Programs	
Email address: Richard.smith2@cdcr.ca.gov		**Telephone number:** 760-921-3000	
Agency Information			
Name of agency: California Department of Corrections and Rehabilitation (CDCR)			
Governing authority or parent agency: *(if applicable)* State of California			
Physical address: 1515 "S" Street, Sacramento, CA 95811			
Mailing address: *P. O. Box 942883, Sacramento, CA 94283*			
Telephone number: (916) 985-2561			
Agency Chief Executive Officer			
Name: Scott Kernan		**Title:** CDCR Secretary	
Email address: scott.kernan@cdcr.ca.gov		**Telephone number:** (916) 445-7688	
Agency-Wide PREA Coordinator			
Name: Shannon Stark		**Title:** Captain	
Email address: Shannon.stark@cdcr.ca.gov		**Telephone number:** (916) 324-6688	

AUDIT FINDINGS

NARRATIVE

A certified PREA audit was conducted at the ISP located in Blythe, California. The audit team consisted of certified PREA auditors Todd Butler and Barbra Storey accompanied by PREA Analyst Matthew Silsbury and PREA Coordinator Khristopher Nevins. The audit was scheduled between the agency and the audit team in April of 2016. Agency wide and facility specific supplemental documentation was mailed to the audit team via U.S. Mail, which was received, by the audit team on June 1, 2016. The documentation arrived in digital format (on a CD) and hardcopy neatly assembled in a three-ring binder. The documentation consisted of agency policy, facility procedure responding to policy, samples of supporting documentation responding to each standard and the completed Pre-Audit Questionnaire. Prior to the audit, the facility was provided with a memorandum noting the scheduled date of the facility tour and the contact information of the audit team to be posted throughout the facility for offender and staff to view. The audit team noted an abundance of postings throughout the facility in areas readily available to staff and inmates. The facility tour was scheduled for, and conducted on, June 13 and June 14, 2016.

The standards were divided among the four auditors with each responsible with reviewing documentation for their assigned standards before and during the facility visit. This provided a method for each member of the audit team to focus their efforts on specific areas of the audit in order to ensure detail and accuracy. The plan for the tour was to meet the facility administrative team on Monday June 13 at 8:30. Following the meeting with the administrative team, the audit team was to split into two groups, one consisting of Khris and Barb, the other Todd and Matt. Khris and Barb were to spend the day interviewing staff and offenders while Todd and Matt conduct the facility tour. The second day of the facility visit would consist of finishing up remaining interviews that were not completed on the previous day including interviews with the Warden, PREA Compliance Manager, Investigative Services Unit Supervisor, Human Resources Manager, Volunteers and any offenders not previously interviewed. Day 2 would also consist of file reviews and a brief exit interview with the administrative team at the facility summarizing the team's findings. The facility tour was completed according to the plan mentioned above. Khris and Barb were able to complete all random inmate and staff interviews on day one while Matt and Todd toured the facility and reviewed files and facility postings throughout the facility. Day 2 allowed sufficient time for the audit team to divide efforts and complete interviews with specialized staff and additional inmates needing to be interviewed, including any inmates identified as having reported sexual abuse. Members of the audit team who were not actively involved with interviews revisited a number of locations throughout the facility in order to verify the facilities efforts to correct areas of concern noted by the team during the initial walk through. The areas of concern noted by the audit team include the holding modules located in the four health care areas throughout the facility, three of the four toilet areas on the yards and the bathrooms in the holding cells located within the infirmary. These are all areas the audit team has identified of violating §115.15 in regard to cross gender viewing of offenders utilizing toilet facilities.

Areas of the facility which were toured consisted of four yards, each consisted of five housing units (all general population), chow hall, gym, medical area, library, prisoner services/education, prisoner vocations, and the unsecure level one housing unit. Additional areas were toured on day two including the warehouse and canteen because no staff were available on day one of the tour. Areas within the administrative building toured include the visiting room, human resources offices, training offices, staff break areas, warden's suite and porter work areas/assignments. Several staff and inmates were interviewed during this time to ensure a sufficient sampling of interviews was conducted representing every aspect of inmate and staff demographic at the facility.

All of the areas visited were well staffed and staff were making rounds/tours and monitoring key areas. Doors were locked and off limits areas were maintained. No areas observed presented any sexual abuse security concerns. PREA information throughout the facility was clearly posted, both in English and Spanish. Posters listed the steps that could be taken to report sexual abuse or sexual harassment incidents, provided contact information for the prisoners to report these incidents and also cited the CDCR's zero tolerance policy related to sexual abuse and sexual harassment. In the units this info was also painted on the wall next to the phones. Information for additional services for victims of sexual abuse was also posted. There was not direct line of sight into the showers or bathroom areas within the prisoner cells which allowed for ample privacy while showering, dressing or utilizing toilet facilities. Bathrooms outside the housing units were behind doors with windows that were partially frosted to allow for privacy while maintaining staff ability to monitor behavior within the bathrooms for security purposes. The general rule the facility had adopted was to frost/paint all windows up to 55 inches. The audit team agreed that this was sufficient to provide sufficient privacy while maintaining security. Log books were reviewed and showed evidence of supervisory rounds on all shifts as well as announcements about opposite gender staff working within the housing unit. Staff and inmates both stated that they were not made aware in advance when supervisors were making rounds and everyone indicated that each female staff member announced their presence prior to entering the housing units. A notice to staff to announce their presences was also painted on the exterior wall of every housing unit adjacent to the entry doors.

The use of security cameras throughout the California prison system is limited. However the California Department of Corrections and Rehabilitation employees more staff and supervision at each of its facilities than this audit team has seen elsewhere providing ample staff coverage in areas that would otherwise benefit from camera coverage. Key areas are covered by cameras, such as the visiting rooms where the potential for contraband introduction is higher than others are. The physical layout of the units also allows good visual coverage by staff.

Cross gender viewing in the medical unit was only conducted by medical staff and traditional privacy screens were seen throughout the

medical areas to allow for privacy during examinations and while dressing/undressing.

During the interview phase of the audit, the auditors randomly selected and spoke with a total of 23 different inmates representing every security level and housing unit within the facility. There were 49 total staff interviewed during the audit tour as well. All staff and prisoners alike had a thorough knowledge of PREA, the agency's zero tolerance policy in regard to sexual abuse and sexual harassment of offenders, and the reporting methods available to offenders, staff and the public. The overall consensus of the prisoner interviews indicated that sexual abuse doesn't occur at this facility and staff echoed this sentiment. The auditors were impressed at the layout of the facility from a security and offender supervision aspect noting there were no blind spots within the housing units and offender movement is closely monitored lending us to believe that the potential/opportunity for assaults to occur is extremely limited if any at all.

The offenders interviewed also indicated that they had received PREA educational materials in the recent past, which would support why everyone at the facility is so familiar with PREA and the facility's response. All inmates felt that they had enough privacy to change and shower without opposite gender viewing them in a state of undress. They all felt safe from sexual abuse and knew how to report abuse or harassment if needed. The only identified transgender at the facility was interviewed and provided responses to questions that were consisted with the rest of the population indicating she felt safe at the facility and stated that she was treated with respect.

All staff interviewed were knowledgeable about PREA and the agency's zero tolerance policy. They knew how to appropriately respond to a sexual assault and their mandatory requirement to report all allegations, notifications or suspicions of abuse or harassment. All staff indicated they had been trained on PREA, which included cross-gender/transgender pat searches. Staff were able to site specific steps that needed to be taken in the event they were first responders to a sexual abuse incident. All staff responded that they absolutely could not strip search a prisoner to verify sexual identification. All staff interviewed had access to "cheat" cards the facility had provided to all its staff. This was a great method to allow staff an immediate resource to guide them through the appropriate steps necessary to address a sexual abuse or sexual harassment allegation/situation if they were the first responder or while receiving a report from an offender.

The team reviewed the documentation provided by the facility prior to the facility visit. During the tour, the team was able to randomly review additional documentation throughout the facility in order to verify the samples provided to the team were consistent with regular facility practice. This included viewing postings, investigative files, prisoner files, employee personnel files, medical and mental health files and training documentation for staff, contractors and volunteers. The audit team then met with the Warden the Administrative team, as well as representatives from all areas of the prison. Representatives from the California Department of Corrections and Rehabilitation Headquarters were also present throughout the audit tour, including entrance and exit interviews.

Throughout the site visit, the audit team had direct access to an abundance of agency and facility staff. They all were very knowledgably and extremely helpful in the audit process. Their assistance enabled the auditors to complete a thorough investigation into the facilities compliance with PREA standards. The immediate response by the facility to issues of concern pointed out by the audit team truly gave an impression that they were engaged with PREA and took great strides to ensure compliance with all standards. It is obvious, based upon postings and interviews, that the facility has done an excellent job educating staff and offenders of the agency's zero tolerance policy regarding sexual abuse and harassment, as well as the various methods in which allegations may be reported. It was certainly a pleasure for the audit team to spend time with facility staff and the CDCR and have the opportunity to assist in their PREA compliance efforts.

The audit team concluded its site visit with an exit interview with the Warden, administrative staff and headquarters staff. The team commended everyone on an excellent job of training staff and informing offenders concerning the agency's zero tolerance regarding sexual abuse and sexual harassment, as well as implementing the various standards applicable to the facility. The overall audit process was explained and an overview of the auditor's findings was presented. The team summarized their preliminary findings and discussed any areas of noncompliance along with an overview of the agreed upon remedial action plan to correct deficiencies.

DESCRIPTION OF FACILITY CHARACTERISTICS

The California Department of Corrections and Rehabilitation operate ISP. The California Department of Corrections and Rehabilitation operational mission is to enhance public safety through safe and secure incarceration of offenders, effective parole supervision, and rehabilitative strategies to successfully reintegrate offenders into their communities. Ironwood State Prison operates within the agency mission statement. The mission of Ironwood State Prisoner is to improve public safety through the confinement of minimum and medium custody offenders while providing them the life improvement skills needed to successfully re-integrate back into society upon parole. These life improvement skills include but are not limited to: Self-help programs, Vocational and Basic Educational, Spiritual and College Programs.

Ironwood State Prison is located at 19005 Wiley's Well Road in Blythe California. This is in southern California in the heart of the desert. It is located just west of the Colorado River and the California/Arizona state line. The Colorado River is a prime recreational site for locals and tourist attraction for visitors to the area. Ironwood State Prison's name was derived from the surrounding area's native Ironwood trees, which share with the prison the qualities of strength, solidity and firmness.

Warden Neil McDowell leads Ironwood State Prison. Warden McDowell has been warden or acting warden at Ironwood State Prison since 2014. He has served in several positions since 1994, including chief deputy warden, captain, correctional counselor, and correctional officer. He was associate warden at Chuckawalla Valley State Prison from 2009 to 2014 and a correctional officer at Eagle Mountain Community Correctional Facility from 1993 to 1994.

Ironwood State Prison is a general population facility consisting of level one and three prisoners. It also contains a special needs yard for the prisoners who cannot be housed in a typical general population setting for various reasons. The facility houses adult prisoners (18 and over) only and contains 69 total buildings, 22 of which are housing units. The designed capacity of the facility is 3,200 prisoners. Its current population is 3,378 prisoners. The audit questioned the administration about why the facility reports its current population above the designed capacity. The reason for this is due to the original facility design when the facility was built. Since its construction, the facility has undergone physical plant changes, which allow for the increased capacity. However, due to political and administrative reasons, the facility cannot report the "designed capacity" as anything other than what the original plans were rated for regardless of physical plant changes occurring since. It should be noted the auditors observed the current physical layout of the facility with the reported capacity and the facility clearly has sufficient space to house the reported number of prisoners in a safe and effective manner.

Ironwood employs 1,099 staff who have contact with offenders and 326 volunteers or contractors who may have offender contact as well.

Ironwood State Prison consists of five facilities, commonly referred to as yards, named alphabetically from A through E. Facilities A through D are designed identically and consist of five housing units each, a kitchen, health care, recreation, school, library, chapel, prisoner services area and an individual yard. Facility E is smaller in design and houses the level 2 prisoners. It consists or the remaining two housing units which are an open bay setting.

Ironwood State Prison has medical care services on grounds to include physical, mental, and dental care for each yard. Upon arrival, inmates are screened for medical concerns. This is also the time that inmates are initially assessed for PREA related concerns. Within 72 hours of arrival, all inmates receive an initial assessment in Diagnostics to identify mental health issues and developmental disabilities. The facility provides medically necessary treatment to prisoners within the scope of their abilities. Any medically necessary treatment outside their scope is provided at Eisenhower Medical Center. Offsite emergency services are provided for any inmate medical needs that cannot be met at the facility.

Ironwood State Prison has a layered security system to protect the public. The facility's two perimeter fences are topped with razor-ribbon wire and there is a lethal electric fence between the inner and outer perimeter fences. Ironwood State Prison has gun towers as well as a perimeter response vehicle. The facility has two entry points, one being the walk through control center gates and the second being a sally port for vehicle entry. All areas of the facility seemed to have adequate staffing levels allowing for observation of inmates during their daily routines. The staffing levels within the housing units and services buildings were appropriate in order to maximize safety and security.

SUMMARY OF AUDIT FINDINGS

115.13; CDCR does not have a formalized process to conduct staffing plan reviews in consultation with the PREA Coordinator. **This standard was sufficiently corrected during the remedial action period.**

115.14; (Not Applicable) CDCR does not house offenders under the age of 18.

115.15; ISP has several areas within the institution which violate the cross gender viewing standard in regard to toilets on the yard, in the health care holding areas and the infirmary holding area. **This standard was sufficiently corrected during the remedial action period.**

115.17; CDCR does not have a process in which to directly ask applicants information regarding previous incidents of sexual harassment. **This standard was sufficiently corrected during the remedial action period.**

115.52; CDCR policy does not meet the time limits imposed by the standard in regard to prisoner's exhaustion of their administrative remedies. Policy also strictly prohibits prisoners from filing on behalf of other prisoners. **This standard was sufficiently corrected during the remedial action period.**

115.61; Facility practice does not meet this standard. Medical and mental health staff do not inform offenders at the onset of services that they are obligated to report and confidentiality is limited. **This standard was sufficiently corrected during the remedial action period.**

115.81; CDCR policy complies with sections a-d of this standard. However, agency policy does not speak of informed consent nor did the facility demonstrate compliance with this section (e) of this standard based off the lack of direction in agency policy and training. **This standard was sufficiently corrected during the remedial action period.**

115.83; CDCR policy and practice adhere to sections a-g of this standard. However, the agency does not have a practice in place to ensure known abusers receive mental health evaluations as required by section (h) of this standard. **This standard was sufficiently corrected during the remedial action period.**

115.88; CDCR does not have a formalized process in place to meet this standard. **This standard was sufficiently corrected during the remedial action period.**

Number of standards exceeded: 0

Number of standards met: 42

Number of standards not met: 0

Number of standards not applicable: 1

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

California Department of Corrections and Rehabilitation (CDCR) provided an agency wide DOM 54040, article 44-Prison Rape Elimination Policy, revised July 1, 2015, which specifically states in section 54040.1, the CDCR is committed to providing a safe, humane, secure environment free from offender on offender sexual violence, staff sexual misconduct and sexual harassment and the CDCR shall maintain a zero tolerance for sexual violence, staff sexual misconduct and sexual harassment in its institutions, community correctional facilities, conservation camps, and for all offenders under its jurisdiction. Section 54040.3 of the policy includes definitions of prohibited behaviors regarding sexual harassment and sexual abuse and section 54040.15 includes consequences for those found to have participated in prohibited behaviors. Article 44, sections 54040.1-22, include details regarding the agency's strategies and responses to reduce and prevent sexual abuse and sexual harassment of inmates. The documentation provided as well as discussion and observation of facility operations during the onsite audit supports that the facility meets the requirements of section (a) of this standard.

The CDCR employs an agency-wide PREA Coordinator, Shannon Stark, who has indicated that she has the time, resources, and authority to perform her duties as the agency's oversight for implementation of the PREA Standards. An organizational chart and a duty statement for the PREA Coordinator position, along the interview of Captain Stark provides support that the agency, including the facility, meets the requirements of section (b) of this standard.

ISP is one of the 35 facilities operated by the CDCR and employs an upper level administrator as the facility's PREA Compliance Manager. PREA Compliance Manager, Associate Warden Smith, has indicated that he has the time, resources and authority to perform his duties as the facility's PREA Compliance Manager. The documentation and information provided by the facility supports that the facility meet the requirements of section (c) of this standard.

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not contract for the confinement of inmates. The facility has not entered into any contracts for the confinement of inmates; therefore, this standard does not apply. The CDCR has included PREA language into the agency's PREA policy, exhibits D and M, regarding contracts which would meet the requirements of this standard, if the institution were to contract for the confinement of inmates.

Standard 115.13 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR has, in recent years, moved to a standardized staffing plan which has taken into consideration the physical plant layout, security level and type of offender and their specific needs when developing the plan for each of its correctional facilities. In addition, other factors considered in developing staffing levels include the operational mission of each facility, video monitoring capabilities, the necessary number and placement of supervisory staff, alleged sexual abuse and sexual harassment incidents, and generally accepted correctional practices in conjunction with ACA standards. It is the general practice for CDCR facilities to review the staffing plan, at least monthly, during the hiring authority meetings and budget meetings. Any request for additional staffing, electronic monitoring equipment or upgrades is identified at these meetings. The facility has hired **66** staff in the last 12 months supporting the Administration works to continuously improve staff and supervisory presence in order to prevent and detect sexual abuse and harassment and maintain overall security of the facility. The approved and reviewed staffing plan was appropriate for the security level and current population of prisoners, programs and activities at the facility. During the tour it was observed there was sufficient custody and support staff coverage in all areas.

The only deviation from the staffing plan was due to reassignment. Staff reassignments occur when the assigned post was no longer needed due to the closure of services, which result in no inmate presence within a given area. The most frequent example is the closure of a facility yard to reallocate the staff member assigned to that position to provide additional coverage in a more crucial area of the facility. Shift schedules were reviewed and found that each shift was adhering to the staffing plan. In addition, any vacancies on the schedule due to employee absences were appropriately staffed with the use of employees on overtime.

As required by section (d) of this standard, the agency's DOM 54040.4, Security Rounds, requires that a custody supervisor assigned to each area conduct regular unscheduled security checks to identify and deter sexual violence, staff sexual misconduct and sexual harassment of any kind. These security checks are documented in the housing unit Log Book. The log books provide the date, time and location the security round was conducted. During the facility tour the auditors were able to verify that appropriate supervisors on all shifts were conducting and documenting required security rounds. This was evidenced by the log book entries reviewed by the audit team. Additionally, all of the supervisors interviewed were able to articulate a method in which to conduct unannounced rounds in a manner that would prevent staff from being able to alert other staff of the rounds being conducted.

CDCR is not in compliance with section (c 1-3) of this standard, due to not currently having a formalized process to assess, determine and document whether adjustments are needed to the staffing plan, deployment of electronic monitoring equipment, or the resources available to commit to adherence of the staffing plan in conjunction with the agency wide PREA Coordinator. Although not immediately apparent at this facility, the lack of this process at an agency level may have an impact sexual safety.

Remedial Action Plan: The agency PREA Coordinator has indicated a plan was drafted to implement a formalized process to address this standard. Final approval should be achieved in the near future. Once the policy revisions are made affective and evidence of the staffing plan review in accordance with section (c 1-3) are provided to the auditor, the agency/facility will meet the requirements of this standard. The agency has agreed to this remedial action plan to achieve compliance and will forward the documentation to prove that final approval was achieved and the process is in place.

Corrective Action Plan Completed: The CDCR has developed and implemented an agency-wide form titled Prison Rape Elimination Act (PREA) Annual Data Collection Tool and Staffing Plan Review to address this standard. The PREA Coordinator is a formal member of this review process.

Standard 115.14 Youthful inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This facility does not house inmates under the age of 18. Therefore this standard does not apply.

Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The CDCR Department Organization Manual (DOM) regarding cross-gender strip searches and cross-gender visual body cavity searches specifically states that correctional personnel, other than qualified medical staff, shall not conduct unclothed body inspections or searches of an inmate of the opposite sex, except in an emergency. The policy also states that staff of the opposite biological sex shall not complete routine unclothed body searches. Policy 54040.5 requires the documentation of all cross-gender strip searches and cross-gender visual body cavity searches in accordance with DOM section 52050.16.5. A review of facility training records indicates that all security staff have been trained with regard to conducting cross-gender and transgender pat down searches and as indicated in the PAQ, **100%** of staff have been trained. Training records which explain the appropriate methods for completing a cross-gender and /or transgender pat down search were provided. In addition, all random staff interviews indicate all have completed the required training and knew the appropriate method of conducting cross-gender and transgender searches. There were no instances of cross-gender strip searches or cross-gender body cavity searches as supported by specialized and random staff interviews, as well as inmate interviews.

Policy 54040.4, Preventative Measures, requires the institution to enable inmates to shower, perform body functions, and change clothing without non-medical staff of the opposite sex viewing their buttocks or genitalia except in exigent circumstances or when such viewing is incidental to routine cell checks. In order to minimize exposure, staff of the opposite sex shall announce their presence upon entering the unit. During the tour, the auditors observed every shower, toilet, dressing area, and prisoner dress-out/strip search area within the institution. The auditors found no areas of concern in regard to cross gender viewing. Each area has either permanently installed modesty screens or frost on the windows in order to provide sufficient privacy while maintaining security. Several random interviews were conducted with both staff and inmates and it was very evident that sufficient privacy was given to the inmates while showering, performing bodily functions, changing and/or performing strip searches. In addition, through interviews and observation, it is evident that female staff are announcing their presence upon entry into the housing units.

However, during the facility tour, the audit team observed the following area, which is in violation of this portion of the standard. The holding areas in health care provide direct view into the toilet by every staff member entering the main door or the services area. This design does not allow offenders to use the toilet without the possibility for non-medical staff of the opposite gender from viewing them in a state of undress while utilizing the toilet facilities. Additionally, there are two toilets in the infirmary holding area that provide non-medical staff of the opposite gender a direct view of offenders utilizing the toilet facilities from the offices

desk/work station. The toilets on the facility yards have no means for an offender to utilize the toilet without being in full view of all staff on the yard, including non-medical staff of the opposite gender. Therefore, the facility does not comply with this standard.

Policy, 52050.16.6, Unclothed and Clothed Body Searches of Transgender or Intersex Inmates, indicates that if in the event that an inmate going through Receiving and Release who self-identifies as transgender or self-identifies as a gender which seems not to match their biological sex, the search will be conducted by staff of the same biological sex. If staff is unable to determine the genital status through medical records or an interview with the inmate, then medical staff will conduct a standard medical examination. Through random staff interviews and inmate interviews, it was evident to the auditors staff are not conducting searches for the sole purpose of determining genital status.

This facility does not house female inmates; therefore, sections (b and c) of this standard do not apply.

Remedial Action Plan: The agency has agreed to a remedial plan to address this standard. A physical barrier will be designed and installed in such a fashion as to allow offenders to utilize the toilets in the holding areas of every facility health care area as well as on the facility yard toilets. Additionally, the windows into the holding area in infirmary will be painted in such a fashion so staff cannot have a direct line of sight into the toilet area allowing offenders to utilize the toilet outside the view of non-medical staff of the opposite gender. Once the facility has provided evidence of the completion of this remedial action plan, the facility will comply with this standard.

Corrective Action Plan Completed: The facility has successfully developed and installed physical barriers in such a way as to provide visual screening of offenders while utilizing the toilets in the holding areas of all facility health care areas, both toilets in the infirmary holding area, and around the toilets on all four facility yards. The facility's Associate Warden provide me with photographs of the work completed as evidence of their efforts sufficiently addressing this standard.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has in place the appropriate steps necessary to ensure inmates with disabilities have equal opportunity to participate in or benefit from all aspects of the agency's efforts. Agency DOM, 54040.7, Detection, Notification and Reporting, states that the department shall not rely on offender interpreters, offender readers, or other types of offender assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the offender's safety, the performance of first-response duties, or the investigation of the offender's allegations. In addition, Title 15 and ADA requirements require assistance to offenders whose TABE score is 4.0 or lower, and policy 54040.12, requires that except in limited or exigent circumstances, investigators shall not rely solely on inmate interpreters, readers or other types of inmate assistance. Through random staff and inmate interviews, it was found that staff and inmates understand that inmates with disabilities or language barriers have equal opportunity and will receive assistance when necessary for reporting purposes.

During the tour, the auditors observed postings were present in all areas, and they include all relevant and necessary information printed in both English and Spanish. The only instances of interpreter services utilized at the facility was the use of staff who have been identified as interpreters to translate English/Spanish on behalf of the Spanish speaking population. CDCR policy allows for appropriately trained staff to be utilized as such an interpreter. These staff receive special pay to perform these duties. Staff identified as interpreters was available during the site visit and preformed interpreter services, which the audit team conducted, interview with Spanish speaking offenders. The staff indicated that they were all aware of the agency's agreement with an interpreter agency to provide additional services if necessary. The agency has a standard agreement with Interpreters Unlimited, Inc., in order to provide interpreter services for any inmate whose needs cannot be met by facility staff or their current implementations of PREA information for non-English speaking or otherwise developmentally disabled.

Standard 115.17 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy Chapter 3, Article 6, Sections 31060.1-3 require the hiring agency not to hire anyone who may have contact with inmates who have engaged in or been convicted of engaging or attempting to engage in, or have been civilly or administratively adjudicated to have engaged in any of the activities outlined in 115. 17. Interviews and employee records reviewed during the audit show the agency does an excellent job of directly asking the information required within this standard. The agency also provided a copy of their employment application which asks all the questions related to sexually abusive behavior.

The agency has a method in place and sufficiently executes said method to capture, on a continuous basis via a "Live Scan" system, any encounters with law enforcement of all applicants and current staff which exceeds the requirements of this standard.
The agency contacts all known employers as a part of an applicant's background checks and willingly provides information for other agency employer's requests provided the former employee has provided said employer with a release allowing CDCR to release such information.

However, the agency currently has no method in place to directly ask applicants about incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist another's services. Therefore, the agency is currently not in compliance with this standard.

Remedial Action Plan: The agency has agreed to a remedial plan to modify an existing pre-employment form (CDCR 1951) in order to capture this information. The agency will forward the documentation to the audit team to show that final approval was achieved and the process is in place. The agency will need to submit documentation to the auditors for the next 180 days to show that the new form is being utilized and the required questions are being asked. Upon completion of the revisions to CDCR 1951 and the facility has provided evidence of its use, the facility will be in full compliance of this standard.

Corrective Action Plan Completed: The agency has implemented a method to directly ask applicants about incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist another's services. The agency's pre-employment application form (CDCR 1951) is utilized in order to capture this information.

Standard 115.18 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

When designing upgrades to existing facilities or electrical surveillance systems, including cameras, CDCR has implemented within its Design Criteria Guidelines the following language: "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, consider and address how such technology may enhance the agency's ability to protect inmates from sexual abuse." There have also been communications between the agency and section heads within CDCR in regard to an agency

wide update and implementation of camera use/installation and how the use/installation will enhance the agency's efforts in protecting inmates from all forms of abuse, including sexual abuse and sexual harassment.

During the facility tour, the auditors observed no newly remodeled areas or recently completed construction projects. There is very limited use of camera systems within the institution. The audit team did observe cameras in the visiting area. The facility design did not appear to have any areas which would cause concern for inmate safety and staff presence was more than sufficient throughout the facility. All doors to rooms which were not in use were locked and larger areas such as the kitchen, dining, recreation and vocational/education were monitored closely by both non-security and security staff. The facility also had many corner mirrors to allow staff visual observation of blind spots in various areas of the facility.

Standard 115.21 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The CDCR Correctional staff/Peace Officers are under the California Penal Code. They are authorized and trained to conduct both administrative and criminal investigations. The staff within the Investigative Services Unit (ISU) receives specialized training to solely conduct investigations, including sexual abuse allegations.

In regard to investigations of sexual abuse allegations, CDCR has multiple methods in place to ensure compliance with this standard. Staff are required to participate in a specialized training program which is based upon POST Guidelines on Adult/Adolescent Sexual Assault Investigations, PREA Resource Center, National Council on Crime and Delinquency, US Department of Justice and a National Protocol for Sexual Assault, Medical Forensic Examinations, Adults/Adolescents, April 2012. This training is in response to this standard and California Penal Code 13516. Policy 54040.9, Forensic Medical Examinations, require the victim be taken to the designated outside hospital where contract staff conduct forensic exams. A telephone interview with contracted staff responsible for conducting said exams verified staff are appropriately trained in accordance with California State Law to conduct forensic exams.

Health Care Services, Chapter 10.1.10, Copayment Program Policy, indicates a copayment shall not be charged if the health care service is treatment relating to sexual abuse or assault.

Victim advocacy and victim support services are addressed in agency policy 54040.8.2. The audit team verified that these services are available to inmates and staff through random interviews. In addition, notification of services is posted throughout the facility as a notice to inmates these services are available. Agency policy requires victim advocate services be offered and made available during both the medical examination and the investigatory interview for any sexual abuse case. The Watch Commander is obligated to contact the local Rape Crisis Center whenever a victim of a sexual violence or staff sexual misconduct is receiving treatment. This was confirmed through an interview with Forensic Nurse Specialists who are responsible for conducting all SANE/SAFE exams. The interview also revealed that qualified personnel are available at all times. Policy 54040.2 defines a victim advocate and their role in an incident and if one is not available a designated employee will be summoned. This employee is one who has been certified by a rape crisis center as trained in counseling of sexual assault victims. They are a psychiatrist, psychologist, licensed clinical social worker, psychiatric mental health registered nurse, staff person with a master's degree in counseling or others listed in Evidence Code section 1010; or a staff person who has 40 hours of specialized training listed in Evidence Code section 1035.2 and is supervised by a staff member listed previously.

Policy states the victim has the right to have a victim advocate from a local rape crisis center at the examination. A Memorandum of Understanding has been implemented in the past with advocacy groups and is currently being updated and reviewed. The Victim Advocacy Group information was posted throughout the institution and available to inmates. In addition, interviews with random inmates supported the information has been posted and the inmates have knowledge of the type of help they can receive from the group.

Standard 115.22 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR policy, Chapter 5, Article 44, Section 54040.12, requires an administrative or criminal investigation must be completed for all allegations of sexual abuse and sexual harassment. Every allegation is referred to the facility's Investigative Services Unit for investigation. ISU staff conduct all criminal investigations and information regarding agency policy is published on the Department's website. Any investigation involving possible staff misconduct is referred to the agency's Office of Internal Affairs (OIA). OIA is responsible for determining which allegations of staff misconduct warrant an OIA investigation and for completing all investigations in a timely and through manner. This was verified during the interviews with the CDCR Agency Head and the ISU/Watch Commander, along with the responses from other random staff.

According to reviews of facility documentation and the PAQ, there were **seven** allegations received and investigated in the past twelve months. None of which was referred for criminal investigation.

Sections (c and e) are not applicable to this facility as all investigations are completed through the facility's ISU.

Standard 115.31 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR DOM Section 32010.10.1 states, "All employees, new to the department, regardless of job classification shall receive orientation training within 90 days of appointment." CDCR DOM requires that PREA training be included as part of staff orientation training. Additionally, CDCR DOM Chapter 5, Article 44, Section 54040.4 also states all staff including volunteers and contractors shall receive instruction regarding the prevention, detection, response, and investigation of offender sexual violence, staff sexual misconduct, and sexual harassment.

Per CDCR policy PREA training staff is required to pass an 8 hour training course. All other staff, including volunteers and contractors, must complete a mandatory 1 hour annual training session. An On the Job Training (OJT) Module has also been developed and is delivered to staff throughout the year. Additionally, agency PREA training is provided during new employee orientation, and included in the CDCR Correctional Training Academy Curriculum.

The CDCR PREA training is comprehensive in scope, defines the purpose and intent of the Prison Rape elimination Act, history of PREA, overview of applicable state law, and the CDCR's "Zero Tolerance Policy" regarding sexual violence towards inmates. Training discusses inmates' right to be free from sexual abuse and harassment and provides information regarding the concept of "consent" which does not exist between staff and offenders, and addresses the LGTBI and gender non-conforming population as a specific group in the PREA standards.

California Penal Code 3430 "Gender Responsive Programs" requires gender specific programming. Additionally, CDCR policy 54040.4 requires training to be gender specific based on the offender population at the assigned institution. Generally speaking CDCR PREA training is applicable to all gender types. Ironwood State Prison houses only male inmates; therefore, the training provided appears to be appropriate given the inmate population. Based on the above CVSP appears to be in compliance with 115.31(b).

ISP employed 1099 employees as of June 14th, 2016. A review of facility training documentation indicates a total of 8 employees (less than 1%) did not complete the CDCR's mandatory PREA training requirements as of June 14th, 2016. These employees were noted as being on extended leave for various reasons (e.g. long term sickness or workers compensation), and are required to complete training upon return to work. The small percentage of staff who did not complete CDCR required PREA training appears to be within an acceptable range. Therefore, ISP appears to be in substantial compliance with standard 115.31(c).

CDCR policy requires an employee to sign the State of California Training Participation Sign-In Sheet ("CDCR 844") upon completion of CDCR required PREA training. ISP provided institutional training documentation for review. ISP also provided signature sheets indicating completion of the CDCR PREA On-the-job-training (OJT) training module. The documentation provided appears to satisfy the requirements of 115.31(d).

All of the random staff interviewed also indicated that they had received PREA training and receive it annually during their block training. All were able to recite the agencies zero-tolerance requirement as well as their responsibilities as they relate to PREA. Training records were supplied which indicated compliance by documenting the training received for each staff member. A sampling of electronic records was taken as well as signature sheets for specific training. All training indicated within their policies and training curriculum were accounted for on the training records.

Based on the above, Ironwood State prison is in compliance with standard 115.31.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The California Department of Corrections and Rehabilitation (CDCR) Department Operations Manual (DOM) Section 32010.10.1 states, "All employees, new to the department, regardless of job classification shall receive orientation training within 90 days of appointment." CDCR policy also requires that PREA training be included as part of staff orientation training. Additionally, CDCR DOM Chapter 5, Article 44, Section 54040.4 states all staff including volunteers and contractors shall receive instruction regarding the prevention, detection, response, and investigation of offender sexual violence, staff sexual misconduct, and sexual harassment.

Volunteers and contractors, must complete a mandatory 1 hour annual training session specifically addressing PREA. In addition, volunteers/contractors are also required to sign the "Volunteer/Contractor Informational Sheet" during orientation. Training encompasses an introduction to PREA legislation, a comprehensive review of the CDCR's policy regarding "zero tolerance" for sexual violence, staff sexual misconduct, and sexual harassment in its institutions, community correctional facilities, conservation camps, and all offenders under its jurisdiction. Also included is the key elements of professional behavior including the communication and the prevention, detection, and reporting of sexual violence, staff sexual misconduct, and sexual harassment.

ISP provided training records for a variety of staff including Volunteers and Contractor. Volunteer/Contractor Informational Sheet" a signed copy of this document is kept on file at the institutional. This form also serves as notice of the volunteer/contractor's responsibility to report any information that indicates an offender is being, or has been a victim of sexual violence, staff sexual misconduct, or sexual harassment. Training documentation is maintained in accordance with CDCR records keeping policy (32010.8.3).

Based on the above, ISP is in substantial compliance with standard 115.32.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The California Department of Corrections and Rehabilitation (CDCR) Department Operations Manual (DOM) Section 54040.4 states, "verbal and written information shall be provided to offenders which will address Prevention/Intervention, Reporting, Treatment, and Counseling." Additionally, policy requires that initial orientation regarding PREA be provided to offenders at CDCR reception centers during initial processing on a weekly basis.

Pre policy, PREA information is provided during initial processing. Information is distributed in both written and multi-media materials in both English and Spanish formats. Agency education materials were provided. Samples of the "Sexual Violence Awareness" brochure and "Sexual Abuse/Assault Prevention and Intervention" booklet. Are provided to inmates and each document provides detailed information about the CDCR's PREA policy, rights regarding PREA, and reporting contact information.

These documents also provide contact information for the CDCR's Regional Officer of Internal Affairs, the California Office of Inspector General PREA Ombudsman, and the local rape crisis center. PREA offender education is documented on the CDC 128-B in accordance with CDCR DOM Section 54040.4 and scanned into the CDCR Electronic Management System (ERMS).

Additionally, agency policy requires posters containing departmental policy, and contact information (addresses and telephone numbers) to report incidents of sexual violence, and staff sexual misconduct to be posted in designated areas throughout each institution and parole office. Per policy, this information is to be posted in all housing units, medical clinics, law libraries, visiting rooms, program offices, and offender work areas at a minimum. A tour of the facility revealed that this documentation is posted in excess of CDCR minimum policy requirements.

CDCR policy also allows for the use of offender peer educators (Master Facilitator's) to "enhance" the inmate population's knowledge and understanding of PREA in addition to the training already required by CDCR policy. Inmate facilitators are used support information already provided to the offender. ISP does provide PREA training via "Master Facilitators" and documentation was provided that demonstrates this practice.

ISP provided documentation indicating that all inmates were issued an addendum to the facility orientation handbook entitled "PREA Information for Orientation Handbook" on September 2nd, 2015. This document contains information regarding CDCR PREA policy; contact numbers to report an incident; victim advocate/support contact information and is provided in both English and Spanish. This information served to provide PREA education to inmates who had not received such education during initial processing.

CDCR DOM Chapter 5, Article 44, Section 54040.4 states, "Appropriate provisions shall be made to ensure effective communication for offenders not fluent in English, those with low literacy levels, and those with disabilities." CDCR policy also requires employees to query an inmate who scores a 4.0 or lower on the Test of Adult Basic Education (TABE) to determine whether or not assistance is needed to achieve effective communication. Priority is then given to the inmate's primary means of communication, which may include but is not limited to: auxiliary communication aids, sigh language interpreter services, and bilingual interpreter services.

As a result, the CDCR contracts with Interpreters Unlimited, Inc. which provides interpreter services via phone, internet, or facsimile (24) hours a day (7) days a week for any one of one hundred forty (140) languages. The agency also provides contract information regarding language interpreter services obtained through LIFESIGNS, Incorporated.

Randomly selected inmates were interviewed and presented as knowledgeable in agency PREA policy. All were aware of the contact information located throughout the institution and were provided PREA specific literature/media presentation during initial processing and upon arrival at CVSP.

Based on the above ISP is in compliance with standard 115.33.

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The California Department of Corrections and Rehabilitation (CDCR) Department Operations Manual (DOM) Section 54040.4 states, "All employees who are assigned to investigate sexual violence and/or staff sexual misconduct will receive specialized training." Therefore, specialized training is a requirement for "all employees" assigned to investigate allegations sexual violence and/or staff sexual misconduct.

CDCR DOM Chapter 3, Article 44, Section 32010.8.3 discusses the specific forms required to document completed training requirements. Specifically, training participation is to be recorded on the Training Participation Sign-In Sheet or CDCR 844. Per policy the Hiring Authority or PREA Compliance Manager shall ensure investigating employees are properly trained.

A copy of the "Specialized PREA Training for Locally Designated Investigators," training manual was provided for review. The training manual serves as the foundation for the 16 hour specialized LDI training course. Training is comprehensive in scope and includes such topics as crime scene preservation, evidence collection, evidence handling, investigative interview preparation, and interviewing techniques. This training also considers inmate victims with disabilities, mental illnesses, those who are LGTBI, the elderly, and those who are limited English proficient. Training addresses the proper use of Miranda, Garrity, and referrals for administrative resolution/criminal prosecution.

ISP Associate Warden/PREA Compliance Manager R. Smith provided documentation regarding PREA investigator training. A review of this documentation indicates that investigative staff has completed specialized investigator training in accordance with the standard.

Based on the above, ISP is in compliance with standard 115.34.

Standard 115.35 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR DOM Chapter 5, Article 44, Section 54040.4 states all staff including volunteers and contractors shall receive instruction regarding the prevention, detection, response, and investigation of offender sexual violence, staff sexual misconduct, and sexual harassment. Section

32010.10.1 states all employees new to the department shall receive orientation training within 90 days of appointment and covers the PREA act. Therefore, all medical/mental health staff receive agency PREA training.

Medical services responsibilities is outlined in Section 54040.8.3 and provides guidance regarding evidence contamination/preservation, outside medical treatment referrals, and follow up testing for sexually transmitted infections/diseases including HIV. ISP provided the audit team with an evidence collection/preservation kit that is utilized in the preservation and collection of evidence prior to sending an offender for outside medical treatment. Per 54040.9, ISP does not conduct forensic medical examinations. Victims are referred to an off-site Sexual Abuse Response Team (SART) at Eisenhower Medical Center located in Rancho Mirage, California.

SART teams are contract staff comprised of medical personnel including SANE. SART staff receives specialized training in sexual assault response. Forensic examinations are performed by SANE personnel who receive specialized training in conducting forensic medical examinations including the victim and offender-suspect. Upon return to the facility, the offender is assessed by a registered nurse and mental health care staff per Section 54040.10.

Agency policy requires medical/mental health care staff to participate in agency PREA training. Training is comprehensive in scope and includes crime scene preservation, evidence collection, evidence handling, investigative interview preparation, interviewing techniques and the detection, notification and reporting of sexual abuse and sexual harassment.

ISP provided documentation of medical/mental health care staff participation in agency PREA training. The training mandated by agency policy appears to meet the criteria stated in 115.35.

Based on the above, ISP is in compliance with standard 115.35.

Standard 115.41 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

California Department of Corrections and rehabilitation (CDCR) policy 54046.5 requires initial screening "upon arrival" at a reception center, program institution, administrative segregation unit, or security housing unit. Upon arrival at his/her, assigned institution the offender is then reassessed and the "electronic Initial Housing Review" is updated as necessary. A custody supervisor in accordance with policy conducts initial assessments. Offenders are subsequently referred to a classification committee to determine single cell status in accordance with CDCR policy 54040.6.

In accordance with CDCR policy 54040.6, all offenders are reviewed for single cell status at reception center processing, during annual classification reviews, upon referral for transfer, or placement. Consideration is given to predatory behavior, documented and verified instances of being a victim of physical or sexual abuse by other inmates, or a determination that single cell designation is appropriate. Again based on the classification committee (including questions related to sexual violence and victimization) the "Electronic Initial Housing Review" is updated to determine the most suitable housing assignment.

The "Electronic Initial Housing Review" is completed electronically and retained in accordance with CDCR record keeping policy. Access to inmate records is restricted based on the employee's position within the organization; therefore, only those who need access to screening information are granted access. ISP provided sample documentation of the "electronic Initial Housing Review" and "Classification Committee" reports for review.

A review of this documentation demonstrates that prior acts of sexual abuse, prior convictions for violent offenses, and a history of prior institutional violence or sexual abuse is considered during the screening process in accordance with CDCR policy. Additionally, consideration is given to all elements of 115.41(d). The committee screening process considers the "electronic Initial Housing Review" as

a whole. During Classification Committee review, the inmate is asked whether or not they received PREA information at intake, and if anything has changed since receiving the PREA information.

It was noted that CDCR policy 54040.6 explicitly prohibits disciplining offenders for refusing to answer, or not disclosing complete information related to their sexual orientation or sexual violence history.

ISP provided the audit team with several "initial Housing Review" reports for review. All reports were completed within 72-hour requirement. Additionally, reassessments were completed on the "Classification Committee Chrono" forms. A review of these documents indicates that reassessments were conducted within the 30-day criteria.

After reviewing the documentation, it appears that the screening instrument and processes utilized to screen offenders is objective. Furthermore, the documentation reviewed demonstrates that Ironwood State Prison completes the required screening well within required time limits.

Based on the above, ISP is in compliance with standard 115.41.

Standard 115.42 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR policy 54040.6 requires that inmates be screened upon arrival at an institution, facility, or program reception center for an appropriate housing assignment. Inmates who are identified/screened as high risk for sexual victimization via the "electronic Initial Housing Review," are not be placed in segregated housing, unless an assessment of all available alternatives has been completed, and there is no available alternative means of separation from likely abusers. Policy 54040.6 also states that inmates who are screened as a high risk of sexual victimization, and subsequently placed in segregated housing, shall have a housing assessment completed immediately or within 24 hours of placement into segregated housing. The offender is then scheduled for appearance before the Classification Committee for discussion of his/her housing needs.

The inmate's views on personal safety are considered at the Classification Committee stage. In accordance with policy 62080.14 transgendered inmates shall be referred to a classification committee in order to determine appropriate institutional placement and housing unit assignment. California Correctional Health Care Services (CCHCS) is also involved in the screening process. CCHS evaluates offender case factors and specific management plans with regard to offenders who are gender dysphoric. Furthermore, the CDCR does attempt to house transgendered or intersex inmates at specific facilities in order to better coordinate medical care of those who are engaged in hormone therapy. Be advised, these facilities are not designated for the sole purpose of housing transgendered or intersex inmates. Additionally, agency policy allows for placement tailored specifically addressing special case factors not explicitly covered in policy

Agency policy Section 54040.4 states, "each institution shall enable offenders to shower, perform bodily functions, and change clothing without non-medical staff of the opposite biological sex viewing their breast, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks." An LGTBI inmate was interviewed and indicated that he has the ability to adjust his routine to shower when he feels comfortable and this practice is not prohibited by staff. Furthermore, showers are single stall showers, and have a privacy barrier permanently affixed to the door. Based on the evidence it appears LGTBI inmates are afforded the opportunity to shower in relative privacy.

Based on the above, ISP is in compliance with Section 115.42.

Standard 115.43 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR policy 54040.6 requires that inmates be screened upon arrival at an institution, facility, or program reception center for an appropriate housing assignment. Inmates who are identified or screened as high risk for sexual victimization via the "electronic Initial Housing Review," are not placed in segregated housing, unless an assessment of all available alternatives has been completed, and there is no available alternative means of separation from likely abusers. Policy 54040.6 also states that inmates who are screened as a high risk of sexual victimization, and subsequently placed in segregated housing, shall have a housing assessment completed immediately or within 24 hours of placement into segregated housing. The offender is also scheduled for appearance before the Institution Classification Committee for discussion of his/her housing needs. Be advised, Ironwood State Prison (IWSP) reported that no inmates were placed in involuntary segregation during the past 12 months.
CDCR policy Title 15, Section 3335 requires Non Disciplinary Segregation (NDS) inmates shall be afforded all programs, privileges, and education. Additionally, Section 3344 states, "Inmates classified to ASU or SPHU shall be permitted to participate and have access to such programs and services as can be reasonably provided within the unit without endangering security or the safety of persons." This includes but is not limited to: education, commissary, library services, social services, counseling, religious guidance and recreation. Staff shall document opportunities that have been limited, the duration of the limitation, and the reasons for the limitations on CDC form 114-A.

Policy also requires that inmates be assigned to NDS only if until alternative means of separation from likely abusers can be arranged and shall not exceed 30 days. Every 30 days the inmate shall be reviewed to ascertain whether there is a continuing need for the inmate to be segregated from the general population. Deviation from the 30 days criteria is to be documented on the CDC Form 128-G. Agency policy appears to be in substantial compliance with regulation 115.43(b) and (e).

Title 15, Section 3336 indicates that an administrative segregation placement shall be reviewed for "retention or release" on the first business day following such placement. Reviews include case factors, reasons for segregations and an interview with the inmate. Additionally, a Classification Committee hearing shall be held within 10 days of placement into administrative segregation. Section 3342 requires continuous case reviews of every inmate, assigned to segregated housing, to be evaluated by custodial and casework staff assigned to the unit. Staff will confer on each case no less frequently than once per week." The rationale for ordering inmate placement in ASU is to be documented on the CDC From 114-D. The documentation provided appears to demonstrate compliance with 115.43(c) & (d).

There were no cases of involuntary segregation during the current audit period. Therefore, documentation of actual practice is limited to policy content.

Based on the above ISP is in compliance with Section 115.43.

Standard 115.51 Inmate reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The Agency DOM, Chapter 5, Article 44, Section 54040 and facility DOM Supplement indicates that prisoners may report through verbal/written report to any staff member, by utilizing the CDCR PREA Hotline (the number is available on the posters found in each housing unit and throughout the facility) or through the prisoner appeal (grievance) process. Reporting may also be done by contacting the Office of Internal Affairs (OIA) and Ombudsman's Office. Random interviewed staff were all aware of various methods for prisoners to report. The PREA Coordinator stated that prisoners can use the OIA for private reporting purposes.

Investigations are initiated as soon as the information is relayed to the PREA Coordinator or Investigative Services Unit (ISU). Random interviewed staff were all aware that reports shall be accepted whether done verbally, in writing, anonymously or from a third party and that documentation and reporting to their supervisors was required to be completed immediately. Agency DOM and facility DOM Supplement indicate staff may privately report sexual abuse or sexual harassment as well. Staff were also aware of the hotline and all avenues available to report. All inmates interviewed indicated that they knew how to report (staff, appeal, hotline, Chrono). All indicated they could also tell a family member or third party if needed and the third party could report on their behalf. All were aware a report could be made without giving their name. All areas of the facility had adequate postings indicating how to report. Some inmates interviewed did indicate they would find it too embarrassing to report or simply would not report something of this nature.

All reports were reviewed in the ISU and all supported compliance with this standard. All indicated immediate action took place and the investigations were immediately started.

All hotlines were called and were in working order. Although the postings in the facility indicate that all calls made from the prisoner phone system are recorded, the calls go the regional Officer of Internal Affairs offices and the information they receive remains confidential to the extent of the source of the complaint outside of receiving it via the hotline.
The facility tour revealed posters readily available for offenders, staff and the public to view which provide the number to the PREA Hotline in all areas accessible and frequented by staff, inmates and visitors to the facility. Randomly interviewed staff are aware of the various methods for prisoners to report. The PREA Coordinator stated prisoners can use the OIA for private reporting purposes. Investigations are initiated as soon as the information is relayed to the PREA Coordinator or Investigative Services Unit (ISU). Randomly interviewed staff are aware reports shall be accepted whether verbal, in writing, anonymous or from a third party, and require appropriate documentation and reporting to their supervisors immediately.

The CDCR does not house detainees for the sole purpose of civil immigration. Therefore this portion of the standard does not apply.

CCR Title 15, Chapter 1, Article 8, section 3401.5(c) states any employee who observes, or who receives information from any source concerning sexual misconduct, shall immediately report the information or incident directly to the institution head, unit supervisor or highest-ranking official on duty who shall than immediately notify the Office of Internal Affairs. Staff may also report utilizing any of the methods for reporting available to offenders.

Standard 115.52 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CCR Title 15, Chapter 1, Article 8, section 3084 and DOM, Chapter 5, Article 53, Section 54100 covers the appeals process for the CDCR. The agency has a formalized appeals process that allows inmates to file an appeal without having to submit to the staff member who is the subject of the appeal and that the appeal will not be forwarded to the staff member. DOM Chapter 5, Article 44, Section 54040.7.2 and 54040.7.3 allows a third part to file on the behalf of an inmate. The agency does not allow an inmate to decline the pursuing of an allegation and will investigate all alleged sexual abuse claims regardless of who filed the original appeal.

Standard 115.52 clearly states the agency shall not impose time limits on when an inmate may submit a grievance, an inmate can file without having to submit to the staff member who is the subject of the grievance, a final decision will be made within 90 days from initial filing, third parties may file on the behalf of an inmate and emergency grievances will have a final agency decision within 5 calendar days. The agencies policies and practice meets the filing portion of the standard but does not meet the time limits imposed.

The agencies current polices do not require a final decision within 90 days and emergency appeals will be responded to within 5 business days in contrast to the required 5 calendar days as outlined in the standard. Although the facility has shown that all of the seven appeals filed were responded to within the 90 day timeframe, the agency does not meet this portion of the standard due to current language within their policies.

CDCR §3084.2 Appeal Preparation and Submittal, section (g) states an inmate or parolee shall not submit an appeal on behalf of another person; §3084.6 section (c)(5) states an appeal may be cancelled for any of the following reasons, which include, but are not limited to…..(5) the appeal is filed on behalf of another person. Additionally, DOM 54100.6 "Appeal Preparation," states an inmate or parolee shall not submit an appeal on behalf of another person. The auditors find this to be contrary to the requirements outlined in PREA §115.52(e).

DOM, Chapter 5, Article 44, Section 54040.15.1 does allow for an inmate to be disciplined for filing an appeal alleging sexual abuse in bad faith. The facility reported on the Pre-Audit Questionnaire (PAQ) that they had no such appeals filed resulting in disciplinary action.

Remedial Action Recommendation: The agency has proposed language to their policies that is pending final approval at the agency level. The proposed language adjusts time limits for appeals and falls within the time limits imposed by this standard. The emergency appeals process updates the time frame for receiving a final decision from 5 business days to 5 calendar days, also complying with this standard. Proposed changes provides for an exception to the prohibition of prisoners filling appeals on behalf of other prisoners in cases alleging sexual violence, staff sexual misconduct and sexual harassment, complying with the standard. Once final approval to the language is achieved and notice of the changes has been provided to all staff and offenders, the agency will be in compliance. The agency has agreed to this remedial action plan to achieve compliance and will forward the documentation to prove that final approval was achieved and that the policies have been updated to reflect compliance.

Corrective Action Plan Completed: Standard 115.52 now clearly states the agency shall not impose time limits on when an inmate may submit a grievance, an inmate can file without having to submit to the staff member who is the subject of the grievance, a final decision will be made within 90 days from initial filing, third parties may file on behalf of an inmate and emergency grievances will have a final agency decision within 5 calendar days. The agencies policies and practice meets all aspects of this portion of the standard.

CDCR §3084.2 Appeal Preparation and Submittal, section (g) now states an inmate or parolee shall not submit an appeal on behalf of another person, unless the appeal contains an allegation of sexual violence, staff sexual misconduct, or sexual harassment. This sufficiently address the requirements set forth in this standard. §3084.6 section (c)(5) states an appeal may be cancelled for any of the following reasons, which include, but are not limited to…..(5) the appeal is filed on behalf of another person, unless it contains allegations of sexual violence, staff sexual misconduct, or sexual harassment of another inmate. Again, this language sufficiently address the requirements of the standard.

Standard 115.53 Inmate access to outside confidential support services

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

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

DOM, Chapter 5, Article 44, Section 54040.8.2 requires that each facility to contract with a Victims Advocacy Group (VAG) for the purposes of providing emotional support services related to sexual abuse. The facility has entered into an agreement with a local crisis

center to provide victims support in sexual abuse cases. The facility has provided a pending MOU and has shown clearly that they have attempted to enter into an agreement and are in the final stages of approval. In the meantime, the VAG has agreed to provide services absent a signed agreement. The facility posts notices in all of the units and other commonly accessed areas for the offenders to review. The posting has the contact information, including a toll free number and an address to be utilized by inmates to contact them. The postings also reference specifically the PREA standard to which this applies (115.21(e)) in the description stating the purpose of the posting. The posting also includes language stating that the VAG will; 1) Maintain confidentiality as required by state and federal laws for Sexual Assault Counselors and 2) Provide emotional support services related to requests from incarcerated victims.

During the interviews with random inmates, the auditors discovered, although not all of the inmates knew the number or address for the services, they were all aware of the postings and where to view them. This is not a negative reflection on the facility, as they have taken great strides to ensure PREA education and related information is disseminated and available to all inmates, who in return also have a responsibility to acknowledge and accept this material.

During the tour, it was noted this posting was adequately posted in the housing units and support buildings. Based on the amount of postings throughout the facility it is not likely any inmate would be unaware of the information and how to contact them unless it was, as indicated during the interviews, they simply have no need to be familiarized with the information.

Standard 115.54 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The CDCR has created three Sexual Abuse Hotlines available to prisoners, staff, and the community. The CDCR website has a reporting option lists all of the reporting options so any member of the public can access it. The website was in working order when checked during the audit. Additionally, the CDCR has entered into an agreement with the Office of Internal Affairs and the Ombudsman's Office to accept reports by mail or phone. All three hotline numbers were called and were in working order. This information is also available throughout the facility on the postings in order to allow an inmate to personally report or give the information to a third party to report on their behalf.

Standard 115.61 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR provided DOM, Chapter 5, Article 44, sections 54040 to support compliance with this standard. Polices provide clear requirements to all staff regarding their obligation to report immediately any suspected or reported incidents involving sexual abuse and/or sexual harassment, regardless of whether the alleged incident took place at the inmates current facility or not. Sections of the same policy require all reports and information related to allegations remain confidential to the extent necessary for treatment, investigation and for other management decisions.

Interviews with random staff all confirmed compliance and all were able to articulate the reporting process and what is required of them when doing so. In every interview the staff person was aware of the requirement to immediately report all allegations of sexual abuse and/or harassment as well as the requirement to document the report in writing as soon as possible. Each was able to articulate the process of being a first responder as well. Numerous custody and non-custody staff were interviewed and all knew the process very well which indicates they receive and absorb the training required.

Medical and mental health staff have a requirement to report information regarding incidents of sexual abuse. This was verified by review of their policy, IMSP&P Volume 1, Chapter 16.1 and 16.2. While interviewing medical and mental health staff, all indicated they are mandatory reporters and will do so as required.

However, the latter half of this portion of the standard requires medical and mental health staff to inform inmates of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services. Interviews with medical and mental health supervisory staff indicated line staff are required to inform offenders of such limitations to confidentiality and the staff member's obligation to report. However, interviews with medical and mental health line staff and offenders prove this practice is not being implemented at the facility. Although supervisory staff indicate this should be happening, the facility cannot demonstrate it is actually occurring, requiring the auditors to rely on the information derived from interviews which indicate non-compliance with this portion of the standard.

Section (d) of this standard does not apply as the facility does not house inmates under the age of 18.

DOM, Chapter 5, Article 53, Section 54100.25 requires all allegations of sexual abuse and/or harassment be investigated. After the initial report is received, ISU staff immediately begin to conduct an investigation into the allegation(s) received. During the interview, the Warden indicated all allegations are immediately reported to the ISU staff for investigation. This was also confirmed during the interview with the ISU investigator.

Remedial Action Plan: The facility will need to develop a method to inform and train medical and mental health staff of the requirement to inform offenders of the limited confidentiality and the staff member's obligation to report. Once this method is developed, a plan of implementation must be put into action to inform staff of the requirements. Additionally, a notice to the offender population must be posted and/or delivered to 100% of the current prisoner population at the facility informing them of this practice. Once completed, the facility will be in full compliance with this standard.

Corrective Acton Plan Completed: The facility provided PREA training to all nursing staff via review of the Inmate Medical Services Policy and Procedure Volume 1, Chapter 16.1 and 16.2. Of the details included in the training, the following language was included: "Providers shall be required to: Report allegations of sexual violence, staff sexual misconduct, and sexual harassment" and "Inform patients of the provider's duty to report, and the limitations of confidentiality, at the initiation of services."

The aforementioned language contained within the training and evidence staff have verified through signature they received and understand the training provided, sufficiently complies with this standard.

Standard 115.62 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

DOM Chapter 5, Article 44, Section 54040.7 addresses this standard and specifically states all staff shall take immediate action to protect prisoners at risk of imminent sexual abuse. The interview with the Agency Head confirmed when an inmate is subject to substantial risk the inmate will be located and assessed in order for staff to take the appropriate action. The Warden indicated the inmate will be immediately separated from the threat in the least restrictive method possible. This was also confirmed by speaking to many staff

members during the tour, both custody and non-custody, and through the random staff interviews that were conducted. All staff members were aware of the requirement to immediately remove the prisoner from the area of the imminent threat.

Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM, Chapter 5, Article 44, Section 54040.7.4 specifically addresses this standard to ensure compliance. Upon receiving an allegation that an offender was the victim of sexual violence or staff sexual misconduct while confined at another institution or facility, the hiring authority (Warden) where the allegation was received shall notify the hiring authority of the institution or appropriate office of the agency where the alleged incident occurred via telephone or email within 72 hours after receiving the allegation.

The facility reported in the 12 months preceding the audit that they had **1** instance of an inmate reporting they were abused while confined at another facility. They also reported for the same time frame they received **1** report from another facility where an inmate reported sexual abuse while housed at the facility. It was found through reviewing facility reports the facility is making the proper notification within 72 hours to other facilities when the abuse is reported at this facility. Copies of the email notifications to the other facility's ISU unit were printed and kept in the investigation report folders as proof of notification. All reports had the proper documentation to support compliance.

When a report is received by this facility from another facility about an allegation of abuse at this facility, the investigation was started immediately as required. This was well documented and all reports were immediately acted upon and documented in the investigation files.

Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

DOM Chapter 5, Article 44, Section 54040.8 has extensive information explaining the duties of staff that are first responders to allegations of sexual abuse or acts of sexual abuse. The policies require all staff to follow the protocol as dictated by this standard, including the separation of the alleged victim from the alleged abuser, preservation of evidence and the crime scene and to not allow the victim or abuser to take any action that would destroy physical evidence if the alleged incident took place within a time frame that would still allow for collection of that evidence.

The facility reported that within the preceding 12 months of the audit that they had **1** reported allegation that an inmate was sexually abused. In that case the first responder was a custody staff person and the proper protocol, as outlined in policy, was followed.

A review of the investigation files indicate staff do an excellent job of managing their duties as first responders and follow all of the required steps to keep both the alleged victim safe as well as the alleged abuser. In this, the only case, staff took immediate action and followed the proper protocol.

The facility provided facility staff with a pocket reference to show compliance. The pocket reference is given to all staff as a quick reference guide for staff response to allegations of sexual violence against inmates. A copy of the pocket reference provided to the audit team as part of the audit and is recognized as an excellent practice by the CDCR. The reference covers all steps to take during incidents of sexual abuse and if followed assures compliance with this standard. All staff interviewed during the tour, during random staff interviews and during First Responder interviews knew how to respond to and appropriately handle allegations of sexual assault as a first responder.

Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Facility as developed a facility specific DOM Supplement to 54040. The DOM Supplement breaks down the required duties of every staff member involved in the handling of sexual abuse cases, from First Responders, Supervisory staff, Medical staff, Mental Health staff, Investigative staff and Administrative staff.

The Warden stated the DOM Supplement has been implemented to outline everyone's responsibilities and the PREA Review Committee is utilized to ensure all elements of the standard are met for each incident reported. The facility pocket reference mentioned in §115.64 also addresses this and is available to all staff. A review of the investigative files shows each incident is reviewed by the PREA Review Committee as required to ensure compliance is met as well looking for areas of opportunity to improve or correct performance and/or to enhance the safety of the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility provided the collective bargaining unit, effective on July 13, 2013. The audit team reviewed the contract and found nothing, which impedes the agency's ability to remove alleged staff sexual abusers from contact with any prisoner(s) pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

An interview with the agency head of the CDCR confirmed compliance with this standard.

Standard 115.67 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM Section 54040.1 specifically states retaliatory measures against employees and offenders who report incidents of sexual violence, staff sexual misconduct or sexual harassment as well as retaliatory measures against those who cooperate with investigations shall not be tolerated and shall result in disciplinary action and/or criminal prosecution. The policy goes on to define retaliatory measures as coercion, threats of punishment, or any other activity intended to discourage or prevent staff or offenders from reporting or cooperating with investigations. Additionally DOM Sections 31010.1 and 31140.10 specifically address a prohibition against retaliation against staff.

The agency employs multiple protection measures as outlined in DOM Section 54040.7 which details staff responsibility to protect the offenders in their custody. This includes immediate reporting, assisting offenders with receiving medical/mental health care, and discussing housing requirements necessary to maintain the offenders safety. This includes considering housing victims with other offenders how have compatible needs in lieu of segregation when appropriate or single cell placement.

(c) Agency DOM Section 54040.13 requires staff to monitor, for a minimum of 90 days following a report, the treatment of inmates and/or employees for treatment which might suggest retaliation. The policy outlines the following as items to be monitored during periods of retaliation monitoring: periodic status checks, disciplinary reports, housing or program changes or negative performance reviews or reassignments. The agency created a "Protection Against Retaliation" form (PAR) as a tracking device to ensure compliance with this standard. The form details when monitoring begins and ends. The form details which investigation it relates to, who is being monitored and what the final outcome of the investigation was. The form has locations to provide ongoing monitoring and status checks of the inmate with areas for comments on housing assignment, support services utilized, disciplinary reports, work assignment evaluations and other possible changes that should be monitored to determine if retaliation is occurring.

Agency DOM Section 54040.13 provides for the assignment of monitoring to anyone who fears retaliation for reporting or cooperating with an investigation. It allows for termination of monitoring in cases where the investigation determines that the allegation is unfounded or proven false.

The facility had no reports of retaliation occurring within the past 12 months.

Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

DOM Chapter 5, Article 44, Section 54040.6 and CCR, Title 15, Sub-chapter 4, Article 7, section 3335(b) & (c) indicates inmates will not be placed in involuntary segregation unless an assessment of all available alternatives has been made and a determination is made that no alternative is available. The facility will assess any inmate in these circumstances within 24 hours and then within 10 days by the Security Classification Committee.

There are no segregation cells located at this facility.

Standard 115.71 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

DOM Chapters 3, Article 14, Sections 31140.6, 31140.11, 31140.16 and DOM Chapter 5, Article 44, Sections 54040.8.1 and 54040.12 addresses investigations of sexual abuse and sexual harassment. The policies dictate all facilities conduct investigations into allegations of sexual abuse and harassment immediately upon becoming aware of the allegation, regardless of how the report is received. This is verified during the interview with investigative staff. The review of investigations during the audit revealed all allegations received were immediately addressed.

The Department's Basic Investigator Training and PREA Locally Designated Investigator (LDI) training detail how and when investigations are conducted. Agency custody staff and investigators are sworn Peace Officers and handle criminal as well as administrative investigations. All ISU staff members have received specialized PREA investigation training as reflected in the training documents reviewed. The investigative staff interviewed covered what was received during training including how to handle sexual abuse investigations, interviewing victims, and evidence collection and preservation. All staff knew the elements of completing a comprehensive investigation. Investigative files were reviewed and all the appropriate documentation was present, including, interviews, evidence collection methods and results, witness reports, information on the methodology on arriving to the conclusion, including the review of both the victim and perpetrator histories, and a proper conclusion, including any referrals for criminal prosecution to the prosecutor's office.

CDCR's Office of Internal Affairs Investigator's Field Guide (May 2008) addresses section (d) of this standard. The guide mandates that should an employee invoke his/her right under Miranda, the investigator shall consult with the SAC and the local District Attorney in the county that the case will be referred to regarding the decision to take a compelled statement. Interviews with the ISU investigators confirmed they do consult with DA when evidence appears to support criminal prosecution.

DOM Chapter 5, Article 44, Section 54040.12 and CCR Title 15, Sub-chapter 5, Article 2, Section 3401.5 addresses the use of polygraph examinations. The referenced policies do not allow agency staff to require an inmate submit to a polygraph. An interview with investigative staff indicates they take into account the totality of circumstances and the facts to determine credibility and the credibility of inmates is not based on their status as such.

DOM Chapter 3, Article 14, Section 31140.11, 31140.16, 31140.21 and 31140.40 addresses section (f) of this standard. The policies require investigative staff to review areas that may have led to the sexual abuse. An interview with investigative staff indicated they look at everything related to the incident to see if anything, including staff actions, may have contributed to the incident. A review of the investigative files showed show appropriate documentation within the reports of the physical evidence as well as interviews and testimony leading to the report's conclusions.

The above referenced policies also indicate investigations will continue even if the alleged abuser has departed from the facility. The facility reported no cases where this occurred. However, an interview with investigative staff indicates they will continue with the investigation regardless of whether the staff person or inmates are present at the facility.

Investigative staff investigates both administrative and criminal investigations. Therefore, section (l) of this standard does not apply.

Standard 115.72 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM, Chapter 3, Article 22, Section 33030.13.1, Penal Code 502 and 1096, DOM Chapter 5, Section 52080.9.3 clearly state the agency shall impose no standard higher than preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Interviews with investigative staff verify the practice of utilizing the preponderance of the evidence standard is utilized at the facility.

Standard 115.73 Reporting to inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM Chapter 5, Article 44, Section 54040.12.5 addresses this specific standard by requiring written notification be provided to the victim to indicate the outcome of the investigation. The notification shall include information on the perpetrator and the status of that person as far as employment, placement and future prosecutions. The Agency also created a notification form (CDCR 128-B) to notify inmates of the findings of the administrative investigations.

The facility reported zero allegations against staff that would have required the notifications in section (c). The facility reported no instances where the notification requirements in section (d) needed to be met. Investigative staff were questioned about what and when an inmate would be notified and all were aware of the requirements in these sections.

Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Article 2, Section 3401.5 DOM, Chapter 3, Article 22, Section 33030.17, Disciplinary Matrix D17, D18, and D19 outline disciplinary standards for employees, volunteers and contractors and meet the requirements set by the standard. Agency police describe termination as the presumptive sanction and that disciplinary history, circumstances of the act and sanctions of similar offenses will be considered. Interviews with staff confirmed the facility is following the standard as written.

The facility reported zero instances on the PAQ. Agency policy and interviews with investigative staff indicate that any criminal behavior will be referred to the prosecutor's office requesting charges.

Standard 115.77 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Requirements covering this standard are provided in Agency policy CDCR Special Terms and Conditions, Attachment D, DOM Chapter 5, Article 44; Section 54040.12.4. The Facility reported on the PAQ no cases of sexual abuse/harassment involving contractors or volunteers. This was confirmed during the facility audit tour. The Facility ISU staff state they will investigate allegations reported against contractors/volunteers as any other PREA case and would refer allegations for criminal prosecution if warranted.

Information regarding remedial measures is written into Agency contracts.

Standard 115.78 Disciplinary sanctions for inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy CCR, Division 3, Subchapter 4, Article 5, Sections 3316, 3320, and 3323 covers this standard and considers all specifics listed in the standard when imposing sanctions. The Agency does not allow for consensual sexual relations. The Facility does however make condoms available to inmates. The Agency and Facility state this program is designed to and has proven to help reduce the transmission of sexual diseases. Although consensual sex is not allowed, they are aware it may occur in a prison setting.

The Facility reported one case of prisoner/prisoner sexual abuse and no cases of discipline against prisoners for consensual sexual acts. During the audit tour staff were asked about consensual acts and all reported they would first confirm it was consensual and not forced, prior to writing violations codes. Staff also indicated they would inform the ISU. ISU staff were questioned about this and indicated they would initially investigate this to ensure it was not a coerced/forced act.

Standard 115.81 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR policy, 54040.7, Detection, Notification and Reporting, requires if reported by an inmate during intake screening, he has experienced prior sexual victimization or previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure the inmate is referred to mental health utilizing the CDCR form 128-MH5, Mental Health Referral Chrono. In addition, any staff member with significant concern an inmate may be subject to sexual victimization, shall immediately notify a custody supervisor who will refer that inmate for a mental health evaluation per existing policy regarding mental health referrals.

The requirements of agency policy and the inmate screens meet the requirements of this standard with regard to the process of referral and mental health follow-up. In the past 12 months, all inmates who have disclosed prior sexual victimization during screening and all inmates who have disclosed any previously perpetrated sexual abuse as indicated in the screening have been referred to Mental Health and a follow-up was completed immediately. The inmate(s) were referred to Mental Health immediately by phone and a Mental Health Referral Chrono was completed and sent to Mental Health. An evaluation is conducted the same day if occurring during normal office hours, and Mental Health staff are on call when incidents occur outside of normal office hours, at which time an evaluation was conducted within a couple of hours of the referral.

Information related to sexual victimization or abusiveness occurring in an institutional setting is strictly limited to medical and mental health practitioners, and other staff only as necessary to inform treatment plans, security and management decisions. Medical and Mental Health staff only have access to the electronic medical records and information would only be shared if it is absolutely necessary for treatment and security decisions as indicated above.

While Mental Health staff utilize an Informed Consent form and it is documented in the electronic medical record, the Informed Consent form does not include reporting information about prior sexual victimization not occurring in an institutional setting. The agency is in the process of revising the Informed Consent form to include this information. However, because this information is not included on the form currently in use, facility does not meet the requirements of section (e) in this standard.

Remedial Action Plan: The agency has agreed to a remedial plan to modify their existing Informed Consent for Mental Health Care form (CDCR 7448) to specifically address sexual abuse in a non-institutional setting. The Agency will also need to advise/train specified staff of the change to ensure future compliance. The agency will forward the documentation to the audit team to show final approval was achieved and the form is in place agency wide. Upon completion and review of this form by the audit team, the agency will be in full compliance of this standard.

Corrective Acton Plan Completed: Following the audit the CDCR revised their Health Care Services Policy volume 1, chapter 16 to state when a patient who is 18 years of age or older alleges he/she was the victim of sexual violence or misconduct that occurred outside of an institutional setting and requests the incident be reported, or upon receipt of a custody referral for the same situation, health care shall obtain authorization from the patient utilizing CDCR form 7552 and submit it to the ISU for appropriate reporting. The CDCR provided a sample of the form, along with documentation all CDCR employees where made aware of this change and requirement. Based on the information provided, the CDCR and Ironwood State Prison are now in compliance with section (e) of this standard.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR policy, Chapter 12, Emergency Medical Response, requires medically necessary emergency medical response, treatment and transportation is made available twenty-four hours per day to inmates. Inmates may request medical attention for urgent/emergent health care needs from any employee. The employee shall, in all instances, notify health care staff. In addition, Chapter 4 requires that CDCR 7362, Health Care Service Request form, which is a confidential medical document for inmate requests, must be made available to inmates. There shall be at least one locked box for depositing of these forms on each yard. In addition, inmates know who they can report sexual abuse to, and the avenues by which they can report if they do not want to verbally report. Through random inmate interviews it was found that inmates were educated on the different ways they could report at orientation and through pamphlets, handouts and a video.

Through Random staff interviews it was found that staff have the knowledge of the proper steps that must be taken in order to protect the inmate victim after sexual abuse is reported and immediately notify a supervisor and/or make a referral to Mental Health.

If the reported sexual abuse occurs outside of normal working hours and Mental Health staff are not currently at the facility, staff indicate that all measures are taken to protect the inmate victim and a referral is made. An interview with the Clinical Social Work Supervisor indicated that there are on call Mental Health staff who can be at the facility within an hour for immediate evaluation. Mental Health electronic records were reviewed for cases of reported sexual abuse and all victims were referred appropriately and were evaluated the same day as the referral, generally immediately.

Medical staff indicated that inmates who report sexual abuse have access to medical treatment and sexually transmitted infection prophylaxis at no charge and no co-payment charge is assessed.

Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy IMSP&P Volume 4, Chapter 4 Access to Care; Chapter 12 Emergency Response; IMSP&P Volume 1, Chapter 16, PREA Policy; Mental Health Program Guide 2009 adhere to sections a-g of this standard. Investigative Reports and medical/mental health reports reviewed during the audit reflect prisoner victims are receiving medical and mental health care as required. During audit interviews all staff reported prisoners who report being sexually abused are immediately referred to medical and mental health services. Medical and mental health staff interviewed indicate prisoner victims would be immediately evaluated and treated. Prisoners are not charged for these services. Treatment and evaluation of prisoners are consistent with community level of care and include follow-up evaluations, treatment and referrals where necessary.

However, agency policy does not require the facility to conduct a mental health evaluation on known abusers within 60 days of learning of such abuse history.

Remedial Action Plan: The agency has agreed to revise existing policy to require attempts to evaluate known abusers within 60 days of

learning of such abuse history in order to be compliant with this standard. Once the agency provides the auditors with an updated and approved policy. The facility will need to demonstrate compliance by providing the audit team with examples of such referral(s) if any are made within 180 days of this report.

Corrective Acton Plan Completed: Implemented changes to DOM 54040.11, Suspect Processing addresses offender reporting of abuse. The addition of the following language sufficiently address the elements of this standard. CDCR has added "the custody supervisor will complete a referral to mental health for a mental health evaluation and assessment of treatment needs", regarding the suspect in a sexual abuse case. Agency policy requires mental health staff to see offenders, once referred, within 5 days.

Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM Chapter 5, Article 44, Section 54040.17 requires reviews to be held within 60 days of discovery of the sexual abuse incident. The policy indicates the Institution Head or designee, PREA Compliance Manager, Designated Managerial employee, In-Service training Manager Health Care and Mental Health staff will be part of the review team. The forms and policies require during the review that teams consider all of the factors listed under element (d) of this standard. The Agency reported their policy changed in July of 2015 to require these reviews to be conducted. The Agency was questioned as to how this 60 day policy complies with the standard, which states that a review ordinarily occurs within 30 days of the conclusion. Their explanation was that they exceed the standard because regardless if the investigation is complete, they meet monthly to discuss the incident to determine if there were contributing factors that may have led to the abuse. By setting the standard that they meet within 60 days of discovery, they ensure that issues that may have contributed do not go without being addressed if the investigation is prolonged for any reason.

A review of facility investigation files provided documentation showing all Sexual Abuse Incident Reviews are being conducted within 30 days of the investigation being finalized. This meets the standard and agency policy regarding the reviews.

There have been no recommendations provided as a result of the Sexual Abuse Incident Reviews for the facility. Staff interviewed indicate if recommendations are made during these reviews, they are immediately addressed by administration.

Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM Chapter 5, Article 44, Section 54040.20 and 54040.19 covers this standard. The policy requires the Agency to collect the data annually. Facilities are required to send the SSV-IA form with every report of sexual abuse/harassment within 48 hours. Investigation files reviewed during audit confirmed the forms are being sent. Agency data is compiled on a yearly tracking report and updated as investigations are concluded. Tracking reports were reviewed and show data being collected from all facilities.

The Agency reports they provide this information to the Department of Justice when requested. However, as of the date of this audit they have not been requested to do so for the previous year.

Standard 115.88 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM Chapter 5, Article 44, Section 5040.17 and 19 requires data to be collected and reviewed in order to improve the effectiveness of its sexual violence prevention, detection and response. Agency policy requires a comparison and assessment and such data will be made available to the public on the Agency's website. Policy also allows for data to be redacted if it presents a threat to safety and security.

However, there is no formalized process in place. The Agency reported the foundation has been laid for a formalized process and it should be completed in the near future and documentation will be posted on the agency's website.

Remedial Action Plan: The agency will need to finalize this process to be compliant with this standard. The agency has agreed to this remedial action plan to achieve compliance and will forward the documentation to prove final approval was achieved and the process is in place.

Corrective Acton Plan Completed: The agency has sufficiently finalized the process of implementing a formalized process of collecting and reviewing data in order to make annual comparisons and assessments of its efforts to address sexual abuse. The agency drafted a formal report and has published it on their website at http://www.cdcr.ca.gov/PREA/index.html.

Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency DOM Chapter 5, Article 44, Section 54040.20 requires data to be securely maintained, requires the data is made available to the public through the Agency website, requires identifiers to be removed and data to be maintained for at least 10 years. Agency policy also ensures data from contracted facilities is included in reports.

Facility files were found to be kept in a secure area and only accessed by authorized staff. The Agency website was reviewed and PREA information was posted and easily available to the public.

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.

Todd Butler — January 17, 2017

Auditor Signature — Date