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

ADULT PRISONS & JAILS

Date of report: December 29, 2016

Auditor Information			
Auditor name: James Schiebner			
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Telephone number: (616) 902-7498			
Date of facility visit: May 18th and 19th, 2016			
Facility Information			
Facility name: North Kern State Prison			
Facility physical address: 2737 W. Cecil Ave., Delano, California 93216			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 661-721-2345			
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 Kelly Santoro			
Number of staff assigned to the facility in the last 12 months: 1355			
Designed facility capacity: 2710			
Current population of facility: 4106			
Facility security levels/inmate custody levels: I & III in General Population. In the Reception Center inmates are unclassified.			
Age range of the population: 18-79			
Name of PREA Compliance Manager: Kevin O'Daniel		**Title:** Captain	
Email address: kevin.odaniel@cdcr.ca.gov		**Telephone number:** 661-721-2345 ext. 6000	
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 North Kern State Prison (NKSP) located in Delano, California. The audit team consisted of certified PREA auditors James Schiebner (author), Christine Wakefield, Barbara Storey and Kristopher Steece; all from the Michigan Department of Corrections. The audit began in late April with the delivery, via CD and emails, of the agency and facility documentation and the required Pre-Audit Questionnaire from the facility. The standards were divided among the auditors with each reviewing the documentation for their assigned standards and using the auditor tool as a guide while working through the initial documentation. Prior to the onsite visit the facility was provided with contact information for posting throughout the facility for inmates to write the audit team (no letters were received). The information was posted April 4, 2016. The onsite facility tour began Wednesday, May 18, 2016 and concluded Thursday, May 19, 2016, with Friday May 20, 2016 being a group teamwork day to assemble documentation and information for the final report. The on-site audit began with a facility greeting from Warden Santoro's administrative team consisting of the Chief Deputy Warden, PREA Compliance Manager, Associate Wardens, Investigative Services Unit staff, several non-custody and custody supervisors along with the agency PREA Coordinator Shannon Stark and PREA Lt. Matthew Rustad, as well as other certified PREA auditors for the CDCR. The audit team introduced themselves and explained the purpose and outline of the audit process as well as an explanation of how the facility tour was going to be conducted along with the audit team's expectations and requirements for a successful audit.

After the initial meeting the auditors divided into two teams. James Schiebner and Barbara Storey began the facility tour, while Kris Steece and Christine Wakefield began conducting the random and specialized inmate and staff interviews. Given the large size of NKSP, after the first yard and two housing units were visited, James and Barb separated to ensure that the entire facility was toured. Barb toured the administration building, mental health services area, housing unit A-1, work change, A-yard dining hall, library, education, gym, chapel, laundry (clothing distribution), medical clinic, vocational trades (Building/Electrical, Janitorial Services), programs (custody office), M-yard-work change area, housing unit M-1, dining hall, canteen, library, medical and dental clinic, visiting area (including inmate strip area, main visiting room, and non-contact visiting booths), the firehouse, vehicle garage, warehouse, physical plant main office, welding shop, paint shop, carpentry shop, and electrical shop. James toured the administration building, mental health services area, medical facility, the crisis bed medical unit, central health administration, housing unit A-1, housing unit A-5, work change, the reception and intake area, Facility B housing units, Facility C housing units, Facility D housing units, maintenance, canteen, food service, facility laundry, education, Facility A, B and C chapel and the yards associated with Facilities A, B, C, and D.

All of the areas visited were well staffed and staff were making rounds/tours and monitoring key areas. Doors were locked and off limits areas were maintained. The only area of concern during the tour was the yard modules in the segregation unit yard. These modules have toilets and sinks in the yard modules themselves. Most are situated in such a fashion that only incidental viewing would take place during security rounds. However, there were three of them that had open views to an officer's station that would pose an issue if a female staff member were assigned to observe the segregation yard area. Even though this officer's station is not a specific assignment post, the area was clearly used as such for the staff person assigned to observe the segregation yard. This issue was addressed with the facility PREA Coordinator, Captain O'Daniel, and before the auditor left the area he had privacy screens delivered to the location that would be used to screen the direct view of inmates using the toilet in those three yard modules. The screens adequately blocked the officer's view but not to the extent of compromising security. The issue was corrected immediately and pictures were taken for documentation purposes. No other areas observed throughout the entire tour presented any sexual safety security concerns

PREA information throughout the facility was clearly posted, both in English and Spanish. Posters listed the steps that could be taken to report sexual abuse or sexual harassment incidents, provided contact information for the prisoners to report these incidents and also cited the CDCR's zero tolerance policy related to sexual abuse and sexual harassment. In the housing units this info was also painted on the walls next to the inmate phone areas. Information for additional services (Alliance Against Violence and Sexual Assault) for victims of sexual abuse was also posted. Privacy curtains were in place on all shower areas, partitions were in place in open bathrooms, windows were partially frosted in enclosed bathrooms, portable privacy screens were stationed in areas that strip searches were conducted and windows were frosted in work change areas; thus giving prisoners ample privacy while being in any state of undress. The work change areas also had signs in the outer door windows indicating that a search was either in progress or that it was okay to enter. This sign was for the benefit of the female staff to be aware when they are not allowed into those areas. Log books were reviewed and showed evidence of supervisory rounds on all three shifts as well as announcements about opposite gender staff working within or entering the housing units. Staff and inmates both stated that they were not made aware in advance when supervisors were making rounds.

The use of security cameras at NKSP is limited to the visiting room and a few observation cells in their medical unit for suicidal prisoners and those suspected of concealing contraband. Cross gender viewing in the medical unit was only conducted by medical staff. Interviews with the Warden and other administrative staff indicated that the facility has considered the lack of cameras in their staffing plan and has supplemented the lack of cameras with additional staff to ensure inmate safety and the overall security of the facility. The physical layout of the units also allows good visual coverage by staff. During the tour it was observed that there was sufficient custody and support staff coverage in all areas which made up for the lack of camera coverage. The facility also had many areas where corner mirrors were mounted and utilized to observe blind spot areas.

During the interview phase of the audit, the auditors randomly selected and spoke with a combined total of 54 inmates and 79 staff members. Of the 54 inmates, 25 of them were interviewed in a private setting with the PRC interview template being utilized. The random inmates and staff interviewed in the more formal setting were selected by reviewing the facility inmate roster and staffing roster for that day. The staff total of 79 was a mix of custody staff, non-custody staff and supervisors. The random staff was from every area of the facility, including all Yards (A, B, C, D, and M), Warehouse, Medical and Mental Health, Maintenance, Chapels, Food Service, Education, Fire House, Programs, Prisoner Industries and Administration. The random inmates were from every area of the facility, including all Yards (A, B, C, D, and M), Warehouse, Maintenance, Chapels, Food Service, Education, Program and Prisoner Industries. Everyone interviewed participated willingly and appeared to have a good understanding of the PREA standards or rights provided by them. They were asked specific PREA related questions derived from the PRC interview questions. The staff and inmates were chosen by ensuring that each area of the facility was represented. The majority of inmates indicated that they had received some sort of PREA educational material; either a pamphlet or watched a video. When the auditors probed further into this it was discovered that the inmates were aware of the postings and simply chose to disregard both. This was not a reflection on the facility's efforts to educate and provide inmates with PREA information. All inmates felt that they had enough privacy to change and shower without being viewed by the opposite gender. Most inmates indicated that female staff announces their presence and all knew that it was posted to do so. They all felt safe from sexual abuse at NKSP and knew how to report abuse or harassment if needed. All staff interviewed were knowledgeable about PREA and the agency's zero tolerance policy. They knew how to appropriately respond to a sexual assault and their mandatory requirement to report all allegations, notifications or suspicions of sexual abuse or harassment. All staff indicated they had been trained on PREA, which included cross-gender/transgender pat searches. Staff were able to site specific steps that needed to be taken in the event they were first responders to a sexual abuse incident. All staff responded that they absolutely could not strip search a prisoner to verify sexual identification.

On May 19, 2016 the audit team returned to the facility and completed a few specialized interviews that were not completed on the first day of the site visit. The team then split up and covered specific areas of their assigned standards, which was necessary for a more in depth observation. The team also gathered additional documentation to help support each standard. The team reviewed the majority of the required facility documentation in the areas where it is supposed to be maintained (ISU, Medical, Training, Human Resources). In some cases the documentation was brought directly to the auditors. The audit team then met with Warden Santoro and her administrative team, as well as representatives from all areas of North Kern State Prison. Shannon Stark and Matthew Rustad were also present to gather information for agency headquarters in regard to any statewide changes or recommendations. The audit team commended facility staff on an excellent job of 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 an overview of the auditor's findings was presented. Warden Santoro and her staff were informed and congratulated that the facility had met all but two of the site specific standards and advised that the agency had yet to meet some statewide standards as well. An explanation of the preliminary findings of noncompliance with facility and agency standards was given with the recommended remedial action plans to correct.

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

On the evening of May 19th and the morning of May 20th, while still on site in California, the audit team collectively reviewed and shared notes, documentation, interview results and report templates from the NKSP audit. Contact by phone and/or email with NKSP staff and agency staff was made to clarify a few questions and request a few additional pieces of documentation, all of which were answered and provided. The team returned to Michigan and individually concluded each of their assigned standards, which were then complied into the final report.

DESCRIPTION OF FACILITY CHARACTERISTICS

North Kern State Prison (NKSP) is operated by the California Department of Corrections and Rehabilitation. Construction for NKSP began in February 1990 on 640 acres of land in the Central Valley, specifically Delano, CA. and received its first inmates in April of 1993. During the construction of the facility, the environmental review process found three endangered species on the Delano Prison site. These are the San Joaquin Kit Fox, Blunt-Nosed Leopard Lizard and Tipton Kangaroo Rat. Due to the sensitive status of these species, construction constraints were implemented to protect them. The CDCR had acquired land off-site to compensate for the loss of habitat caused by the construction of the prison facility. Three hundred and sixty acres of NKSP property has been designated as protected wildlife habitat. NKSP also has on site a 5.7 megawatt solar power plant that solely provides power for the facility which will result in significant costs savings and lessen the carbon footprint of the facility. NKSP is a sister facility to Wasco State Prison and is operated as a Reception Facility which also operates as the site for the Central/Southern California Transportation Hub for the CDCR. In addition to its Reception Center, NKSP has two mainline facilities, housing Level I and Level III inmates, along with a 16 bed Correctional Treatment Center (CTC). It has a designed capacity of 2694 with a current population of 4106. As a reception center, NKSP received 15,600 prisoners in the last 12 months. 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 or they were open dorm style units with multiple bunk beds throughout the unit. NKSP is an adult male facility with all male inmates, ranging in age from 18-79.

NKSP has several facilities within the boundaries of the perimeter fences, these facilities are commonly referred to as yards. Each facility is designated as a letter with a range of A through D and M, such as "Facility A", Facility C", etc... NKSP has several different style housing units which include multi-level double occupancy cells, open bay/dorm and one single cell housing unit with 175 segregation cells. At the time of the audit there were 90 inmates housed in the segregation unit. Each facility has its own programs, education, medical/mental health and dining areas. The facilities are broken down as follows:

FACILITY A: Consists of five level III housing units that house level III general population inmates. The inmates on this yard provide the work force for the institution's support services assignments, such as, kitchen, prison industry, clerical, and housekeeping. Vocational and academic education programs are also available.
FACILITY B: Consists of six reception center housing units that house general population reception center inmates while being classified and completing the diagnostic process.
FACILITY C: Consists of six dorm style housing units that house minimum and medium custody level type inmates. Buildings 1-3 and 6 house general population reception center inmates and buildings 4-5 house sensitive needs yard (SNY) inmates.
FACILITY D: Facility D has the same design as Facility B. Buildings 1-5 house general population reception center inmates while being classified and completing the diagnostic process. Building 6 is designated as Administrative Segregation Unit (ASU) that has a capacity to house 175 inmates.
FACILITY M: A Minimum Support Facility (MSF) has 2 tri-level units and a recreation yard. Institutional and support workers, who provide institutional maintenance, housekeeping and landscaping for outside the secure perimeter, are housed on this yard. Additionally, Emergency Fire Fighters are processed and assigned to the Fire House from this yard. The fire department provides mutual aid to the local community and to the facility.

NKSP provides educational services to the inmate population as well as Career Technical Education (CTE). Curriculum is personalized to each student's individual learning needs with a focus on completion of the GED exam. Beginning in 2016 Bakersfield College will be offering on-site college courses to inmates housed on Facility A. Inmates will have the ability to earn a transfer ready Associates Degree. Other students may participate in one of the Career Technical Education programs to learn vocational skills needed in the workforce.

NKSP has medical care services on grounds to include physical, mental, and dental care for each yard. Upon arrival, inmates are screened for medication issues. This is also the time that inmates are initially assessed for PREA related concerns. Within 72 hours of arrival, all inmates receive an initial assessment in Diagnostics to identify mental health issues and developmental disabilities. The facility provides medically necessary diagnostic and specialty services in Ultrasound, CT Scan, MRI, Fibro Scan, Orthotics, Optometry, Podiatry, Orthopedics, Audiology, Orthotics, Oral Surgery and Physical Therapy to inmate-patients. Offsite emergency services are provided for any inmate medical needs that cannot be met at the facility.

NKSP has approximately 76 volunteers and 385 individual contractors, 12 investigators with a total of 1355 staff that work there.

NKSP has a layered security system to protect the general public. The facility's two perimeter fences are topped with razor-ribbon wire and there is a lethal electric fence between the inner and outer perimeter fences. NKSP also has multiple gun towers as well as a perimeter response vehicle. The facility has two entry points, one being the walk through control center gates and the second being a sally port for vehicle entry.

NKSP is a large facility and as such, the yards, housing units and program rooms were not overcrowded and the amount of staff observed was appropriate for the number of prisoners. 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.

115.67, sections (c) and (d) NKSP did not meet the 90 day retaliation monitoring requirement following a report of sexual abuse. In addition the agency does not require follow-up on transferred inmates. If the facility had transferred inmates they would not be able to show proof that the monitoring continued for at least the required 90 days.

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

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

North Kern State Prison (NKSP) is one of the 35 facilities operated by the CDCR and employs an upper level administrator, Captain Kevin O'Daniel, as the facility's PREA Compliance Manager. Capt. O'Daniel has indicated that he has the time, resources and authority to perform his duties as the facility's PREA Compliance Manager. The documentation and information provided by NKSP and Captain O'Daniel supports that the facility 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 and NKSP have indicated they do contract for the confinement of offenders. CDCR and NKSP has not entered into nor renewed any contracts since assuring to comply with PREA therefore no current contracts contain the required language. The CDCR has included PREA language into the agency's PREA policy, exhibits D and M, regarding contracts which would meet the requirements of this standard, if the institution were to contract for the confinement of inmates.

Standard 115.13 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR has, in recent years, moved to a standardized staffing plan which has taken into consideration the physical plant layout, security level and type of offender and their specific needs when developing the plan for each of its correctional facilities. 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 the staffing plan at least monthly during the hiring authority meetings and budget meetings. Any request for additional staffing, electronic monitoring equipment or upgrades are identified at these meetings. NKSP has hired 205 staff in the last 12 months which supports that the Administration has made great strides in improving staff and supervisory presence in order to prevent and detect sexual abuse and harassment. The approved and reviewed staffing plan was appropriate for the security level and current population of prisoners, programs and activities at the facility. During the tour it was observed there was sufficient custody and support staff coverage in all areas.

The only deviation from the staffing plan was due to reassignment. This was only utilized when the assigned post is no longer needed due to the closure of services. Shift schedules were reviewed and each shift was adhering to the staffing plans. Any vacancies on the schedules based on absences were appropriately staffed with the use of employees on overtime.

DOM 54040.4, Security Rounds, requires that 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. The Unit log book shall indicate the date, time and location the security round was conducted. During the tour of NKSP, the auditors were able to verify that appropriate supervisors on all shifts were conducting and documenting required unannounced security rounds as supported by the documented rounds in the Unit log books, as well as through random supervisor, staff and inmate interviews. In addition, all of the supervisors who were interviewed were able to provide their method in which to conduct unannounced rounds in a manner which would prevent staff from being able to alert other staff of the supervisory round.

CDCR was not in compliance with section (c 1-3) of this standard at the time the audit was conducted due to not having a formalized process to assess, determine and document whether adjustments were needed to the staffing plan, deployment of electronic monitoring equipment, or the resources available to commit to adherence of the staffing plan in conjunction with the agency wide PREA Coordinator. Although not apparent at NKSP, the lack of this process as an agency could possibly impact sexual safety.

Remedial Action Plan: The agency PREA Coordinator has indicated a plan was drafted to implement a formalized process to address this standard. Final approval should be achieved within the next 30 days according to the agency. Once the policy revisions are made effective and evidence of the staffing plan review in accordance with all requirement of section (c 1-3) are provided to the auditor, the agency/facility will meet the requirements of this standard. The agency has agreed to this remedial action plan to achieve compliance and will forward the documentation to prove that final approval was achieved and the process is in place.

Corrective Action: During the Corrective Action Period (CAP), 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. The CDCR and NKSP are now in full compliance with this standard.

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.

NKSP 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 is not applicable to NKSP.

Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Policy 54040.4, Preventative Measures, requires that the institution shall enable inmates to shower, perform body functions, and change clothing without non-medical staff of the opposite sex viewing their buttocks or genitalia except in exigent circumstances or when such viewing is incidental to routine cell checks. In order to minimize exposure, staff of the opposite sex shall announce their presence upon entering the unit. During the tour, the auditors observed every shower, toilet, clothing change, or stripping area within the institution for possibility of cross-gender viewing. Each area has either permanently installed modesty screens, frost on the windows, or portable modesty screens available in the area. Several random interviews were conducted with both staff and inmates and it was very evident that sufficient privacy was given to the inmates while showering, performing bodily functions, and/or changing and stripping clothing. In addition, through interviews and observation, it is also evident that female staff are announcing their presence upon entry into the housing units.

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

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

During the tour, the auditors observed that postings were present in all areas, and the postings included all relevant and necessary information and the postings were in both English and Spanish. The PAQ, along with the interviews of both staff and inmates indicated that there were no circumstances in which interpreters have been need related to PREA allegations. The staff indicated that they were all aware of the agency's agreement with an interpreter agency if necessary. Also, the agency pays a monthly stipend to multi-lingual staff that can pass an aptitude test in their second language which enhances the ability of the agency to avoid using inmates as interpreters. The agency has a standard agreement with Interpreters Unlimited, Inc., in order to provide interpreter services for any inmate whose needs cannot be met by facility staff or their current implementations of PREA information for non-English speaking or otherwise developmentally disabled.

Standard 115.17 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

However, at the time of the audit, the agency had no method to directly ask about incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist another's services. Therefore, the agency was not in compliance with this standard.

Remedial Action Plan: The agency has agreed to a Corrective Action Plan (CAP) to modify an existing pre-employment form (CDCR 1951) in order to capture this information. The agency will forward the documentation to the audit team to show that final approval was achieved and the process is in place. Upon completion of this form, the agency will be in full compliance of this standard. Final approval should be achieved within the next 30 days according to the agency. The agency will need to submit documentation to the auditors for the next 180 days to show that the new form is being utilized and the required questions are being asked.

Corrective Action: During the CAP, the CDCR has developed and implemented an agency-wide 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) was revised; question #4 was added to cover 115.17(b), a process to ask applicants about previous incidents of sexual harassment. The CDCR and NKSP are now in full compliance with this standard.

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 inmates from sexual abuse/harassment.

During the facility tour of NKSP, auditors observed that there was no newly completed construction. There is very limited camera systems used within the institution; there were only cameras in the visiting area, not including the area in which inmates are strip searched for visiting, and a few observations cells in the medical area. The facility design did not appear to have any areas which would cause concern for inmate safety and staff presence in all areas of the institution is evident. All doors to rooms which were not in use were locked and larger areas such as the kitchen, dining, recreation and vocational/education were monitored closely by both non-security and security staff. The facility also had many corner mirrors to allow staff visual observation of blind spots in various areas of the facility.

Standard 115.21 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

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

In regard to investigations of sexual abuse allegations, CDCR has multiple methods in place to ensure compliance with this standard. Staff 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 requires the victim be taken to the designated outside hospital where contract staff will conduct the forensic exam. A telephone interview with contracted staff responsible for conducting the exam verified that staff are appropriately trained in accordance with California State Law to conduct such exams.

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

Victim advocacy and victim support services are addressed in agency policy 54040.8.2 and verified that these services are available to inmates and staff through random interviews. In addition, postings were placed throughout the facility as a notice to inmates that these services are available. The agency policy requires that 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. This was confirmed through the interview with Forensic Nurse Specialists who indicated that they are responsible for conducting all SANE/SAFE exams and that in every instance there would be a qualified SANE/SAFE available at all times. Policy 54040.2 defines a VAG and their role in an incident 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 also requires that the victim has the right to have a victim advocate from a local rape crisis center at the examination. A Memorandum of Understanding has been implemented in the past with advocacy groups and is currently being updated and reviewed. The Victim Advocacy Group (Alliance Against Violence and Sexual Assault) information was posted throughout the institution and available to inmates. In addition, interviews with random inmates supported that the information has been posted and the inmates have knowledge of the type of help they can receive from the group.

NKSP indicated in their PAQ that in the past twelve months preceding the audit they had one instance where a forensics medical examination was conducted and it was completed by a SANE.

Standard 115.22 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR policy, Chapter 5, Article 44, Section 54040.12, requires that an administrative or criminal investigation must be completed for all allegations of sexual abuse and sexual harassment. Every allegation is referred to the facility's ISU for investigation. ISU staff conducts all of the facility's criminal investigations and all information regarding agency policy is published on the Department website. Any

investigation that involves possible staff misconduct is referred to the agency's Office of Internal Affairs (OIA); OIA is responsible for determining which allegations of staff misconduct warrant an Internal Affairs investigation and for completing all investigations in a timely and through manner. This was verified during the interviews with the CDCR Agency Head and the ISU/Watch Commander, along with the responses from other random staff.

According to review of facility documentation, there were fourteen allegations received and investigated in the past twelve months at NKSP, none of which was referred for criminal investigation.

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

Standard 115.31 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CDCR 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 on the agency's zero-tolerance policy, how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. A review of PREA training curriculum and staff training records revealed that all staff who have contact with inmates have participated in a comprehensive training program that gives detailed information addressing all 10 required topics complying with section (a) of this standard. CDCR §3391 also address employee conduct which directly responds to this standard. The training provided by the agency is gender specific and includes information on working with both male and female inmates.

NKSP provided a July 13, 2015 memorandum - subject Prison Rape Elimination Policy (completion memo) addressing 100% completion of PREA staff training with the exception of staff that was on extended leave. On May 18th NKSP Training staff produced training records indicating all but 5 of the extended leave staff had completed the PREA training and as the remainder returned to work; they too would receive the PREA training before being allowed to go to work inside the institution. NKSP Training staff also produced a record keeping system called BIS (Business Information System) which shows all staff training records, including PREA training, and has the ability to specifically look at PREA training as a whole to identify whether or not each employee has received the specific PREA training. The CDC's T4T PREA Training curriculum is clear and concise and addresses elements 1-10 in standard 115.31. A July 24th, 2015 Memorandum to Jay Virbel Prisoner Rape Elimination Act Policy Implementation of Policy and Training for Trainers explains that all staff including contractors and volunteers will be provided structured training on the revised PREA Policy. The Facility provided extensive training records; both digital and copies of hand written signatures indicating that PREA training had been attended.

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.

The agency's DOM, Chapter 5, Article 44, Section 54040.4, Prison Rape Elimination Policy, Volunteer/Contractor Information Sheet outlines and complies with all the requirements stated in sections (a) through (b) of this standard and require the volunteer/contractor to sign and date receipt of the documentation. The agency maintains the signed documentation confirming the volunteers/contractors receipt and understanding of the agency's zero tolerance standard and reporting duties.

NKSP provided examples of signed volunteer/contractor documentation showing that all volunteers and contractors are made aware of PREA and are trained regarding the guidelines mandated by PREA standards. The facility provided documentation out of CDCR's operations manual 32010.83 related to Record Keeping Forms and the retention of these documents. NKSP provided proof of Education and Prevention – Staff Training which includes volunteer and contractors, stating that they shall receive instruction related to the prevention, detection, response and investigation of offender sexual violence, and that the training will be gender specific based on the offender population at the assigned institution. This training is documented on CDCR844.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency's departmental policy, DOM Chapter 5, Article, 44, Section 54040.4 under Offender Education requires that verbal and written information shall be provided to offenders which will address prevention/intervention, reporting and treatment and counseling in regard to sexual abuse/harassment. Initial offender orientation on PREA is provided to all offender populations in reception centers via either written or multi-media presentation on a weekly basis in both English and Spanish. Inmates are provided information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment during the intake process. CDCR's general practice is to require inmates to meet with the Classification Committee within 14 days of arrival at a new facility where they receive comprehensive education regarding their rights to be free of sexual abuse/harassment and to be free from retaliation for reporting such incidents and procedures for reporting such incidents.

NKSP provided both Spanish and English examples of PREA Posters that outlined the steps to take in the event of a PREA related issue as well as how to go about reporting such incidents, The facility also has booklets and brochures that were made readily available to the inmate population upon arrival at NKSP (Spanish and English) outlining what PREA is and explaining what steps to follow should they or someone they know become a victim of sexual abuse. While touring NKSP I observed that the PREA posters were clearly posted throughout the facility in both English and Spanish and while speaking with random inmates, each one of them was aware of where they had to go to receive PREA information. A November 2, 2015 memorandum from Warden Kelly Santoro to Amy Miller addresses that each inmate housed at NKSP received the "PREA Information for Orientation Handbook". A November 4th, 2015 Memorandum from Jay Virbel – Associate Director of the Female Offender Programs and Services/Special Housing informed Lieutenant M.J Rustad that the entire female population had also received the PREA Information for Orientation Handbook. 115.33d - The facility provided proof regarding PREA Offender Education and what is addressed with offenders. Those non-fluent in English and low literacy levels and disabilities are addressed and how they will be handled. The Facility /Agency Meets this Standard.

After viewing NKSP's intake process, it was very clear the facility had an excellent system in place to ensure all incoming inmates received their PREA education within hours of arrival at the prison. Every single new inmate coming to NKSP goes through this exact process,

therefore ensuring each inmate is receiving their PREA Education. NKSP provided both Spanish and English examples of PREA Posters that outlined the steps to take in the event of a PREA related issue as well as how to go about reporting such incidents. While touring, there were PREA Posters hung in clear view all throughout the facility and in every housing unit, on each side, and this information was painted on the wall neat every prisoner phone inside the units.

During tours of the housing units random interviews were conducted with staff and inmates to establish their knowledge of PREA and how to report any instances of abuse or harassment. Each of the inmates interviewed were aware of PREA, the steps they would need to take in the event that they, or someone they knew were sexually assaulted/harassed and they knew the avenues they had available to them to report such instances of Sexual Abuse or Sexual Harassment. Prisoners referred to the PREA posters and also acknowledged receiving PREA education via pamphlets and booklets, although some indicated they did not read them

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.

In addition to the general training provided to all employees pursuant to Standard 115.31, the agency also trains all employees assigned to investigate sexual abuse investigations on conducting such investigations in confinement settings. This training requirement is specifically outlined in CDCR policy 54040.4 Education and Prevention, Staff Training which states all employees who are assigned to investigation sexual violence and/or staff sexual misconduct will received specialized training per PC Section 13516 (c). Auditors reviewed the training curriculum used for this training and verified it meets the requirements of this standard including the proper use of Miranda and Garrity, sexual abuse evidence collection and criteria used to substantiate a case. The agency requires signatures from every employee who has participated in the training. The agency provided examples of the signature sheets verifying those employees assigned investigations have participated in the specialized training.

115.34 a, b, c, d - NKSP provided proof of 54040.4 Education and Prevention – Staff Training, which specifically stated that all employees assigned to investigate sexual violence and or staff sexual misconduct will receive specialized training per PC Section 13516©. And that this training will be documented on CDCR844, training participation Sign In Sheet. 115.34 a, b, d NKSP provided documentation showing that all staff including volunteers and contractors shall receive instruction related to the prevention, detection, response and investigation of offender sexual violence, staff sexual misconduct and sexual harassment and when it will be conducted. 115.34C NKSP also provided proof of record keeping practices 32010.8.3. NKSP provided training documentation showing that each individual who conducts PREA investigations had received Basic Investigator Training. The investigative staff at NKSP were extremely knowledgeable of the PREA investigative processes and it was clear they had received the training that the documentation indicated.

Section (d) does not apply to this facility.

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 policies 54040.4 Education and Prevention, Staff Training, 54040.7 Detection, Notification and Reporting, and 54040.8 Response apply to all staff employed by the facility. Additionally, 54040.8.3 Medical Services Responsibilities is required of all California Correctional Health Care Services (CCHS) medical staff which requires medical staff to provide indicated emergency medical response taking steps not to contaminate evidence. The training required of CCHS staff covers how to detect and assess, how to preserve physical evidence, how to respond effectively and professionally to victims and how, and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

NKSP provided proof related to Response 54040.8 (115.35 A3) indicating that staff shall act professionally when interacting with an alleged victim of sexual violence or staff sexual misconduct and will display sensitivity. This training covers confidentiality and disclosure made only to employees who have the need to know and to others required by law.

NKSP provided detailed proof of Medical Services Responsibilities (115.35 (a) 2) which addresses steps to not contaminate evidence and follow up testing for STD's, etc. NKSP training department provided documentation showing that PREA training had been provided and there was a detailed procedure in place to deal with inmates who had reported or experienced sexual abuse and harassment has been well established. Medical and Mental Health staff receive two hours of PREA related training during In-service Training and also receive PREA refresher training via the OJT PREA training module every other year. The facility provided documentation related to the record keeping of training documents (32010.8.3 Record Keeping Forms (115.35C)) as well as documentation showing Proof of Education and Prevention-Staff Training (115.35D) and Detection, Notification and Reporting (115.35 (A) 4). NKSP medical and mental health staff were interviewed and it was clear they too had received PREA training and that an excellent plan was in place to deal with any PREA related issues or incidents.

NKSP does not conduct Forensic Medical Exams. The agency provided 54040.9 Forensic Medical Exams which explains that the victim will be taken to an outside hospital where the SART/SANE Contract staff will complete the forensic examination, and (54040.10) upon the return of the victim from the off-site SART/Sane Exam, the offender will be assessed by facility medical and mental health staff. It was clear upon interviewing Medical and Mental Health Staff that they do lay out steps that shall be followed regarding post trauma. The Facility provided documentation stating that a SART TEAM - Sexual Assault Response Team will be utilized at the local community hospitals to conduct all Sexual Assault medical exams. The SART Teams are medically trained staff that is proficient in conducting sexual assault exams including proper evidence protocols; the hospitals Victims' Advocates are also utilized. The facility also has their own IPRC (institutional PREA review committee) team that does not conduct forensic exams, but are trained on how to appropriately deal with issues of sexual abuse from the onset, at the facility, prior to the inmates departure to the local hospital.

The facility provided proof of Mental Health Responsibilities, showing how they are incorporated and what steps they will take to ensure the victims of sexual violence or staff sexual misconduct are treated appropriately.

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.

In accordance with CDCR policy 54040.6, and Article 1.6 Inmate Housing, the process for review and evaluation for single cell status is initiated during the receiving process. Single cell status is CDCR's procedure to separate abusive offenders from non-abusive offenders. All inmates received at the facility are processed into the facility through the Receiving and Release area where they are screened for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. The same screening takes place when prisoners are reviewed for transfer to another facility, a process called Endorsement. Intake staff provided copies of Initial Housing Reviews containing a checklist of information reviewed in making bed assignments and single cell determinations. The information is collected from the inmate's file, contained on the department's computerized database, and from an interview with each individual inmate, and contains

information regarding the inmate's risk of being sexually abused by or sexually abusive toward other inmates. The same information is reviewed, along with information contained on the Classification Committee Chrono and information collected during an interview with the inmate, when the inmate is reviewed for transfer to another facility. This screening process is conducted immediately upon arrival at the facility. This screening process is conducted immediately upon arrival at North Kern State Prison in their intake area (115.41a).

NKSP provided physical documentation stating that the process of review and evaluation for single cell status shall be initiated during Reception Center processing as part of the initial screening. The Facility provided proof of Article 1.6 Inmate Housing which addresses a thorough screening of each incoming prisoner's background including any incidents dealing with PREA related issues. A September 17th, 2015 memorandum to Associate Directors, Division of Adult Institutions Wardens and PREA Coordinators was sent out by Director Kelly Harrington indicating that changes had been made to the Department Operations Manual (DOM) related to PREA standard 115.41, Screening for Risk of Victimization and Abusiveness, this memorandum gave direction on how to immediately comply with 115.41 due to it being only partially addressed in the DOM because it was still under development. The facility also provided proof in a September 17th memorandum to Associate Directors, Wardens and PREA Compliance Managers that Prisoners will be re-assessed for any risk of victimization or abusiveness within 30 days of arrival at the facility, and outlined the process that will be followed. The facility's documentation also dictated that prisoners would not be disciplined for refusing to answer or not disclosing complete information related to their sexual orientation or sexual violence history during the screening process.

NKSP provided a thorough explanation of the Departments Offender Tracking System which they refer to as SOMS (Strategic Offender Management System). It is in this system that the screening for Risk of Victimization and Abusiveness takes place at the time of intake. All 10 points mandated in 115.41(d) are in-fact covered during the intake interview. This is an objective screening instrument; it does contain information related to prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence or sexual abuse. This information is used to determine an inmate's risk of being sexually abusive. The facility did show that a prisoner is re-screened within 30 days of arrival if more information is received regarding the inmates history of abusiveness. The facility explained the process that is used to re-assess a prisoner's risk level in the event a prisoner is involved in a PREA related incident. NKSP utilizes an Institutional Classification Committee which consists of the Warden, Mental Health, Custody Staff and Investigative Staff (ICC), who will re-assess the prisoners risk level and determine proper housing/bunking placement within the facility in order to ensure a safe environment for all inmates. The facility showed that appropriate controls were in place related to the sensitive information contained in the Risk Screening. SOMS has different levels of access and only staff that would need access to the information contained in the Risk Screen would have access to it.

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. Of all the inmates interviewed during the tour, the majority of them indicated that they were asked about PREA issues during intake. During the tour, the intake area was closely observed and staff were able to verify the intake and screening process is followed per their agency policies. Risk screening is conducted during the intake process using an objective screening instrument within hours of arrival at NKSP and all incoming inmates are assessed for their risk of being sexually abused, or sexually abusive. The screening process considers all 10 criteria mentioned in 115.41(d). During the tour there were no incoming inmates but through observation and auditing it was determined that the process is clearly in place based on the documentation and physical process of conducting the intake process. There were many inmates in the intake area but they were court returns and not initial placement inmates. Interviews of 4 randomly chosen inmates in the area were completed and all indicated that they received PREA education and screening during their intake process.

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.

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10 points mandated in 115.41(d) are in-fact covered during the intake interview. This is an objective screening instrument; it does contain information related to prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence or sexual abuse. This information is used to determine an inmate's risk of being sexually abusive. The facility did show that a prisoner is re-screened within 30 days of arrival if more information is received regarding the inmates history of abusiveness. The facility explained the process that is used to re-assess a prisoner's risk level in the event a prisoner is involved in a PREA related incident.

NKSP utilizes an Institutional Classification Committee which consists of the Warden, Mental Health, Custody Staff and Investigative Staff (ICC), who will re-assess the prisoners risk level and determine proper housing/bunking placement within the facility in order to ensure a safe environment for all inmates. The facility showed that appropriate controls were in place related to the sensitive information contained in the Risk Screening. SOMS has different levels of access and only staff that would need access to the information contained in the Risk Screen would have access to it.

The facility provided documentation of Section 54040.6 Offender Housing – showing that offenders at high risk of sexual victimization shall not be placed in a segregated housing unit, unless there are no other available alternatives to keep the inmate separate from likely abusers. Screening will take place immediately or within 24 hours. If segregation is required administrative segregation will be issued with explanation. Single Cell Status is looked at during the review process at the reception center. It is also looked at again upon the prisoners arrival to their assigned institution, offenders will not be disciplined for not answering questions during this process for refusing to answer questions related to their sexual background. (115.52a,b)

62080.7 Treatment Categories Psychiatric General – Inmates who suffer impaired functioning sufficient to require a mental health treatment program due to symptoms of major mental illness shall be transferred to CMF, CMC-E or CIW for psychiatric evaluation.

North Kern State Prison does consider where transgender and intersex prisoners are assigned on a case by case basis, and they do take the inmates health and safety into consideration when making this placement. NKSP provided a copy of Policy 4.26 Gender Dysphoria Management Policy – Chapter 26 (effective date 6-2007, revised 6-2015) which is an in depth guide and process related to this process. Based on the documentation reviewed while on site and information obtained during interviews it is apparent that they are following this guide (115.42c).

North Kern State Prison does have a system in place, via Health Care, to assure any intersex or transgender inmates are reassessed at least 2 times per year to review any threats to safety (115.42d). At the time of the audit, NKSP did not have any identified transgender inmates housed at the facility. Intake staff interviewed indicated that if any were identified during intake, they would be asked about their sexual safety and would be informed on how and where to report if they had any issues related to their status (115.42e).

Interviewed staff indicated that transgender inmates would be housed in general population units with the same privileges as all other GP prisoners and that they would be given the option to shower in areas that provide them privacy and they could shower at times separate from other inmates if they so desired (115.42 f, g). NKSP provided documentation (Article 1.6 Inmate Housing - Inmate Housing Assignments) related to inmate housing expectation and the process that is used to determine housing needs.

After reviewing this documentation and conducting interviews with staff and inmates it was clear inmates are not placed in specific facilities or units based solely on the identification of being lesbian, gay, bisexual, transgender, or intersex. Placement of inmates is assigned based on the overall needs, safety and security of the inmate using the standardized risk assessment screening

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.

NKSP provided documentation of Section 54040.6 Offender Housing – showing that offenders at high risk of sexual victimization shall not be placed in a segregated housing unit, unless there are no other available alternatives to keep the inmate separate from likely abusers. NKSP had ZERO instances of having to place a prisoner into Segregation due to a PREA related incident, because of their ability to place a

prisoner into their Special Needs Units (Protective Housing Units). The facility did show that in the event a prisoner had to be placed into Segregation, screening would take place immediately or within 24 hours, and if Administrative Segregation is required it will be issued with explanation.

Single Cell Status is looked at during the intake review process at the reception center utilizing SOMS. Upon interviewing Intake staff, it was explained that they will look at the offender's history, but will also look at each individual to determine whether or not they might be at risk for sexual victimization or that they might be an aggressor. Single Cell Status is also looked at again upon the prisoner's arrival to their assigned institution. Intake staff explained that offenders will not be disciplined for refusing to answer questions related to their sexual background, this stipulation is documented and during random interviews staff was aware that inmates would not be disciplined for refusing to participate in any part of the PREA related interviews. North Kern State Prison does consider on a case by case basis where their Transgender or intersex inmates will be placed and they do take the inmates health and safety into consideration. Upon interviewing staff and prisoners it was evident that Transgender and Intersex inmates were allowed to shower separately and upon touring NKSP housing units there were barriers which allow prisoners privacy during the showering process.

NKSP provided proof related to detection, notification and reporting which mandated that all staff are responsible for reporting immediately and confidentially to the appropriate supervisor any instances of sexual violence, staff sexual misconduct or sexual harassment. Staff shall assist the offender and refer the offender to mental and medical health. The custody supervisor conducting the initial screening shall discuss housing alternatives with the offender in private. The offender shall not automatically be placed into administrative segregation. They may be placed with another inmate who has a similar circumstance; single cell placement may even be an option if deemed necessary.

The facility provided documentation that should an inmate be placed in segregation for Non-Disciplinary Segregation (NDS), the inmate will be afforded all programs, privileges and education in accordance with the NDS policy.

Standard 115.51 Inmate reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Investigations are initiated as soon as the information is relayed to the PREA Coordinator or Investigative Services Unit (ISU). Random interviewed staff were all aware that reports shall be accepted whether done verbally, in writing, anonymously or from a third party and that documentation and reporting to their supervisors was required to be completed immediately. 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. All of the inmates interviewed 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. All were aware that a report could be made without giving their name. All areas of the facility had adequate postings indicating how to report. Some inmates interviewed did indicate that they would find it too embarrassing to report or simply would not report something of this nature.

More than 10 reports were reviewed in the ISU and all supported compliance with this standard. A good sampling of verbal 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 NKSP, 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 the filing portion of the standard but did not meet the time limits imposed.

The agencies polices at the time of the audit did not require a final decision within 90 days and emergency appeals would be responded to within 5 business days. The facility had 4 appeals filed in the 12 months preceding the audit that alleged sexual abuse. Of those 4, all 4 of them reached a final decision within 90 days. The agency does inform the inmate when an extension is requested which will delay a final decision. No appeals were received in the 12 months preceding the audit that were of an emergent nature that would've required a final decision within 5 calendar days.

DOM, Chapter 5, Article 44, Section 54040.15.1 does allow for an inmate to be disciplined for filing an appeal alleging sexual abuse in bad faith. The facility had zero instances in the 12 months preceding the audit that fell under this provision of the standard.

The facility reported on the Pre-Audit Questionnaire (PAQ) that they had 4 reported sexual abuse cases reported via the appeals (grievance) process in the last 12 months preceding the completion of the PAQ. All of the reports indicated they were completed and a final decision was made well within the 90 days.

CDCR §3084.2 Appeal Preparation and Submittal, section (g) which 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 addresses 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.

Remedial Action Recommendation: The agency has proposed language to their policies that is pending final approval at the agency level. Final approval should be achieved within the next 30 days according to the agency. Once final approval to the language is achieved, the agency will be in compliance. The proposed language was received and falls within the time limits imposed by this standard. The emergency appeals process updates the time frame for receiving a final decision from 5 business days to 5 calendar days. The agency has agreed to this

remedial action plan to achieve compliance and will forward the documentation to prove that final approval was achieved and that the policies have been updated to reflect compliance.

Corrective Action: During the Corrective Action Period (CAP), the CDCR updated the California Code of Regulations (CCR), Title 15; changes were updated and have been promulgated into law. The changes address Appeals and the Exhaustion of Administrative Remedies (115.52). The amended language referencing third party reporting by an inmate (CCR 3084.2 (g), 3084.6 (c) (5)) was also changed. The changes were published on the Office of Administrative Law, Notice of approval or Regulatory Action, on October 20, 2016. The CDCR and NKSP are now in full compliance with this 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. North Kern State Prison has entered into an agreement with Alliance Against Family Violence and Sexual Assault crisis center in Bakersfield, California 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 AAFVSA, including a toll free number and an address to be utilized by inmates to contact them. The postings also reference specifically the PREA standard to which this applies (115.21(e)) in the description stating the purpose of the posting. The posting also includes language stating that the VAG will; 1) Maintain confidentiality as required by state and federal laws for Sexual Assault Counselors and 2) Provide emotional support services related to requests from incarcerated victims.

During the interviews with random inmates, 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 postings were for and would refer to them if ever needed. This is not a negative reflection on NKSP, as they have taken great strides to ensure PREA education and related information is disseminated and available to all inmates, who in return also have a responsibility to acknowledge and accept this material.

During the tour it was noted 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 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 to be familiarized with the information. An additional fact is that this is a reception facility, so the inmates are new or returning inmates. With the amount of inmates coming into the facility, it is likely the process can be overwhelming to some, which would also add to the fact that some were not aware of the VAG. The intake process was visited and reviewed during the audit and the facility is providing each inmate with the information about the VAG.

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. Numerous custody and non-custody staff were interviewed and all knew the process very well which indicates they receive and absorb the training required.

Medical and mental health staff have a requirement to report information 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 NKSP, 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 begins 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, both custody and non-custody, 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.

NKSP had 2 reports that any prisoner was subject to substantial risk of imminent threat in the past 12 months. A review the reports indicated that in both instance the inmates were caught in the act and staff response was immediate to stop the act and to protect both the victim and perpetrator. 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.

NKSP reported that in the 12 months preceding the audit that they had 3 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 3 reports from other facilities where inmates reported they were sexually abused at North Kern State Prison while previously housed there. It was found through reviewing facility reports that the facility is making the proper notification within 72 hours to other facilities when the abuse is reported at this facility. Copies of the email notifications to the other facility's ISU units were printed and kept in the investigation report folders as proof of notification. All reports had the proper documentation to support compliance.

When a report is received by North Kern State Prison 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.

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 14 reported allegations that an inmate was sexually abused. In 7 of those 14 cases, the first responder separated the victim and abuser. In addition, 1 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 1 of the cases the first responder was a custody staff person and the other 6 were non-custody staff members, in all cases the proper protocol was followed.

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 NKSP 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.

NKSP 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.

It was found that during the review of the facility's investigation files that some files had the PAR forms in the files but nothing was filled out. Other files were found to not have the forms in them at all. Retaliation monitoring is not taking place at NKSP in substantiated or unsubstantiated cases indicating non-compliance with the standard. Due to NKSP being a Reception Center facility, it is common for all the incoming inmates to be transferred to a main line facility in a short time frame. In cases where an inmate transfers to another facility, the monitoring process is transferred with the inmate and the receiving facility is required to continue the monitoring for the duration of the 90 day period. However, there is no requirement by the agency for the facility to follow up to ensure that this actually takes place making it impossible for an auditor to ensure that the 90 day retaliation monitoring is being completed in those cases without tracking the process to the next facility where the inmate was transferred to. This does not affect this facility's inmates' sexual safety due to the fact the inmate transferred to a main line facility which does not affect this facility, it may however affect the receiving facility's inmates' sexual safety if they do not follow through with the monitoring.

Remedial Action Plan: NKSP 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 at the facility level as long as all requirements are met in the reports. The agency agrees due to the findings and potentially becoming an issue of logistics and possible non-compliance. It was agreed that all facilities will need to start mandating that the completed retaliation monitoring forms be returned to the originating facility for retention in the investigation files for compliance with agency DOM and PREA standards. The agency has agreed that they will be making the necessary changes to instruct all facilities to start this process for compliance purposes. The agency will need to provide proof to the audit team that they have completed this process in order to be compliant with this standard.

Corrective Action: During the Corrective Action Period (CAP) the facility forwarded all PAR forms as well as the facility log to indicate that they are completing and maintaining retaliation monitoring on all required substantiated and unsubstantiated cases. The facility has met the requirements for retaliation monitoring for both the reporting individual and victim ensuring that further victimization and/or retaliation does not take place. Following the audit the CDCR revised their DOM, section 54040.13 to state that when a prisoner is transferred to another institution within the 90 day monitoring period, the CDCR form 2304 shall be forwarded to the receiving institution. The sending institution shall make contact with the receiving institution to provide an overview of the case, noting the remaining monitoring timeframes. Upon completion of the monitoring period the form shall be returned to the sending for retention in the file and audit purposes. Based on this revision the CDCR and NKSP is now in compliance with this standard as this will further ensure that prisoner victims are properly monitored if transferred and prevent further victimization.

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, the Warden, segregation Sergeant and segregation officers 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 segregation Sergeant indicated that he was not aware of an instance like this taking place at this facility. The staff interviews confirmed compliance and that no offenders were segregated in the past 12 months for the purposes stated in this standard. The tour also showed that the facility has multiple options for alternate housing other than segregation. Being a reception facility, they also have the ability to transfer an inmate out as needed to avoid that very situation. If it were to be truly necessary to house a victim of sexual abuse due to not having any alternative, it was made clear that they would still have the same privileges as any other general population inmate other than being able to work a job. They would be allowed access to the library, programs, canteen and all other privileges otherwise given in a general population setting.

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. The review of investigations during the audit revealed that all allegations received were immediately addressed.

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.

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

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 shows that investigators documented in the reports the 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 is present at the facility.

Investigative staff investigates 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 North Kern 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 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 inmates of the findings of the administrative investigations.

Facility investigative files were reviewed for allegations reported within the past 12 months. All notifications forms to inmates were found in these files. The forms explain to the inmate what the conclusion was and the status of the investigation. They all appeared to be provided to the inmate in a timely manner.

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

Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Article 2, Section 3401.5 DOM, Chapter 3, Article 22, Section 33030.17, Disciplinary Matrix D17, D18, and D19 outline disciplinary standards for employees, volunteers and contractors and meet the requirements set by the standard. Agency polices describe that termination is the presumptive sanction and that disciplinary history, circumstances of the act and sanctions of similar offenses will be considered. 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 one incident of a staff member who violated the agency's sexual abuse or sexual harassment policies. During the audit tour this investigation was reviewed and is still ongoing. The incident involved an inmate initiating sexual contact with a staff member who failed to report it. The investigation is currently under review with the agency's Office of Internal Affairs. Facility staff indicated that the staff member would be disciplined if found to be in violation. The facility reported zero cases where a staff member was reported to a law enforcement agency. 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. The Facility reported on the PAQ no cases of sexual abuse/harassment involving contractors or volunteers. This was confirmed during the facility audit tour. The Facility ISU staff 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 and considers all specifics listed in the standard sections when imposing sanctions. The Agency does not allow for consensual sexual relations. The Facility does however make condoms available to inmates. The Agency and Facility state that this is a pilot program to help reduce the transmission of sexual diseases. Although consensual sex is not allowed, they are aware that it does occur in a prison setting.

The Facility reported no substantiated cases of prisoner/prisoner sexual abuse and therefore no discipline has been taken. 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 ISU. ISU staff were questioned about this and indicated they would initially investigate this to ensure that it was not a coerced/forced act.

North Kern is a reception center and therapy and programming is limited. The Facility indicated that if such programming was warranted during a risk assessment the inmate would be transferred to a facility that could accommodate. Medical staff interviewed indicated that the offending inmate would be referred to mental health staff for possible counseling and follow up therapy; however, it should be noted that this is not required by Agency policy and because of this standard 115.83 is not met.

A review of unfounded investigation was conducted and no inmates were issued disciple for making the allegation. ISU staff indicated they would consider the inmates motive for making the allegation prior to issuing discipline.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The requirements of agency policy and the inmate screens meet the requirements of this standard with regard to the process of referral and mental health follow-up. In the past 12 months, all inmates who have disclosed prior sexual victimization during screening and all inmates who have disclosed any previously perpetrated sexual abuse as indicated in the screening have been referred to Mental Health and a follow-up was completed immediately, well within 24 hours. The inmate(s) were referred to Mental Health immediately by phone and a Mental Health Referral Chrono was completed and sent to Mental Health. An evaluation is conducted the same day when it occurred during normal office hours, and Mental Health staff are on call when incidents occur outside of normal office hours, at which time an evaluation was conducted within a couple of hours of the referral.

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

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

Remedial Action Plan: The agency has agreed to a remedial plan to modify their existing Informed Consent for Mental Health Care form (CDCR 7448) to specifically address sexual abuse in a non-institutional setting. The Agency will also need to advise/train specified staff of the change and requirement to ensure future compliance. The agency will forward the documentation to the audit team to show that final approval was achieved and the form is in place agency wide. Upon completion and review of this form by the audit team, the agency will be in full compliance of this standard. Final approval should be achieved within the next 30 days according to the agency.

Corrective Action: 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 and NKSP are now in compliance with section (e) of this standard.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

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

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy IMSP&P Volume 4, Chapter 4 Access to Care; Chapter 12 Emergency Response; IMSP&P Volume 1, Chapter 16, PREA Policy; Mental Health Program Guide 2009 adhere to sections a-g of this standard. Investigative Reports and medical/mental health reports reviewed during the audit reflect 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 these 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 Plan: 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 will have to provide documentation that verifies attempts are being made for the next 180 days. Final approval should be achieved within the next 30 days according to the Agency. The Agency has agreed to this remedial action plan to achieve compliance and will forward the documentation to prove that final approval was achieved and the process is in place.

Corrective Action: During the Corrective Action Period (CAP), the CDCR 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 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 will be part of the review team. 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 to be conducted. The Agency was questioned as to how this 60 day policy complies with the standard, which states that a review ordinarily occurs within 30 days of the conclusion. Their explanation was that they exceed the standard because regardless if the investigation is complete, they meet monthly to discuss the incident to determine if there were contributing factors that may have led to the abuse. By setting the standard that they meet within 60 days of discovery, they ensure that issues that may have contributed do not go without being addressed if the investigation is prolonged for any reason.

Investigations into reported sexual abuse were reviewed during the audit. It was discovered that the Facility has not been conducting incident reviews as required per this standard or as required by Agency policy. The Facility had conducted some reviews but generally was not conducting them.

Remedial Action Plan: The Facility will have to conduct the required incident reviews on all prior allegations of sexual abuse (unless unfounded) and provide documentation to the audit team 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.

Corrective Action: During the Corrective Action Period (CAP) the facility supplied all the required documentation and incident review forms for the 180 day period. They supplied all the incident 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 DOM Chapter 5, Article 44, Section 54040.20 and 54040.19 covers 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 were reviewed and do show data being collected from all facilities and from contracted facilities.

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

Standard 115.88 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

However, there is 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.

Remedial Action Plan: The agency will need to finalize this process to be compliant with this standard. Final approval should be achieved within the next 30 days according to the agency. The agency has agreed to this remedial action plan to achieve compliance and will forward the documentation to prove that final approval was achieved and the process is in place.

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

Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

James Schiebner December 29, 2016

Auditor Signature Date