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

ADULT PRISONS & JAILS

Date of report: November 4, 2016

Auditor Information			
Auditor name: James Schiebner			
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Telephone number: (616) 902-7498			
Date of facility visit: 4/13/16 to 4/15/16			
Facility Information			
Facility name: Mule Creek State Prison			
Facility physical address: 4001 Hwy 104, Ione, CA 95650			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 209-274-4911			
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: Warden Joe A. Lizarraga			
Number of staff assigned to the facility in the last 12 months: 1293			
Designed facility capacity: 1708			
Current population of facility: 2805			
Facility security levels/inmate custody levels: I/III/IV			
Age range of the population: 18-87			
Name of PREA Compliance Manager: Juan Cantu		**Title:** Associate Warden	
Email address: juan.cantu@cdcr.ca.gov		**Telephone number:** 209-274-4911 ext. 5544	
Agency Information			
Name of agency: California Department of Corrections and Rehabilitation			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1515 S. Street, Sacramento CA 95811			
Mailing address: *(if different from above)* PO Box 942883, Sacramento CA 94283			
Telephone number: 916-324-6688			
Agency Chief Executive Officer			
Name: Scott Kernan		**Title:** Secretary	
Email address: scott.kernan@cdcr.ca.gov		**Telephone number:** 916-323-6001	
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 Mule Creek State Prison located in Ione, California. The audit team consisted of certified PREA auditors Todd Butler, Kristopher Steece, Yvonne Gorton and James Schiebner (author). The audit began in early March with the delivery, via CD, of the statewide and facility documentation and the required Pre-audit Questioner from the facility. The audit team began the pre-audit portion shortly after receiving the CD from the facility. The fillable audit tool was completed by each auditor for the standards assigned to them. The onsite facility tour began Wednesday, April 13, 2016 and concluded Friday, April 15, 2016, with Friday the 15th being a group teamwork day to assemble the audit report and all documentation. The audit began with a facility greeting from Warden Lizarraga and his administrative team consisting of the Chief Deputy Warden, PREA Compliance Manager, Associate Warden Cantu, the Public Affairs Officer, several non-custody and custody supervisors along with the agency headquarters PREA Coordinator Shannon Stark and PREA Lt. Matthew Rustad. The purpose and outline of the audit process and facility tour was explained along with the audit team's expectations and requirements for a successful audit.

On the first day of the site visit, two auditors, Kris Steece and Todd Butler, toured facilities D and E as well as the support buildings and Level I stand-alone unit outside the secure perimeter while myself and Yvonne Gorton toured facilities A, B and C. Upon completion of the walkthrough tour, the team reconvened and split up the interviews to be conducted.

Upon arrival to the facility, PREA posters (English and Spanish versions) were visible in the front entrance (gate area) for both staff and visitors to view. As the team toured the facility, posters were present in every building available to offenders, mainly at entrances and on bulletin boards where offenders, the public and staff had access. Based upon our random discussions with staff and offenders, PREA posters were readily available at any location available to staff and offenders alike. Along with the PREA posters, a memorandum outlining the facilities agreement with Operation Care, a victim advocacy group available to victims of sexual abuse, was posted. 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.

The use of cameras at Mule Creek is limited to exterior locations and some specific locations within some buildings. The limited camera coverage is due in part to the age and funding for significant camera system upgrades. However, while conducting interviews with the Warden and other administrative staff, it was apparent that the facility has considered the lack of cameras in their staffing plan and supplemented with additional staff to ensure offender safety and the overall security of the facility. The physical layout of the units also allows good visual coverage by staff. The implementation of cameras was done in a manner which provided additional monitoring where limited staff were available and to cover any blind spots while not impeding upon prisoner privacy. The newly constructed D and E facilities within the Mule Creek Complex has extensive camera coverage which clearly indicates the agency and facility considered areas of limited visibility and additional camera coverage a priority for custody and security purposes.

During the audit tour, the team observed camera placement, sufficient custody staff coverage in the absence of camera coverage, reviewed log books, offender files, spoke with offenders, staff, volunteers and contractors. The facility has implemented measures such as mobile and permanent modesty panels placed in showers and bathrooms to ensure prisoner privacy while showering, using the toilet or otherwise in a state of undress. Log books were reviewed for and showed evidence of supervisory rounds on all three shifts as well as announcements about opposite gender staff working within the housing unit. Staff and offenders were questioned regarding PREA and reporting/responding requirements. All answered with appropriate levels of understanding in regard to PREA and agency policy and procedure. Prisoners and staff interviewed also indicated that staff of the opposite gender does in fact make the announcements when entering the housing units.

During the interview phase of the audit, members of the audit team spoke with random offenders and staff as well as specialized staff and any specialized offenders present at the facility during the time of the audit. Interviews were conducted in areas of relative privacy. Everyone interviewed participated willingly and appeared to have a good understanding of the PREA standards and the agency's response, requirements regarding the standards, zero tolerance and reporting. Prisoners had a thorough understanding of their right to be free from sexual abuse and harassment and everyone knew the appropriate channels in which to report allegations. The facility has a number of transgender inmates and a number of them were interviewed at random. The facility appears to do an excellent job on not isolating transgender inmates into one area and has them assigned to cells throughout the facility. All interviewed indicated that they felt very safe at the facility.

On April 14, 2016 the audit team completed the needed interviews that were not completed on the first day of the site visit. The team also split up and covered specific areas necessary for more in depth observations. Any issues brought forward on the first day were addressed on the second day. The team also met with Warden Lizzaraga and his administrative team, as well as representatives from every administration within Mule Creek State Prison. Shannon Stark and Matthew Rustad were also present to gather information for agency headquarters in regards to any statewide changes or recommendations. The audit team commended facility staff on an excellent job training staff and informing offenders in regard to 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 instructions given for any preliminary findings of noncompliance with individual standards. The efforts put forth by Mule Creek State Prison staff were evident and

staff was commended for their efforts. Of the noncompliant standards found during the Mule Creek State Prison audit, six fell under the jurisdiction of agency headquarters and three fell under the jurisdiction of the facility. It was certainly a pleasure for the audit team to spend time with the staff of Mule Creek State Prison and have the opportunity to assist in their PREA compliance efforts.

The supplied documentation for the pre-audit was adequate to make preliminary decisions on the agency wide standards but lacked facility documentation which caused more time to be spent asking for facility documentation that could have easily been provided ahead of time. The on-site audit was managed very well and the audit team was able to observe and tour all areas within the facility. The post audit process consisted of the team members collaborating with one another to share notes, documentation, interview results and report templates.

The team reviewed the majority of the required facility documentation in the areas they are supposed to be maintained. In some cases the documentation was brought to the auditors. The interviews were conducted in private settings for staff and inmates, except for those that were randomly interviewed while the team moved about the facility. The specified staff were either interviewed in their office locations or they were interviewed in a private location. The random staff interviews were conducted by interviewing them during the walkthrough or in a private location when requested. The staff were selected by randomly selecting them from a shift roster of employees on shift that day. The random staff consisted of staff from varying shifts that were interviewed during the walkthrough. The random prisoner interviews were assembled by randomly selecting them from the current population list as well as the specific inmates based on past allegations of sexual abuse and specific transgender inmates.

DESCRIPTION OF FACILITY CHARACTERISTICS

Mule Creek State Prison is operated by the California Department of Corrections and Rehabilitation. It has a general population consisting of level I, III and IV prisoners with a total capacity of 1708 and a current population of 2805. During the facility tour the facility did not appear to have overcrowding issues as the cells were double bunked like many other facilities throughout the country. MCSP is an adult male facility with all male inmates. The facility complex was built in the mid 1980's with an additional two facilities recently built, one of which has been brought on line within the last month and the second to be brought on line in the very near future. The complex consists of five facilities, commonly referred to as yards. Each facility is designated as a letter with a range of A thru E. The complex consists of 15 buildings and 21 total housing units with 2 dorm style units for the level I detached facility. Facilities A, B and C are the original complex, each consisting of 5 housing units with double bunked cells and a yard common to the units. Each facility has its own programs, education, and dining area, as well as prison industries specific to each facility. The two additional facilities that were recently built are in a separate location on the complex grounds with its own facility perimeter and control center area. The two facilities contained within the new portion each have three housing units with 6 man pods and separate yard, programs and dining areas. These are referred to as D and E facilities. As indicated, each facility has its own programming, education, chapel, dining and industries area in order to contain the different levels within their facilities. The complex has a total of 123 segregation cells which are single bunked, all of which were occupied at the time of the audit.

Mule Creek State Prison has basic medical care services on grounds to include physical, mental, and dental care for each yard. The facility has a Central Health building that houses a triage and emergency room, with on-site specialty services, medical records, telemedicine, laboratory, radiology, pharmacy and an inpatient unit comprised of 10 licensed beds. Offsite emergency services are provided by San Joaquin General Hospital for any inmate medical needs that cannot be met at the facility.

MCSP has approximately 230 volunteers, 10 investigators and 1293 staff that work at the complex.

MCSP offers education services to target inmates that do not have their High School Diploma or GED. They also offer Career Technical Education throughout the facility. The facility also has a myriad of programs that inmates can participate in.

MCSP has an extensive mental health program with approximately 1690 inmate patients that participate in the Mental Health Services Deliver System. This consists of 615 Enhanced Outpatient and 1067 Correctional Clinical Case Management Services inmate patients.

Both separate complexes within the overall Mule Creek State Prison consist of layered security systems to protect the general public. Each has two perimeter fences topped with razor-ribbon wire. Unique to this design is that each also has a lethal electric fence between the inner and outer perimeter fences. Each also has multiple gun towers as well as a perimeter response vehicle. Each 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.

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

115.17, CDCR does not have a process in which to directly ask applicants information regarding previous incidents of sexual harassment.

115.52, CDCR policy does not meet the time limits imposed by the standard in regard to prisoner's exhaustion of their administrative remedies.

115.63 sections (b) and (c), MCSP did not meet the requirement of making notifications within 72 hours of receiving an allegation to another facility.

> The remedial action plan for 115.63 is the facility will submit documentation to the auditor via email verifying notification to other facilities of allegations of sexual abuse occurring at those other facilities within 72 hours of becoming aware of the allegation for the next 180 days…must show 100% compliance.

115.67, sections (c) and (d) MCSP did not meet the 90 day retaliation monitoring requirement following a report of sexual abuse.

> The remedial action plan for 115.67 is the facility will submit documentation to the auditor via email verifying the 90 day retaliation monitoring has occurred for all subsequent allegations for the next 180 days…must show 100% compliance.

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 section (e) of this standard based off the lack of direction in agency policy and training.

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.

115.86, section (b) MCSP did not have supporting documentation to show they were completing the incident reviews within 30 days of the completed investigation. They did indicate that they complete them monthly but files were lacking adequate proof.

> The remedial action plan for 115.86 is that the facility will submit documentation to the auditor via email verifying incident reviews are being completed in accordance with CDCR policy. Send scanned copies of the completed and signed forms for all subsequent incident reviews conducted for the next 180 days…must show 100% compliance.

115.88; CDCR does not have a formalized process in place to meet this standard.

No remedial action plan by the facility is necessary for standards 115.13, 115.17, 115.52, 115.81, 115.83 and 115.88. The agency wide PREA Coordinator will provide all documentation within 180 days that is necessary to become compliant with these standards. At the time of this report the agency is in the final stages of updating and issuing the necessary forms and policy changes to be compliant with all six non-compliant agency-wide standards.

SUMMARY OF CORRECTIVE ACTION PERIOD

During the Corrective Action Period of 180 days, the agency completed all the required updates and changes to their policies and procedures as well as forms to meet all the applicable standards that were initially found to be noncompliant. In addition, the facility also completed all the required forms and documents as required to be compliant with the standards that were initially found to be noncompliant. At this time, Mule Creek State Prison is in full compliance with all standards with the exception of 115.14 which does not apply to this facility. Refer to each individual standard in this report for the details and specifics on how each standard was found to be compliant.

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 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. The agency employees an agency-wide PREA Coordinator (Shannon Stark) who has indicated she has the time, resources and authority to perform her duties as the agency's oversight for implementation of the PREA standards.

Mule Creek State Prison is one of 35 facilities operated by the CDCR and employees an upper level administrator (Associate Warden Cantu) as the facility's PREA Compliance Manager. AW Cantu has indicated he has the time, authority and resources to perform his duties as the facility's PREA Compliance Manager and meets 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.

CDCR has indicated they do contract for the confinement of offenders. CDCR has not entered into nor renewed any contracts since assuring to comply with PREA therefore no current contracts contain the required language. The new contract template/format was provided to the audit team which is the template/format being used by CDCR for any new or renewed contracts going forward. For this reason, CDCR is in compliance with this standard. The agency has agreed to provide any samples of new or renewed contracts to the audit team should any come available before the final audit report is published.

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. The factors considered in developing staffing levels include the operational mission of each facility, video monitoring capabilities, and generally accepted correctional practices in conjunction with ACA standards. It is the general practice for CDCR facilities to review its staffing plan at least monthly during the hiring authority meetings and budget meetings. Any requests for additional staffing or electronic monitoring equipment or upgrades are identified at these meetings.

The only deviation from the staffing plan was due to reassignment. This was only utilized when the assigned post is no longer needed due to the closure of services.

Section (c) (1-3) of this standard requires having a formalized process to assess, determine and document whether adjustments are needed to the facility's 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. 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.

CDCR DOM 54040.4, Security Rounds section requires a custody supervisor assigned to each facility or unit shall conduct weekly unscheduled security checks to identify and deter sexual violence, staff sexual misconduct and sexual harassment of any kind. These security checks shall be documented in the Unit Log Book in red pen. The Unit Log Book shall indicate the date, time and location the security check was conducted. During the tour of the facility, the audit team was able to verify log book entries of appropriate supervisors on all three shifts.

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.

MCSP does not house offenders under the age of 18. The CDCR operates the Division of Juvenile Justice which manages youthful offenders in completely separate facilities than adult inmates. Therefore this standard does not apply in this audit.d

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.

CDCR Department Organization Manual (policy) regarding cross-gender strip searches and cross-gender visual body cavity searches specifically states correctional personnel, other than qualified medical staff, shall not conducted unclothed body inspections or searches of an inmate of the opposite sex, except in an emergency. The policy goes on to state that routine unclothed body searches shall not be completed by staff of the opposite biological sex. Policy 52050.16.4 reads body search procedures for clothed female inmates recognize, address, and minimize the effects of cross-gender contact inherent in the body search process by limiting this function to female correctional staff unless an emergency exists that threatens death, inmate escape, or great bodily injury to staff, inmates, or visitors. Policy section 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 and shall document all cross-gender pat-down searches of female inmates in accordance with DOM Section 52050.16.4 utilizing the Notice of Unusual Occurrence (NOU) form. Completed NOU forms are reviewed by supervisors and routed to the institutional PREA Compliance Manager for retention and audit purposes. A review of MCSP training records and as indicated in their PAQ, 97% of the staff have been trained in conducting cross-gender and transgender pad-down searches. The agency supplied a copy of the training documents that appropriately covered the correct way in which to complete a cross-gender and/or transgender pat-down search. All random staff interviewed indicated that they did in fact have the required cross-gender and transgender pat-down search training and were able to demonstrate the process when asked.

There were no instances of cross-gender strip searches, body cavity searches or pat-down searches within the past 12 months requiring the use of an NOU. This information was verified through random and specialized interviews with both staff and offenders. Policy section 54040.4 requires each institution to 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. Except in circumstances where there would be an impact to safety and security, modesty screens shall be placed strategically in areas that prevent incidental viewing. The same policy section requires that staff of the opposite biological sex shall announce their presence when entering the housing unit. The announcement is required at the beginning of each shift and/or when the status quo within the housing unit changes. The audit team observed every shower and toilet area within the housing units, programs building, intake area, industries building, health care building and yard for the possibility of cross gender viewing. The facility has done an excellent job either installing permanent modesty screens, such as shower areas within the housing units, or portable modesty screens for use in areas when offenders are strip-searched or using the toilet. The audit team interviewed random prisoners in all of the noted areas and in every case they acknowledged that they felt they received privacy when showering and using the toilets. They also indicated that staff do in fact announce the presence of female staff when they will be working in the unit for the shift or when the status quo changes.

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 offenders with disabilities have equal opportunity to participate in or benefit from all aspects of the agency's efforts. During the audit tour, the team noted that postings were present but not as readily available as other CDCR facilities. However, this did not prevent the facility from meeting the standard. While touring the facility, the auditors made mention of the difference, at which time the facility PREA Compliance Manager appointed staff to immediately post the postings more conspicuously throughout the facility. The PREA postings are all available in both English and Spanish. The interviews conducted with staff and inmates indicated that there were no circumstances in which interpreters have been needed related to PREA allegations. The staff

indicated that they were all aware of the agencies agreement with the interpreter agency if needed. Something unique to CDCR was also that the agency pays a monthly stipend to multilingual staff that can pass an aptitude test in their second language; this not only adds to the ability of the agency to avoid ever using inmates as interpreters but also encourages staff to enhance their skills. The agency has a standard agreement with Interpreters Unlimited Inc. in order to provide interpreter services for any offender whose needs cannot be met by CDCR staff or their current implementations of PREA information for non-English speaking or otherwise developmentally disabled. Agency DOM 54040.7, Title 15, and ADA requirements require assistance to offenders whose TABE score is 4.0 or lower. CDCR policy 54040.12 outlines, except in limited circumstances or exigent circumstances, investigators shall not rely solely on inmate interpreters, readers, or other types or inmate assistance.

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.

CDCR operation manual, sections 31060.1 through 31060.2 and 31060.3 require the hiring agency to not hire anyone who may have contact with offenders 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 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.

The agency has a method in place and sufficiently executes said method to capture, on a continuing basis via a "Live Scan" system. Any and all criminal encounters of all contractors, applicants and current staff is provided to the agency on a continuous basis which exceeds the requirements of this standard to conduct background checks every 5 years. The agency contacts all known employers as a part of an applicant's background checks and willingly provides information for other agency employer requests provided the former employee has provided said employer with a release allowing CDCR to release such information.

The employer application questionnaire directly asks questions pertaining to this standard and the disciplinary matrix for the agency outlines the discipline imposed for supplying false information, which includes dismissal.

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 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 offenders from sexual abuse/harassment.

Upon the facility tour, the audit team witnessed significant facility upgrades to its physical plant. In every case, consideration was given to PREA in the planning phase. Some instances the team witnessed were privacy panels in the shower areas, line of sight, elimination of blind spots, and implementation of a new camera system in recently constructed areas of the facility to name a few. Facilities A, B and C are in the area of the complex that was constructed in the 1980's and had limited camera coverage throughout. Facilities D and E are newly constructed buildings and had an extensive camera system that allowed visual observation of a majority of the facilities from the Control Center camera controls and monitoring system. The newly installed system is evidence that consideration was given to PREA planning and to enhance overall security.

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 are Peace Officers under 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. Investigative staff area 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 and 54040.8.1 requires the victim be taken to the designated outside hospital where Sexual Assault Response Team (SART) contract staff will conduct the forensic exam. SANE's are required by the contract for all forensic examinations and SANE will always be available per the contract. A telephone interview with contracted staff responsible for conducting the exam verified staff are appropriately trained in accordance with California State Law to conduct such exams. The facility reported that in the last 12 months they had 10 instances where a forensics exam was completed by the outside hospital and all 10 were conducted by SANE.

A health care services memo to all facilities addresses the copayment program policy for offenders and states a copayment will not be charged for any offender in the case of treatment services relating to sexual abuse or assault.

Victim advocacy and victim support services are addressed in agency policy 54040.8.2 and verified that these services are readily available to offenders and staff by conducting random interviews which verified the information is provided throughout the facility and the audit team witnessed sufficient postings throughout the facility where staff and offenders are likely to view them. The DOM requires that the VAG be offered and 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 treated at the local SART location or outside hospital for a forensic examination. DOM 54040.2 defines what a VAG is and if one is not available a designated employee will be summoned who has been certified by a rape crisis center as trained in counseling of sexual assault victims and who is either 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 requires that the victim has the right to have a victim advocate from a local rape crisis center at the examination. A MOU has been implemented in the past with advocacy groups and is currently being updated and reviewed. The VAG for MCSP is Operation Care and all the contact information for this VAG was available on the postings observed during the facility tour.

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 departmental policy, DOM Chapter 5, Article 44, Section 54040.12 requires that an administrative or criminal investigation be completed for all allegations of sexual abuse and sexual harassment. Every allegation is referred to the facilities ISU where the unit completes the investigation. Any investigation that involves possible staff misconduct is referred to the agencies Office of Internal Affairs (OIA). This was also verified during the interview with the CDCR Agency Head.

Review of documents revealed that, in the past 12 months, 43 allegations were received and investigated. Of those, four are pending evidence and remain with the OIA which, as outlined in DOM Chapter 3, Article 14, Section 31140.3 and 31140.4.3, is responsible for determining which allegations of staff misconduct warrant an Internal Affairs investigation and for completing all investigations in a timely and thorough manner. The facility conducts its own criminal investigations and all information regarding agency policy is published on the Department website. Interview with staff revealed that the facility does investigate all allegations of sexual abuse and sexual harassment and does refer all investigations for criminal investigation.

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 departmental policy, DOM Chapter 5, Article 44, Section 54040.1, 54040.4, 54040.12, CR, Title 15, Sub-chapter 5, Article 1, Section 3391, and California Penal Code Section 13516 require that all staff who may have contact with inmates be trained in the agencies zero tolerance policy, how to fulfill their responsibilities related to PREA, inmate's right to be free from sexual abuse and harassment, the dynamics of sexual abuse and harassment, the common reactions of sexual abuse and harassment, detection, response, how to avoid inappropriate relationships with inmates, how to communicate effectively and professionally with inmates, including LGBTI or gender nonconforming inmates, and investigations of offender sexual violence, staff sexual misconduct and sexual harassment. Review of PREA training curriculum revealed that all staff who have contact with inmates participate in a comprehensive training that gives detailed information addressing all 10 required topics, that is gender specific and includes a knowledge quiz to ensure that all participants understand.

The training is regularly conducted during New Employee Training, as part of Annual Block Training and in OJT training. A Proof of Practice memorandum demonstrated that 1194 of 1261 staff had been trained as of July 10, 2015 for a compliance rating of 94.7% indicating that staff not trained were on leave. All staff on leave of absence is required to complete New Employee Orientation upon return to work. Staff that were on leave on July 10, 2015 and have returned to work since then have completed New Employee Orientation and staff currently on leave will be required to complete the same immediately upon their return to work. At the time of the completion of the PAQ for this audit, the facility indicated that 1293 staff employed by the facility have been trained on the PREA requirements. 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.

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.

CDCR departmental policy, DOM, Chapter 5, Article 44, Section 54040.4 requires that all volunteers and contractors receive instruction related to the prevention, detection, response and investigation of offender sexual violence, staff sexual misconduct and sexual harassment. Review of training curriculum and documentation of training completion revealed that volunteers and contractors are notified of agency's zero-tolerance policy regarding sexual abuse and sexual harassment and receive instruction related to the prevention, detection, response and investigation of offender sexual violence, staff sexual misconduct and sexual harassment and on how to report such incidents. The agency provided documentation confirming that volunteers and contractors are now trained during Volunteer Orientation and that volunteers and contractors not previously trained were trained as of July 24, 2015. At the time of the PAQ completion the number of volunteers and contractors was 230 and all 230 had received the required training.

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.

CDCR departmental policy, DOM Chapter 5, Article, 44, Section 54040.4 requires that prisoners will be provided both verbal and written information which will address prevention/intervention, reporting, and treatment and counseling. Intake staff provided samples of printed information given to prisoners immediately upon their arrival at the institution. The information is printed in both English and Spanish, and staff reported that they read the information to prisoners who cannot read, or are developmentally disabled, and require them to repeat the information so that they can ascertain that prisoners know what they have been told. They will also read the information to prisoners who are sight disabled and will point to the information for prisoners who have hearing disabilities, again to ensure they receive the information.

Staff were able to provide signatures of prisoners who received the information during intake. Additionally, all prisoners participate in a Classification Committee interview within 14 days of arrival at the institution, where they are assessed by a committee that again informs them of their rights. Documentation from those evaluations includes prisoners' signatures indicating they were given information. Proof of Practice Memorandum, dated 11/02/2015, verified that all prisoners not previously educated were properly informed by that date. Facility provided ample documentation showing prisoners who participated in the training. In addition, tour of the facility revealed information posted adequately for prisoners to see. Random prisoners from throughout the facility, consisting of prisoners from all five facilities and various units from within those facilities were interviewed said they saw the posters and verified that the information is also provided by closed circuit TV. Of the 15 documented interviews and more than a dozen more randomly questioned prisoners while completing the tour, a majority of them indicated that they had received PREA education and information. The inmates who have arrived within the last 2 years all indicated that they received the information during intake. The inmates that have been at the facility for longer than 2 years indicated that they have been inundated with PREA information in the form of pamphlets and the video being played on a regular looping basis on the TV. The only inmates that did not seem to recall receiving any PREA education information were the inmates in segregation. When questioned further they did indicate they may have received a pamphlet recently but would've thrown it away. Based on the overwhelming response from a majority of the interviewed inmates, it is clear the facility has done everything possible to provide the population with all the necessary PREA education.

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.

CDCR departmental policy, DOM, Chapter 5, Article 44, Section 54040.4 requires that all employees who are assigned to investigate sexual violence and/or staff sexual misconduct will receive specialized training using an OTPD approved curriculum. Facility indicated 11 investigators have been trained and provided training sign-in sheets from that training as proof. The curriculum provided, upon examination, met all requirements of the standards and included a knowledge quiz, and interviews with Investigative Staff revealed that they were adequately trained.

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 Departmental Policy DOM Chapter 5, Article 44, Section 54040.4, CR, Title 15, Sub-chapter 5, Article 1, Section 3391, and California Penal Code Section 13516 require that all employees who may have contact with inmates be trained the department's zero-tolerance policy, on sexual abuse and sexual harassment prevention, detection, reporting and response policies and procedures, evidence preservation, crime scene preservation, on inmates' rights to be free from sexual abuse and harassment and to be from retaliation for reporting, the dynamics of such in confinement, common reactions of victims, how to detect and respond to signs of such, how to avoid

inappropriate relationships with inmates, how to communicate effectively and professionally with inmates and how to comply with relevant laws related to mandatory reporting. The training is gender specific and the facility documents that all employees completed the training. Medical and Mental Health staff complete the same training that all other employees complete. No exceptions are made. Medical staff do not complete forensic examinations on site. Training staff provided ample documentation of PREA Training curriculum and staff sign-in logs verifying that staff are trained as required by policy in Annual Block Training, in New Employee Orientation and in OJT sessions offered in between Annual Block trainings. Also provided as documentation were statements signed by employees verifying that they understood the training they received. Proof of Practice Memorandum verified that training of all medical and mental health staff was completed on 6/30/2015. Interviews with both medical and mental health staff verified that they had received the proper training and were aware of their responsibilities on detection, assessment, evidence preservation and reporting requirements.

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.

DOM, Chapter 5, Article 44, Section 54040.6 requires that all inmates be assessed during intake screening and upon transfer for risk of being sexually abused or for being sexually abusive. Review of Receiving and Release process verified that all inmates are screened immediately upon arrival at the facility, for risk, and the information is used for making bed assignments. The screenings are done using the Initial Housing Review, an objective instrument that requires information regarding whether the inmate has any type of disability, the age and physical build, any previous incarcerations, criminal history, whether the inmate is gay, lesbian, bisexual, transgender, intersex or gender nonconforming, any previous sexual victimization, and the inmate's own perception of vulnerability. Ample documentation was provided to verify the process during the tour. Within 14 days, inmates meet with the Classification Committee where a reassessment is done, and any additional, or new, information is taken into consideration and risk level is adjusted accordingly. The agency documents this information on the Classification Committee Chrono. Agency policy stipulates that inmates may not be disciplined for not answering questions or not disclosing information, and inmates interviewed were aware of that stipulation in policy. The agency controls the dissemination of information, throughout the facility, by assigning computerized database profiles that regulate access to information to the various job descriptions. CDCR does not house inmates for the sole purpose of civil immigration purposes; therefore #10 of section (d) of this standard does not apply.

Interviews with staff that conduct risk screening verified the intake and screening process is followed per their agency policies. They indicated that the process is very structured and time lines are adhered to. The PREA Coordinator also verified that the agency controls access to the information and dissemination by allowing access to the database based on employee position and the need to access the information. At the time of the tour there were 4 inmates in the intake area of the facility, although they were not new arrivals and were returning from various appointments from outside the facility, 3 of the 4 indicated they were assessed for PREA related issues during intake and their classification committee meetings. Of the 15 random inmate interviews and the more than a dozen more interviewed during the tour, the majority of them indicated that they were asked about PREA issues during intake but all indicated they are asked about PREA related issues during their 14 day classification interview and annually thereafter.

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 departmental policy CCR, Title 15, Sub-chapter 4, Article 10, Section 3377.1(c), DOM, Chapter 5, Article 44, 54040.6 require the agency to use information from the risk screening required in Standard 115.41 in making bed, housing, work and programming assignments with the goal of keeping inmates at high risk of being abused separate from inmates at high risk of abusing. The Facility uses information on the Initial Housing Review forms, completed during Intake, to fulfill this requirement. In addition the Classification Committee Chrono, in the Committee Action Summary, identifies how decisions are made using information collected and documented on the Initial Housing Review. An interview with the PREA Compliance manager confirmed that all inmates with risk of being an aggressor are single cell designated to ensure they cannot prey on others. Staff responsible for risk screening verified that the information on the IHR is always used to make bed assignments as well as to make referrals to mental health or to medical. Information is taken from the Initial Housing Review and used at Classification Committee to review bed assignments and make housing, work, program and education assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. Decisions about how to ensure the safety of each inmate are always individualized using information from each inmate's IHR.
Departmental policy requires placement and programming assignments for each transgender or intersex inmate to be reassessed at least twice each year to review any threats to safety experienced by the inmate and staff confirmed that and provided Classification Committee Chronos as documentation. An interview with the PREA Compliance manager verified that transgender or intersex inmates' own views with respect to his or her own safety are considered. The PREA Implementation memo dated 8/13/2015 was offered as evidence that transgender and intersex inmates are provided the opportunity to shower separately and a tour of the facility revealed that accommodations are available for transgender or intersex inmates to shower separately. Additionally, interviews with 6 transgender inmates from various facilities throughout the complex verified that all are allowed to shower separately and are interviewed by the Classification Committee twice per year. During the interview they indicated that they are asked about their safety and if they are under any type of threat sexual abuse or harassment. Two of the transgender inmates interviewed indicated they were not asked about their safety during intake but those two had been at the facility for years and indicated that they have been well informed since about PREA and are asked about their safety during their bi-annual committee meetings. All transgender inmates interviewed indicated that they felt very safe at MCSP and appreciated that they were not segregated based on their status and are allowed to live throughout the facility without being place in one location. Some did indicate that they would prefer to all be in the same unit with all other transgender inmates. The Facility is not a dedicated facility, and does not have dedicated units or wings. The Facility is not under a consent decree, legal settlement, or legal judgment requiring a facility to establish a dedicated facility, unit, or wing for lesbian, gay, bisexual, transgender or intersex inmates.

Standard 115.43 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR departmental policy CCR Title 15 Sub-chapter 4 Article 10 Section 3377.1(c) and DOM, Chapter 5, Article 44, 54040.6 requires that inmates at high risk of victimization not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made and there is no available alternative. CCR, Title 15, Sub-chapter 4 outlines that inmates placed in involuntary segregated housing for the purpose of protection shall have access to programming, privileges, education and work opportunities and that the facility must document any restrictions identifying any opportunities that are limited, the duration of the limitation and the reason. Interviews with the Warden and other staff revealed that every available alternative means to protect an inmate are utilized beforehand and that segregation is an option only as a last resort after every other available option has been exhausted. In the rare instance that it might happen, the inmate would be reassessed for placement or transfer within 10 days. This facility has not placed an inmate in segregated housing for this reason in the last 12 months. Although they did not have any instances of placing an inmate in segregation for the purposes of being at high risk of victimization, all staff interviewed indicated that prisoners placed in segregation for that reason are immediately assessed and if alternate

placement is not available at MCSP, the inmate would be transferred prior to the next required 30 day review, most likely within two weeks. They also indicated that they would reassess the inmate every 10 days until they were properly placed in alternate housing or transferred.

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 staff interviewed 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 staff interviewed were all aware that reports shall be accepted whether verbal, in writing, anonymous or from a third party and that documentation and reporting to their supervisors was required to be completed immediately. The Agency DOM and facility DOM Supplement indicate that staff may privately report sexual abuse or sexual harassment as well. The staff were also aware of the hotline and all avenues available to report. Of the 15 randomly interviewed prisoners and more than a dozen more interviewed during the tour, all indicated that they knew how to report (staff, appeal, hotline, Chrono). All also indicated that they could also tell a family member or third party if needed and that they could report on their behalf. Most were aware that a report could be made without giving their name, only a few were unsure that this was possible. After further discussion they realized that if done through a third party, through the hotline or in writing that they weren't required to give their name. The few that were unsure of this fact were not from the same area of the facility which indicates that there is not a particular area that is lacking in the education portion on reporting. All areas of the facility had adequate postings indicating how to report.

More than 10 reports were reviewed in the ISU and all supported compliance with this standard. A good sampling of verbal reports, hotline reports and reports through the appeals (grievances) process were reviewed and all indicated immediate action took place and the investigations were immediately started.

All three hotlines, Northern California, Central California and Southern California 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 CDCR, specifically MCSP, does not house detainees for the sole purpose of civil immigration; therefore that portion of this standard does not apply.

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 also 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, that an inmate can file without having to submit to the staff member who is the subject of the grievance, that a final decision will be made within 90 days from initial filing, that third parties may file on the behalf of an inmate and that 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.

DOM, Chapter 5, Article 44, Section 54040.15.1 dies allow for an inmate to be disciplined for filing an appeal alleging sexual abuse in bad faith. The facility had one instance in the 12 months preceding the audit that fell under this provision of the standard. The report was received by the audit team and reviewed. The investigation was complete and clearly showed where the appeal was filed in bad faith warranting the need for the disciplinary action to be taken.

Four inmates who had filed appeals alleging sexual abuse were randomly selected from the 21 documented filed within the 12 preceding months. All of them indicated they were aware of the 90 time limit to receive a final decision as well as the extension process. All of them received their final decision well within the 90 days and felt that the investigatory process and response after filing the appeal was rapid and well handled. None had concerns over the process and how their cases were handled. These 4 inmates were from three different facilities within the complex.

CDCR §3084.2 Appeal Preparation and Submittal, section (g) 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 addresses 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 for the purposes of providing emotional support services related to sexual abuse. Mule Creek State Prison has entered into an agreement with Operation Care 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 for Operation Care, including a toll free number and an address to be utilized by inmates to contact them.

During the interviews with 15 random inmates and more than a dozen more during the facility tour, it was discovered that not all inmates knew this information was available. When probing those that were not aware this information was available, all of them had seen the postings on PREA but had not taken the time to read them because they indicated they didn't have a need for it. All of those indicated they now knew what the posting were for and would refer to them if ever needed. During the tour it was noted that this posting was adequately posted throughout the facility in the housing units and support buildings. Based on the amount of postings throughout the facility it is not

likely that any inmate would be unaware of the VAG and how to contact them unless it was as indicated during the interviews that they simply have no need for knowing 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 and 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 that 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.

Medical and mental health staff have a requirement to report information on 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 during the formal interviews and during the tour, all indicated they are mandatory reporters and will do so when required.

Section (d) of this standard does not apply as the CDCR, specifically MCSP, does not house inmates under the age of 18.

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

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 that all staff shall take immediate action to protect prisoners that are at risk of imminent sexual abuse. The interview with the Agency Head confirmed that 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 that 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 and through the random staff interviews that were conducted. All staff members were aware to immediately remove the prisoner from the area of the imminent threat. The facility had zero reports that any prisoner was subject to substantial risk of imminent threat in the past 12 months. It was evident through the tour and speaking with staff that all knew what their required responsibilities were and responded with such without hesitation. In speaking with inmates throughout the tour and interviews, all felt that staff responded to their safety needs appropriately and immediately.

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.

The 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 that in the 12 months preceding the audit that they had 8 instances of an inmate reporting that they were abused while confined at another facility. They also reported for the same time frame that they received 7 reports from other facilities where inmates reported they were sexually abused at MCSP while previously housed there. It was found through reviewing facility reports that the facility is not making the proper notification within 72 hours to other facilities when the abuse is reported at MCSP. One report did not have any documentation indicating notification was sent to the other facility. Another report had documentation showing that notification was sent via email three weeks after the alleged incident was reported to MCSP staff. An interview with the warden revealed that when an allegation is received it is reported by the ISU staff to the other facilities ISU staff via phone and/or email with a copy to the warden of each facility. An

interview with the investigative staff was conducted when the documents were found to not support compliance with the standard. Investigative staff interviewed indicated that they normally would make the notification within 72 hours but no supporting documentation was present in the files to support the claim. Upon further questioning he indicated that notification was made but he didn't print the documentation (email) and place it in the investigation file.

When a report is received by MCSP from another facility about an allegation of abuse at their 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.

Remedial Action Plan – For 180 days the facility has agreed to send all instances to the auditor to prove compliance will be met on all future reports of abuse allegations made at their facility that occurred at another facility. The facility will need to provide proof that future notifications are made within 72 hours and compliance will be met.

The facility supplied all referrals and documentation for the 180 day period sufficiently supporting that they are in full compliance with the standard. The facility supplied the notifications as well as a copy of their log indicating when and how the referral was made. The facility is now in full compliance with this standard.

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 requirements are for all staff, both custody and non-custody with the one difference being that it is a non-custody staff person they immediately summon custody staff to respond and assist.

The facility reported that within the preceding 12 months of the audit that they had 43 reported allegations that an inmate was sexually abused. In 20 of those 43 cases, the first responder separated the victim and abuser. In addition, all 20 of the reported cases allowed for the collection of physical evidence and the first responder followed the required protocol to allow collection of that evidence. In 2 of the cases the first responder was a non-custody staff person and the proper protocol was followed in those cases as well.

A review of the investigation files all indicate that 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 every case they took immediate action and followed the proper protocol to allow for evidence collection if applicable.

The facility provided the staff at MCSP with a pocket reference book to show compliance. The pocket reference guide 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 guide was gathered as part of the audit and is recognized as an excellent practice by the CDCR. The guide covers all steps to take during these incidents and if followed assures compliance with this standard in every instance. All staff that were interviewed during the tour, during random staff interviews and during First Responder interviews knew how to respond 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 provided their agency DOM 54040 to show the parent document that is used to develop the facility DOM Supplement. The facility DOM Supplement breaks down the required duties of every staff member that is involved in the handling of sexual abuse cases, from First Responders, Supervisor staff, Medical staff, Mental Health staff, Investigative staff and Administrative staff.

This was confirmed by the warden during the interview process. The warden indicated that the facility specific DOM Supplement has been implemented to outline everyone's responsibilities and that the PREA Review Committee is utilized to ensure all elements of the standard are met for each incident reported. The facility pocket guide also addresses this and is available to all staff. A review of the investigative files shows that each incident is in fact reviewed by the PREA Review Committee to ensure compliance is met as well looking for areas of opportunity to improve or correct performance 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 that was effective on July 13, 2013. A review of the contract found that nothing in the contract impedes the agency's ability to remove alleged staff sexual abusers from contact with any prisoners pending the outcome of an investigation or of a determination of whether and to what extend discipline is warranted.

An interview 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.

DOM Chapter 5, Article 44, Sections 54040.7 and 54040.17 along with DOM Chapter 3, Article 1 & 14, Sections 31010.1, 31140.10 and 31140.11 covers the agencies requirement to implement retaliation monitoring on inmates and staff that report or cooperate during an investigation of sexual abuse or harassment. The DOM requires 90 day retaliation monitoring of any sexual abuse allegation for both staff and prisoners. The agency created a "Protection Against Retaliation" form (PAR) as a tracking device to ensure compliance with this standard. The form has locations indicating when monitoring began and ended as well as headings to identify which investigation the form 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 evaluation and other possible changes or areas that should be monitored to determine if retaliation is occurring.

The facility reports that in the 12 months preceding this audit that they have had no reports of retaliation taking place against an inmate who reported or cooperated with a sexual violence investigation. An interview the warden indicated that if any reports of retaliation were to occur that an immediate investigation would take place and the appropriate discipline would be taken on the individual retaliating.

A review of the facility investigation files indicate that some retaliation monitoring was not taking place for 90 days and in unsubstantiated cases no monitoring was taking place at all. It was indicated by the facility that there was confusion on their interpretation of unsubstantiated versus unfounded cases and they thought that unsubstantiated cases did not require monitoring. They indicated that they now had a clear understanding and would begin monitoring all substantiated and unsubstantiated cases.

During the interviews with prisoners who had reported alleged sexual abuse incidents, it was found that they all indicated that they were immediately investigated and they felt safe based on how the incidents were handled by facility staff. The interviews took place well after the 90 retaliation monitoring period would've been expired and none of the interviewed inmates expressed any concerns of treatment or retaliation after the reports were made. Even though the interviews did not take place specifically to cover this standard, it is of this auditor's opinion that the fact that some retaliation monitoring did not take place or was ended prematurely, it did not contribute to any of the inmates safety concerns or put them at risk in any way.

Remedial Action Plan - facility has agreed to supply PAR forms for all currently open and future cases for 180 days. Once reports are received and reviewed, compliance will be met as long as all requirements are met in the reports.

The facility supplied sufficient documentation for the 180 day period to support that all allegations that required retaliation monitoring in fact receive the required monitoring. All Protection Against Retaliation (PAR) forms were received as well as the log indicating that all substantiated and unsubstantiated cases had monitoring completed on all the required individuals. That facility is now in full compliance with this standard.

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 that 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. During the interviews, all segregation staff and the warden indicated that they have available alternatives to segregation and their process is to place them in alternate housing as soon as possible. They indicated they would not house an inmate in segregation longer than a couple of weeks to make the placement or transfer. The facility did not segregate any offenders in the past 12 months. The staff interviews confirmed compliance and that no offenders were segregated in the past 12 months for the purposes stated in this standard.

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 that all the 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 also verified during the interview with investigative staff. During the random interviews with inmates and those that have made reports of sexual abuse, all felt that once their allegation was received that staff began the investigation process immediately.

The Department's Basic Investigator Training and PREA Locally Designated Investigator (LDI) training details how and when investigations are conducted. California staff and investigators are sworn Peace Officers and they handle criminal as well as administrative investigations. All 11 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, evidence collection and preservation. All the staff knew the elements of completing a comprehensive investigation. Investigative files were reviewed and all the appropriate documentation was present, interviews, evidence collection methods and results, all 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.

As per DOM Chapter 3, Article 44, Section 54040.8.1, Article 14, Section 31140.21, California corrections officers and investigators are sworn peace officers and can compel interviews when appropriate without consultation with the prosecutor. However, investigative staff indicated that they do consult when necessary but it is not required.

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 that they take into account the totality of circumstances and the facts to determine credibility and that the credibility of inmates is not based on their status as such. Interviews with inmates who reported a sexual abuse all indicated that they were not asked or required to submit to a polygraph during their investigation.

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 all areas of an investigation, including contributing factors that may have led to the sexual abuse. An interview with investigative staff indicated that they look at everything related to the incident to see if anything, including staff actions that may have contributed to the incident. A review of the investigative files show that investigators documented in the reports descriptions of the physical evidence as well as interviews and testimony that led to the conclusion of the reports.

Documentation was provided to show compliance of the standard. Documents included referrals to the prosecutor's office for any possible criminal charges.

All reports are retained according to the agency and facility records retention schedule. The ISU maintains all investigative files for all PREA related cases. The retention schedule showed compliance with the standard.

The above references policies also indicate that investigations will continue even if the alleged abuser has departed from the facility. An interview with investigative staff indicates that they will continue with the investigation regardless of whether the staff person or inmate are present at the facility.

Investigative staff investigate both administrative and criminal investigations; therefore section (l) of this standard does not apply. However, investigative staff indicated if an outside agency was in fact conducting an investigation, they would give them their full cooperation.

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.

The DOM, Chapters 3, Article 22, Section 33030.13.1, Penal Code 502 and 1096, DOM Chapter 5, Section 52080.9.3 clearly states the agency shall impose no standard higher than preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. An interview with investigative staff confirmed the same.

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 policy DOM Chapter 5 Article 44 Section 54040.12.5 addresses this specific standard by requiring that 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 offenders of the findings of the administrative investigations. Facility investigative files were reviewed for allegations reported within the past 12 months. These files were found to be incomplete and inconsistent with documentations and report writing. In addition, several clerical errors were noted in the reports and files which initially lead the auditors to believe this and other standards were not being met. Additional time had to be spent to determine if the Facility was in compliance. Required documentation was eventually located that proved the Facility was in substantial compliance with this standard. However, it is highly recommended that the facility adapt better practices for their Investigative Services Unit and PREA Compliance Manager that will ensure complete documenting and filing occurs. This will also help ensure that PREA requirements are not missed, as their current practice has the potential to do so.

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 standard requirements. Interviews with staff also confirmed the facility is following the standard as written and would discipline staff if warranted. The facility initially reported on the PAQ no incidents of sexual abuse within the past 12 months involving staff; however, during the audit they presented two allegations against staff. One was closed and unsubstantiated and the other is still on-going, according to the investigative file. The policies and interviews with investigative staff indicated that any criminal behavior will be referred to the prosecutor's office for possible 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 Facility reported no cases of sexual abuse/harassment involving contractors or volunteers. Facility Investigative Services Unit stated that they would investigate allegations of contractors/volunteers as any other PREA case and refer 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. The Agency does not allow for consensual sexual relations. The Facility reported no substantiated cases of prisoner/prisoner sexual abuse and therefore no discipline has been taken. One case is still under review and if substantiated staff indicated they would take disciplinary action against the offender. The Facility reported that they had 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 that is was consensual and not forced, prior to writing violations codes. Staff also indicated they would inform the Investigative Services Unit. Medical staff interviewed indicated that the offending inmate would be referred to mental health staff for possible counselling and follow up therapy...

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.

Agency policy IMS&P, Volume 4, Chapter 2, Section 4.2.2 covers the process to request mental health services. DOM 54040.7, Article 44, complies with sections a-d of the standard. All screens cover sexual abuse and prisoners are screened by medical and mental health staff upon intake to the facility. Agency policy does not speak of informed consent (section e of this standard). The PAQ indicated that they were not complying with this section of the standard. During the audit the Agency reported that they were in the process of updating this policy and forms to document consent. The Agency submitted documentation following the audit that indicated they had a previous meeting/training where informed consent was discussed and additional language was added to their consent forms to cover sexual abuse. However, the documentation provided speaks of the prisoner being sexually abused/harassed by prisoner or staff and this standard section speaks specifically about abuse in the community. Corrective Action Recommendation: The Agency will need to update/revise their policy to specifically address this standard section and update/revise their documenting system. The Agency will also need to advise/train specified staff of the change and requirement to ensure future compliance.

Following the audit the CDCR revised their Health Care Services Policy volume 1, chapter 16 to state that 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 that the incident be reported, or upon receipt of a custody referral for the same situation, health care shall obtain authorization from the patient using the CDCR 7552 form and submit the form to the ISU for appropriate reporting. The CDCR provided a sample of the form, along with documentation that all CDCR employees where made aware of this change and requirement. Based on the information provided, the CDCR is 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.

Agency policy indicates that victims of sexual abuse will receive timely emergency medical services and treatment. First responders will also summon medical or mental health staff immediately if they are on grounds at the time the report is received. Reports reviewed during audit showed that victims had immediate medical response. Victims of sexual abuse are allowed medical or mental health services without financial costs to them. Interviews with Medical and Mental Health Staff during the audit confirmed that services would be provided and there would be no charge to the victims for seeking medical or mental health care. Handout information for prisoners regarding sexually transmitted diseases was reviewed and is made available. All prisoners who reported SA were referred to medical and/or mental health; however, this was not documented correctly, or at all, in the investigation files. The majority of the files indicated the victim had not been referred to mental health. Further investigation into this resolved the issue and all prisoners were found to have been referred. Although the Facility is substantially compliant with this standard, their documenting practices should be evaluated and updated to ensure compliance with this standard continues. Facility investigative files should be regularly reviewed for properly completed documents.

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 that prisoner victims are receiving medical and mental health care as required. During audit interviews all staff reported that prisoners who report being sexually abused are immediately referred to medical and mental health. Medical and mental health staff interviewed all indicated that prisoner victims would be immediately evaluated and treated. Prisoners are not charged for the services. Treatment and evaluation of prisoners appeared consistent with community level of care and included follow-up evaluations, treatment plans and referrals where necessary. However, Agency policy does not indicate that attempts to conduct a mental health evaluation on known abusers will be conducted (section h).

Remedial Action Recommendation: The Agency will need to revise/update their policy to ensure that attempts to evaluate known abusers are required and the attempt/evaluation is being documented. The Agency/Facility will have to provide documentation that verifies attempts are being made for the next 180 days.

The Agency implemented changes to DOM 54040.11, Suspect Processing addresses offender reporting of abuse. The addition of the following language sufficiently addresses 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 policy 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 that the Institution Head or designee, PREA Compliance Manager, Designated Managerial employee, In-Service training Manager Health Care and Mental Health staff. The forms and policies require that during the review that teams consider all of the factors listed under element (d) of this standard. The Agency reported that their policy changed in July of 2015 to require these reviews 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, as well as monthly, ensure that issues that may have contributed do not go without being addressed if the investigation is prolonged for any reason. Investigations into reported sexual abuse were reviewed

during the audit. The Facility has not been conducting incident reviews as required per this standard or as required by Agency policy. The Facility response was that they had just been instructed to complete these reviews and were confused about the difference between Unsubstantiated and Unfounded conclusions. The forms used for these reviews were found unsigned in the investigation files, yet the questions had been answered as if they had been done. When questioned about this, Facility staff indicated there was miscommunication with getting the forms ready for the reviews and that they should not have been filled out prior to the reviews being conducted. The completion of these forms prior to the reviews being conducted gave the appearance that the Facility was attempting to document that the reviews were being conducted just to pass the audit.

Remedial Action Plan: The Facility will have to conduct proper incident reviews on all prior allegations of sexual abuse (unless unfounded) and provide documentation when complete. The Facility will also have to conduct incident reviews on all future allegations of sexual abuse as required by this standard and/or Agency policy and provide verification that they are being completed for the next 180 days. An investigation log will also need to be provided as reference for allegations being reported.

The facility supplied all the required documentation and review forms for the 180 day period. They supplied all the review forms with all the required signatures and participants as well as the log indicating that all cases had reviews completed. The facility is now in full compliance with this standard.

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 policy DOM Chapter 5, Article 44, Section 54040.20 and 54040.19 cover this standard. The policy does discuss that the Agency shall collect the data annually. Facilities are required to send the SSV-IA form reporting allegations within 48 hours. Investigation files reviewed during audit confirmed that the forms are being sent. Data is compiled on the Agency yearly tracking report and updated as investigations are concluded. Tracking reports do show data from contracted facilities.

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.

DOM Chapter 5, Article 44, Section 5040.17 and 19 require that the agency policy requires data to be collected and reviewed, requires comparison of data and assessment requires data to be available to the public and allows for data to be redacted. However, there is not a formalized process in place. The Agency reported that 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. Corrective Action Recommendation: The Agency will need to finalize this process to be compliant with this standard.

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 policy DOM Chapter 5, Article 44, Section 54040.20 requires data to be securely maintained, requires that the data is made available to the public through their website, requires identifiers will be removed and requires data to be maintained for at least 10 years. Facility files were found to be in a secure area and only accessed by authorized staff. 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.

James Schiebner November 4, 2016

Auditor Signature Date