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

LOCKUPS

Date of report: August 10, 2015

Auditor Information				
Auditor name: Alberto F Caton				
Address: PO Box 582105, Elk Grove, CA 95758				
Email: albertocaton@comcast.net				
Telephone number: 916 714-9570				
Date of facility visit: February 5, 2015				
Facility Information				
Facility name: Ridgecrest Substation				
Facility physical address: 128 East Coso Avenue, Ridgecrest, CA				
Facility mailing address: *(if different from above)* Click here to enter text.				
Facility telephone number: 661 384-5800				
The facility is:	☐ Federal	☐ State	☒ County	
	☐ Military	☐ Municipal	☐ Private for profit	
	☐ Private not for profit			
Facility type:	☐ Police	☒ Sheriff	☐ Court Holding	☐ Other
Name of facility's Chief Executive Officer: Tom Little				
Number of staff assigned to the facility in the last 12 months: 5				
Designed facility capacity: 14				
Current population of facility: 0				
Age range of the population: 18 - 70				
Name of PREA Compliance Manager: Rhonda Turnbaugh		**Title:** Sergeant		
Email address: turnbaugh@kernsheriff.com		**Telephone number:** 661 391-7882		
Agency Information				
Name of agency: Kern County Sheriff's Office				
Governing authority or parent agency: *(if applicable)* County of Kern				
Physical address: 1115 Truxton Avenue, 5th Floor, Bakersfield, CA 93301				
Mailing address: *(if different from above)* Click here to enter text.				
Telephone number: 661 868-3588				
Agency Chief Executive Officer				
Name: Danny Youngblood		**Title:** Sheriff-Coroner		
Email address: sheriff@kernsheriff.com		**Telephone number:** 661 391-7500		
Agency-Wide PREA Coordinator				
Name: Kevin Wright		**Title:** Lieutenant		
Email address: wright@kernsheriff.com		**Telephone number:** 661 391-7853		

FINAL PREA AUDIT REPORT – RIDGECREST SUBSTATON

AUDIT FINDINGS

NARRATIVE

The Sheriff Department of the County of Kern, State of California, located at 1350 Norris Rd, Bakersfield, CA 93308, requested professional consulting services, specifically a Prison Rape Elimination Act (PREA) audit of its six detention facilities, from Synergy Technology Services, a California Corporation located at 9706 Rim Rock Circle, Loomis, CA 95650. Synergy Technology Services provided United States Department of Justice – Certified PREA Auditor, Alberto F Caton to conduct the audit. The terms and scope of the audit have been memorialized in a Personal/Professional Services Agreement.

The auditor conducted PREA audits of Central Receiving Facility (CRF) located at 1415 Truxtun Avenue, Bakersfield, CA; Max-Medium Facility located at 17645 Industrial Farm Road, Bakersfield, CA; Mojave Sub-station located at 1771 Highway 58, Mojave, CA; and Ridgecrest Sub-station located at 128 E. Coso Avenue, Ridgecrest, CA. The two sub-stations were audited as Lockup facilities and the other two facilities as adult jails. The on-site audit took place February 2 - 5, 2015. The agency requested audit of its two remaining facilities, Pre-Trial located at 17695 Industrial Farm Road, Bakersfield, CA; and Minimum Facility located at 17635 Industrial Farm Road, Bakersfield, CA during the month of May or June 2015.

PRE-AUDIT PHASE

The auditor provided the notice of upcoming audit to PREA Compliance Manager Sergeant Rhonda Turnbaugh on December 8, 2014. The notice was posted at least six weeks before the scheduled on-site audit. On January 14, 2015, the auditor interviewed Director Karin Stone of Women's Center High Desert, a community-based victim-advocacy agency that provides services to inmates/detainees in the custody of KCSO. Director Stone provided information about three cases, one each at the Minimum Facility, Max-Medium and Pre-Trial; there were no allegations from Ridgecrest Substation. Each case will be addressed where applicable in the audit tool.

On January 16, 2015, the auditor received completed pre-audit questionnaires for each of the four facilities scheduled for the February on-site audit. On January 20, 2015, the auditor received via currier service, a Universal Storage Bus (USB) flash drive with applicable agency policies, training records/documents, facility staffing plans and several other documents required for the pre-audit portion of the audit tool. The package also included a compact disc with the agency's PREA Education Video for inmates. With the items receive from the PREA Compliance Manager, the auditor began the process of completing the "Pre-Audit" portion of the audit tool for each facility. During the two-week period preceding the on-site audit, the auditor requested staffing

rosters for CRF and Max-Medium facilities and interview locations for management and some specialized staff. One week before the on-site audit, the auditor provided a schedule of activities to the PREA Compliance Manager; a few days later, after receiving the staff rosters, the auditor provided a list of security staff selected randomly for interviews and a checklist of policies/procedures and additional documents to be reviewed during the on-site audit.

ON-SITE AUDIT

On February 5, 2015, the auditor arrived at the Ridgecrest Substation for the on-site audit. Representing the agency was PREA Compliance Manager, Sergeant Rhonda Turnbaugh and representing the facility was Facility Director Lieutenant Little and the Senior Deputy in charge of the facility. Following introductions and a brief orientation, staff took the auditor on a tour of the facility. The tour started at the Intake and booking area where staff explained the booking and screening process; the auditor recorded notes as needed on the walking tour form. There were no surveillance cameras covering the area, but staff indicated that a camera for that area is expected soon. Next, the auditor toured the inmate housing area and noted the surveillance cameras covering the interior of the cells; however, there is a modesty screen that provides privacy for detainees using the toilet. The auditor asked impromptu questions of some of the detainees and recorded answers on the walking tour form. The showers are single person use and not covered by the surveillance cameras. On the day of the audit, there were three detainees housed at the facility; one was cited and released, and the auditor interviewed the remaining two. After detainee interviews, the auditor interviewed the two deputies on duty. By the time those interviews concluded, the Facility Director, who oversees both substations, arrived at the facility. The auditor conducted the Facility Director interview for both substations. The auditor reviewed a binder with facility procedures; staff explained that the procedures at the Mojave substation are identical. The auditor concluded the on-site audit, departed the facility and headed to the Mojave substation.

POST AUDIT PHASE

After organizing completed staff and inmate questionnaires, the walking tour form and additional documents provided during the audit, the auditor began the process of completing the "Audit" portion of the audit tool. Following completion of the audit tool, the auditor completed the preliminary audit report, identified documents to be uploaded with the audit tool and submitted a preliminary audit report package to the agency. This submission triggered the start of the six-month corrective action period. The Compliance Manager developed a template for the corrective action plan and began the process of developing proposed corrective actions in response to each standard where the audit report found the facility out of compliance. She submitted each proposed corrective action to the auditor for approval; the auditor either approved the action as submitted or provided suggestions for bringing the proposed action into compliance with the standard. The Compliance Manager and auditor continued the proposed corrective action plan review process until all proposed corrective actions were approved. The

auditor determined that none of the approved corrective actions required on-site verification. On July 31, 2015, the auditor received the complete Ridgecrest corrective action plan from the Compliance Manager and conducted a thorough review of the entire plan. On August 3, 2015, the auditor approved the facility's corrective plan and gave notice of approval to the Compliance Manager. This approval triggered the 30-day period for the auditor to prepare and submit the final audit report.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Ridgecrest jail opened in 1975 with a Board of State and Community Corrections rated bed capacity of 14, but averages only 4–6 inmates.

The Ridgecrest jail provides booking and short term housing accommodations for male and female inmates that have no immediate medical or mental health needs. Also, if no female Deputy is on duty, new female arrestees are transported to the Sheriff's Central Receiving Facility (CRF) in Bakersfield. Inmates booked at the jail facility stay less than 24 hours due to daily transportation to CRF, the Sheriff's reception facility in Bakersfield. Some stay over the weekend or holiday and are transported on the next court day, making 48 to 96 hours the maximum stay at the facility. During the week inmates transported from Bakersfield for appearances at the Ridgecrest court are held at the facility. There are three 4-man cells, two single cells, and one holding cell. Ridgecrest jail has a jail/booking office, receiving/holding area which leads to three hallways; first hallway has two attorney booths and two 4-man cells, there is a shower between the cells. The second hallway has a padded holding cell, a kitchen, storage room and the janitorial supply closet. The third hallway has the two single cells, a storage cell, and one 4-man cell with a shower between the single cell and a pre-booking holding cell at the other end of the third hallway next to the booking room.

A substation Deputy Sergeant supervises both the substation and jail, and a Detentions Senior Deputy manages the jail staff and day to day operations. There are four Detentions Deputies, one for each 12-hour shift.

SUMMARY OF AUDIT FINDINGS

On February 5, 2015, a Prison Rape Elimination Act (PREA) audit of the Kern County Sheriff's Ridgecrest Substation found that the facility is not in compliance with the PREA standards. Of 33 standards in the Lockups audit tool, the facility exceeded 0 standard, met 18 standards, did not meet 12 standards and 3 did not apply. The facility met 60% of the 30 standards that applied. Below is a summary of standards the facility exceeded, standards met, standards not met and standards that did not apply.

STANDARDS EXEEDED

None

STANDARDS MET

PREVENTION PLANNING
115.111 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
115.113 - Supervision and monitoring
115.116 - Detainees with disabilities and detainees who are limited English proficient

RESPONSIVE PLANNING
115.121 - Evidence protocol and forensic medical examinations.
115.122 - Policies to ensure referrals of allegations for investigations

TRAINING AND EDUCATION
115.134 - Specialized training: Investigations

REPORTING
115.151 - Detainee reporting
115.154 - Third-party reporting

OFFICIAL RESPONSE FOLLOWING A DETAINEE REPORT
115.162 - Agency protection duties
115.163 - Reporting to other confinement facilities
115.165 - Coordinated response
115.166 - Preservation of ability to protect detainees from contact with abusers

INVESTIGATIONS
115.172 - Evidentiary standard for administrative investigations

DISCIPLINE
115.176 - Disciplinary sanctions for staff
115.177 - Corrective action for contractors and volunteers
115.178 - Referrals for prosecution for detainee-on-detainee sexual abuse

MEDICAL AND MENTAL CARE
115.182 - Access to emergency medical services

DATA COLLECTION AND REVIEW
115.186 - Sexual abuse incident reviews

STANDARDS NOT MET

PREVENTION PLANNING
115.115 - Limits to cross-gender viewing and searches
115.117 - Hiring and promotion decisions

TRAINING AND EDUCATION
115.131 - Employee and volunteer training
115.132 - Detainee, contractor, and inmate worker notification of the agency's zero-tolerance policy.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS
115.141 - Screening for risk of victimization and abusiveness

OFFICIAL RESPONSE FOLLOWING A DETAINEE REPORT
115.161 - Staff and agency reporting duties
115.164 - Staff first responder duties
115.167 - Agency protection against retaliation

INVESTIGATIONS
115.171 Criminal and administrative agency investigations

DATA COLLECTION AND REVIEW

115.187 - Data collection.
115.188 - Data review for corrective action.
115.189 - Data storage, publication, and destruction

STANDARS NOT APPLICABLE

PREVENTION PLANNING
115.112 Contracting with other entities for the confinement of detainees
115.114 Juveniles and youthful detainees
115.118 - Upgrades to facilities and technologies

FINAL SUMMARY OF AUDIT FINDINGS

On July 31, 2015, the auditor received the complete corrective action plan for Ridgecrest Substation from the Compliance Manager. Following a complete review, the auditor approved all corrective measures in the facility's corrective action plan and notified the Compliance Manager of the approval on August 3, 2015. Below is the

revised summary of audit findings for Ridgecrest Substation. With the submission of this final audit report, the auditor certifies that agency-wide policies and procedures for Kern County Sheriff's Office's Ridgecrest Substation comply with relevant PREA standards.

Number of standards exceeded:	0
Number of standards met:	30
Number of standards not met:	0
Number of standards not applicable:	3

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.

_____ August 10, 2015

ALBERTO F CATON
Certified PREA Auditor
Adult Facilities

Date

Standard 115.111 - 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.

115.111(a) - Policy P-100, specifies the agency's commitment to zero-tolerance of any form of sexual abuse, sexual harassment and retaliation for reporting or cooperating with investigations. Policy P-100 specifies that the agency has a Detentions Bureau PREA Coordinator and a PREA Compliance Manager with sufficient authority to develop, implement and oversee efforts to comply. All bureau staff, medical, MH, contractors and volunteers are expected to comply with the policy. Prohibited acts and behavior are specified. The policy includes sanctions for those found to have violated the policy.
115.111(b) - PREA Coordinator is part of the Detentions Bureau, under the Lerdo Facilities Division and heads the Compliance Section. PREA Coordinator would be better positioned under the Detentions Bureau above all divisions with detention facilities. The PREA Coordinator has other responsibilities besides PREA; he meets responsibilities only with help from Compliance Manager who works on PREA issues full-time.

Standard 115.112 - Contracting with other entities for the confinement of detainees

☐ Exceeds Standard (substantially exceeds requirement of standard)

N/A ☐ 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.

N/A, the agency does not contract with other entities for confinement of detainees

Standard 115.113 - 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.

115.113(a) - The Kern County Sheriff Jail Facility Staffing Plan Process describes the agency's staffing plan process and specifies that Facility Managers now consult with the PREA Coordinator who is also a Facility Manager about the requirements of the standards. The agency provided a three-page staffing plan for the Ridgecrest Substation. The plan was developed to ensure adequate staff to provide a safe environment for detainees and staff and to protect against sexual abuse. The plan reflects staffing under three operational scenarios, normal, limited and restricted. The staffing plan includes consideration of all elements in the standard plus 7 others.
115.113(b) - The Facility Director communicates with the Sergeant and Senior Deputy, if there is no staff available, detainees are transferred to CRF and the facility is closed. The Facility Director stated that all instances of non-compliance with the staffing plan are documented and explained; however, no sample documentation was provided.
115.113(c) - Pages 2 and 3 of the facility's Staffing Plan include statements that address the four issues required by the standard, specifically, whether adjustments are needed to:

(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The lockup's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the lockup has available to commit to ensure adequate staffing levels.

CORRECTIVE ACTION: The preliminary audit report and the audit tool mistakenly reflect this subsection as not meeting the standard. The Compliance Manager requested clarification and the auditor explained that the audit finding was an error and the correct finding is "Meets Standard."
115.113(d) - Policy P-400, includes procedures for 5 types of vulnerable populations. The agency's computerize PREA Risk Screening includes the criteria in the standard and more; however, Pol P-400 does not include the criteria for screening for risk of victimization specified in 115.141(d). Security Staff indicated that they will house detainee in single cell away from potential abusers, notify Classification staff and monitor closely.

Standard 115.114 -Juveniles and youthful detainees

☐ Exceeds Standard (substantially exceeds requirement of standard)

N/A ☐ 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.

N/A, The agency does not house juveniles or youthful detainees.

Standard 115.115 -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.

115.115(a) - Policy P-200, Directive C-2, specifies that strip and visual body cavity searches will be conducted by a staff member of the same gender of the inmate being searched. The agency asserts that cross-gender strip

searches are not allowed. There are no logs because the agency does not allow cross-gender strip or body cavity searches.
115.115(b) - There are no logs because the agency does not allow cross-gender strip or body cavity searches. If there are no female deputies on duty, female detainees are transported to CRF.
115.115(c) - Policy P-200, Procedure D, specifies that inmates will not be viewed by non-medical staff of the opposite gender as specified in 115.115d-1 and that staff of the opposite gender are required to announce their presence when entering a housing unit. The showers are single person use and are not covered by cameras. The toilets in the cells have a half wall to provide privacy from the tier and from cameras. Staff of the opposite gender announces their presence before entering housing unit.
115.115(d) - Policy P-350, Procedure E, provides that medical staff will ensure any gender identification is made only as a result of a broader medical examination. The policy assigns responsibility for compliance with the standard to medical staff. The policy needs to specifically prohibit these searches for all staff. The auditor interviewed both deputies on duty and both are aware of the standard.
115.115(e) – Training record reflect that 5 detentions deputies from Ridgecrest received the training in December 2014. Staff received the training at the end of the audit period; thus the standard was not met for the majority of the year. No corrective action required.
CORRECTIVE ACTION: Training records and staff interviews confirm that all staff at the substation has been trained as specified above. NO CORRECTIVE ACTION REQUIRED.

Standard 115.116 -Detainees with disabilities and detainees 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.

115.116(a) – Policy P-400, Procedure B, specifies that the agency shall provide TTY and language interpreters for inmates with hearing impairments and written materials in formats and methods that ensure effective communications. The policy does not include the complete language in the standard relative to qualified interpreter, i.e.: communicate both "... receptively and expressively using any necessary specialized vocabulary." The agency has a Service Agreement with Language Line Services Inc. for foreign and ASL interpreter services and uses PREA comic books with illustrations of jail and prison interactions and scenarios where sexual assault is evident. Also, the education brochure and the PREA dayroom poster are in both English and Spanish, the education video is played in both English and Spanish each with sub-titles in the corresponding language and there is a deputy who is fluent in Spanish.
115.116(b) – Policy P-400, Procedure C, specifies that the agency employs multiple staff certified as fluent in Spanish who are available to translate when needed and that the agency provides interpreter services to Limited English Proficient inmates via a telephone service. PREA materials are printed in Spanish and other languages and explained verbally as needed. The agency has a contract with Language Line for language translation services, the education brochure and the PREA dayroom poster are in both English and Spanish. Also, the education video is played in both English and Spanish each with sub-titles in the corresponding language. There is a deputy who is fluent in Spanish.
115.116(c) - Policy P-400, Procedure B, specifies that the agency shall not use inmates interpreters unless necessary for safety. The policy does not include all of the provisions of the standard, e.g.: "inmate readers or other types of inmate assistance "and the complete language for the exceptions in standards were not included. Two deputies interviewed and both said "Yes" to agency using inmate interpreters/readers, etc. for inmate alleging abuse, but neither knew of any instances in which that occurred. The pre-audit questionnaire indicates there was

no report of sexual abuse at the facility; therefore, there is no data to support this answer. Auditor believes there is confusion about the provisions of the standard and additional training might be needed. The policy should be modified to comply with the standard. The standard does not require written policy, only compliance with the standard; there is no evidence of practice that violates the standard

Standard 115.117 -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.

115.117(a) - Policy P-900, Procedure B, specifies that employee misconduct is documented in various employee personnel files and these files are reviewed when an employee is considered for promotion or assignment that require contact with inmates. The policy further specifies in Directive 1 that the agency shall not contract with anyone who has engaged in, has a civil judgment or administrative adjudication for sexual abuse in a penal institution or who has been convicted for non-consensual sex by force. Policy P-900, Directive1 does not cover all the scenarios in 115.17(a)(2), specifically, the policy does not exclude attempting to engage in sexual activity in the community by force, nor does it specify overt or implied threats of force if the victim did not consent or was unable to consent, or refuse. The agency's new Promotional - Supplemental Application covers these questions, but the policy should include the complete language in the standard to ensure the practice complies with the standard.

115.117(b) - Policy P-900, Procedure A, specifies that KCSO requires all applicants to disclose on their Personal History Statement Application any accusation of discrimination against them, (including, but not limited to, sexual harassment, racial bias, sexual orientation harassment) by a co-worker, superior, subordinate, or customer. The second paragraph of the policy states there are procedures in place that require KCSO to decline or terminate the services of any contractor or volunteer who has been convicted of sexual abuse or sexual harassment, or who has a civil or administrative adjudication against them for sexual abuse or sexual harassment.

115.117(c)(d) - Policy P-900, Procedure A, specifies that the KCSO performs a criminal history records check on all applicants and contacts prior employers for information that could disqualify the applicant from employment. Auditor selected at random and reviewed 12 background files, for deputies, detention deputies, civilian staff, contractors and volunteers. Every file included documentation of background investigation completion.

115.117(e) - Policy P-900, Procedure A, specifies that the KCSO uses DOJ and FBI fingerprint system for the duration of employment to receive notification of any arrest or charges against an employee or contractor. All files reviewed, included documentation of this system being in place.

115.117(f) - The supplemental application for promotions ask the 115.117(a) questions; however, the date on the form reflects that it was created in January 2015; the agency has not established that it complied with the standard over a substantial portion of the audit period. Does not meet standard; no corrective action required.

CORRECTIVE ACTION: On May 26, 2015, the Sheriff's issued a letter that imposes upon all employees a continuing affirmative duty to disclose misconduct listed in 115.17(a). The letter further requires all staff to confirm annually and during the promotional process that they have not engaged in any PREA prohibited behavior. During an audit of another facility in June 2015, the auditor verified that the agency implemented use the supplemental application for hiring and promotions. Policy P-900, Procedure B, should be modified to include the provisions of the standard and the Sheriff's letter. CORRECTIVE ACTION APPROVED.

115.117(g) - The policy is not specific about consequences to current employees for misstatements or omissions about the misconduct listed 115.117(a) in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The standard specifies

that "Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination." The auditor requested from HR, a statement on how the agency deals with material omissions or false information on Supplemental Applications from current employees and HR has not provided a response. The standard does not require written policy, only compliance with the standard; still, the policy should be modified to include the language in the standard to ensure the practice is compliant with the standard.
115.117(h) - Policy P-900, Procedure A, specifies that unless prohibited by law, the KCSO will disclose substantiated cases of sexual abuse or harassment involving present or former employees to prospective employers. During the interview, the Internal Affairs Investigator indicated that if the prospective new employer provides a waiver signed by the former employee, the agency will allow the background investigator to review the former employee's personnel file. Note: The standard does not condition release of this information on the prospective employer providing a waiver from the employee or former employee.

Standard 115.118 -Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

N/A ☐ 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.

115.118(a) – N/A
115.118(B) - N/A, the facility has not installed new video monitoring.

Standard 115.121 -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.

115.121(a) - The agency's protocols for conducting administrative and criminal investigations are found in Policies P-500, P-550 and P-600. Also, both deputies interviewed indicated they were familiar with the agency's protocol for obtaining usable physical evidence.
115.121(b) - Auditor reviewed the DOJ publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescent" and determined that the agency's protocols in Policies P-500, P-550 and P-600 are consistent with the publication. However, each of the 3 policies, list protocols for different disciplines; P-500 is for Security staff, P-550 for Medical and MH and P-600 for Investigators. Under II.4, the publication recommends that "A correctional protocol for an immediate response to sexual assault should include the integrated policies and procedures of all responders."
115.121(c) - Policy P550 specifies that KCSO provides free community level medical and MH services to all sexual abuse victims. Also, the agency provided a copy of its agreement for these services to be provided by Forensic Nurse Specialists of Central California at a community hospital.
115.121(d) - The agency's agreement with Women's Center High Desert includes a long list of services, one of

which is victim advocate.
115.121(e) - The WCHD Agreement requires includes the services listed in 115.121(e). See Page A-2 of WCHD Agreement in "Service Agreements" folder.
115.121(f) - N/A

Standard 115.122 -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.

115.122(a) - Policy P-600, Directive 5, specifies the KCSO's procedures for criminal investigations of sexual abuse allegations. The policy specifies the steps for security staff in these investigations. The Agency Head stated that administrative or criminal investigations are completed for all allegations of sexual abuse/harassment and explained the flow of the process. No reports of sexual abuse at this facility during the audit period.
115.122(b) – N/A, the agency conducts its own investigations.
115.122(c) - N/A

Standard 115.131 -Employee and volunteer 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.

115131(a) – KCSO has a 70-slide PP presentation titled PREA, Ensuring Inmates' Rights. The presentation covers all elements required by the standard except 115.131(a)(6), Mandatory reporting to outside authorities. The agency has not provided sign-in sheets but did provide acknowledgment slips showing that Ridgecrest employees received 115.31 training in November 2013. Two deputies interviewed and both reported receiving the training required under the standard. The training needs to include the requirement of 115.131(a)(6) regarding relevant laws related to mandatory reporting to outside authorities.
THE CORRECTIVE ACTION STATES: "Incident investigators are required to make verbal notification to the PREA coordinator. If it is known the victim is a vulnerable person, Lt. Wright is told. If the victim is vulnerable due to mental illness, the investigator may not know, but CMH will advise in the review if the victim is a vulnerable person due to mental health issues. Incidents are reported in annual reports by SAAIU to the State of California, and the PREA coordinator to the Department of Justice. Staff training discussed the law, the type of people it covers, and that it must be reported to outside agencies. As for what agency to notify and how, they did not get that because they will NEVER use it. They are required to notify their supervisor and Lt. Wright." The auditor is satisfied that the process explained in the corrective action will satisfy the requirement for mandatory reporting to outside authorities. CORRECTIVE ACTION APPROVED.
115131(b) – The agency has not provided training records showing that employees were trained within one year of

the effective date of the standards. No corrective measure required.
CORRECTIVE ACTION: NO CORRECTIVE ACTION REQUIRED.
115131(c) - Training records include 6 acknowledgment-of-understanding slips for 115.31 training in November 2013; the slips do not identify participant work location but the auditor recognized names of Ridgecrest employees from the on-site audit.

Standard 115.132 -Detainee, contractor, and inmate worker notification of the agency's zero-tolerance policy

- ☐ 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.

115.132(a) – The facility provides the Inmate Education Brochure and the PREA Detainee Information sheet to detainees upon arrival. Both documents include the agencies Zero-Tolerance policy. However, only 10 of 1,160 or 0.86% of detainees admitted during the audit period received the required information. The facility needs to implement a process where the policy is provided to all detainees during the intake process.
THE CORRECTIVE ACTION STATES: "Posters throughout the facility and inmate brochures with that information have been provided to inmates since the week of April 13, 2014. Mojave is now showing inmates the PREA video at the time of booking before they are placed into a cell. Monthly logs will be provided." During the audit, the auditor verified that the PREA information posters are on the wall in the Intake area and the substation issues the education brochure to detainees. CORRECTIVE ACTION APPROVED.
115.132(b) - There are no inmate workers in the security area and persons entering have security clearance or are escorted by staff. During the audit, staff explained that contractors are not used at this facility and that any work needed at the facility is done by maintenance employees from one of the other agency facilities who already received the training.

Standard 115.134 -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.

115.134(a) - The agency provided training material on Case Management, Crime Lab, Detentions Investigator Training, Detentions Sex Assault Investigations, Interview and Interrogation, etc. Training records reflect that a Senior Deputy from Ridgecrest attended the 16-hour training on 5/29/14.
115.134(b) - Policy P-300, Directive A-3, specifies that specialized training for investigators will include: interviewing sexual assault victims, proper use of Miranda and Garrity, sexual assault evidence collection in confinement, and criteria and evidence needed to substantiate administrative action or prosecution referral. One SAAIU investigator interviewed and he indicated that he received training on all four topics under the standard

(including Garrity). The Internal Affairs investigator said he did not receive the training required by the standard. The standard requires the training to include proper use of Garrity warning; however, agency policy specifies that SAAIU will investigate all allegations of staff sexual abuse. The agency provided the course outline for SAAIU Investigator training and it does not include Garrity warning. The agency needs to provide documentation of this training for SAAIU investigators. The auditor recognizes that the trained investigator at this facility would not conduct investigations requiring Garrity warning; that would be an agency-level investigation.
115.134(c) - Sing-in sheets reflect that a Senior Deputy from Ridgecrest attended the 16-hour Detentions Sexual Assault School training on 5/29/14.

Standard 115.141 -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.

115.141(a) – N/A, the facility houses detainees overnight.
115.141(b) – Question #6 on the PREA Screen, asks: "Do you feel that you may be at risk of sexual victimization?" Although staff presently screens detainees, the percentage screened over the audit period is relatively low, 216 of 1,160 or 19%. Although the PREA Holding Cell Risk Questions ask the detainee about prior acts of abusive behavior towards inmates, the CJIS PREA page does not include questions that screen for risk of being sexually abusive to other detainees. The facility needs to screen all inmates for risk of being victimized and being sexually abusive towards other detainees.
THE CORRECTIVE ACTION STATES: "Staff is now screening inmates based on the revised CJIS screen which asks inmates about convictions of sexual abuse, physical violence, and domestic violence. Due to the low number inmates held at one time, staff is able to house inmates separately." The substation has a process in place where all inmates are screened, during intake, for risk of victimization and abusiveness. CORRECTIVE ACTION APPROVED.
115.141(c) – Question #6 on the CJIS PREA screen asks about the inmate about his or her concerns of sexual victimization. Although staff presently screen detainees, the percentage screened over the audit period is too low, only 19%.
THE CORRECTIVE ACTION STATES: "Staff have asked inmates about their perception of vulnerability since the CJIS risk screen was activated in July 2014 and shall continue to do so." The substation screens all detainees. NO CORRECTIVE ACTION REQUIRED.
115.141(d) - All five items prescribed in 115.141(d) are included in the screening instrument.

Standard 115.151 -Detainee 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.

115.151(a) - Policy P-450, Directive 4, lists 7 internal and 3 external methods for inmates to report sexual abuse, retaliation, or staff neglect or violation that may have contributed to retaliation. The inmate brochure lists several alternatives for reporting sexual abuse to both internal and outside sources. Two deputies interviewed and both provided a variety of alternatives for inmates to report sexual abuse.
115.151(b) - Policy P-450, Directive 5, lists the process for inmates to report sexual abuse to external entities that are not part of the agency. The inmate brochure lists three ways for inmates to report sexual abuse to outside agencies. Two detainees interviewed and both knew how to report abuse to someone on the outside and are aware of the different ways to report. The PREA Compliance Manager explained the agreement with the local Police Department where inmates can use the hot-line to report sexual abuse; she indicated that there could be problems investigating if the caller remains anonymous.
Remaining anonymous is a legitimate option for inmates reporting abuse. Agency investigators should be able to use information provided by an anonymous caller to develop investigative leads.
115.151(c) - Policy P-450 specifies in the 2nd paragraph that staff shall accept anonymous and third party verbal or written reports of sexual abuse. Both deputies interviewed indicated they accept reports as specified in the standard and would document promptly.
115.151(d) - Policy P-450, Directive 1, specifies that staff shall report staff misconduct via confidential email to their immediate supervisor, the PREA Coordinator, or IA. Both deputies interviewed, one would report to supervisor and the other would report to Women's Center High Desert; neither said they would use confidential email.

Standard 115.154 -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.

115.154(a) - Policy P-450, Directive 6, indicates that the agency's website includes a link for reporting sexual assault. Auditor visited the website and confirmed that the PREA link leads to a page where third party may contact the PREA Coordinator or file reports of sexual abuse or harassment. The agency has a Lobby Poster in English and Spanish with information for the public on how to report sexual abuse in agency facilities. The poster is on the wall in the lobby at the facility. Also, the agency has an agreement with Bakersfield PD where third parties can report sexual abuse in KCSO's facilities to the police and the police would follow notification protocols to KCSO.

Standard 115.161 - 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.

115.161(a) - Policy P-450, Directive 1, requires staff to report any knowledge or suspicion of abuse, harassment or

retaliation on inmates or staff, or staff neglect that may have contributed to the incident. Directive 9 specifies that the agency is required to report abuse that occurred at another facility. Both deputies interviewed are aware of their duty to report sexual abuse under agency policy.

115.161(b) - Policy P-450, Directive 2, prohibits staff from revealing information on abuse to anyone not involved in the response and investigation. The directive does not clearly reflect the standard, i.e.: "staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment and investigation decisions." Although the standard does not require written policy, policies P-450 and P-500 should be modified to include all of the language in the standard. Apart from their supervisor, one deputy would notify classification and the other would enter into CJIS and notify Women's Center High Desert.

115.161(c) - Policy P-450, does not include the requirement of the standard to report allegations of sexual abuse to the designated State or local services agency under applicable mandatory reporting laws if the alleged victim is under 18 or considered a vulnerable adult under a State or local vulnerable persons statute. Policy P-450 should be modified to include this reporting requirement. The Facility Director indicated there would be no difference in response from other classifications and he did not include mandatory reporting to State or local services agency; however, the PREA Coordinator did include mandatory reporting in his response. Also, the agency should provide refresher training to ensure all employees, including supervisors, are aware of their duty to report to the local and State services agency under mandatory reporting laws. Does not meet standard.

THE CORRECTIVE ACTION STATES: "In accordance with mandatory sexual abuse reporting laws, all staff are required to notify their supervisor and/or the PREA coordinator about incidents or reports they receive of sexual abuse involving an inmate that may be considered a vulnerable adult. KCSO SAAIU reports annually to the State of California and the PREA coordinator report all incidents of sexual abuse in annual reports to the Department of Justice." The auditor verified that Policy P-450, Directive 1, requires notification to the PREA Coordinator in accordance with mandatory reporting laws. CORRECTIVE ACTION APPROVED.

115.161(d) - Neither policy P-450 nor P-500 require staff to notify facility investigators of anonymous and third party allegations of sexual abuse as specified in the standard. Both policies should be modified to include this requirement. The Facility Director indicated that allegations of sexual abuse including third-party and anonymous are reported to investigators

Standard 115.162 - 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.

115.162(a) - Policy P-500 does not include provisions relative to this standard; the policy deals with response to actual assaults. Policy P-450 is also silent on Agency Protection Duties. All relevant policies should be modified to include the provisions of this standard. The auditor recognizes that the standard does not require written policy, only compliance with the standard; also, all staff responses to the hypothetical situation were consistent with the requirements of the standard to take immediate action to protect the detainee.

Standard 115.163 - 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.

115.163(a) - Policy P-450, Directive 9, requires the Section Manager, who is also a Facility Manager, to notify the agency where the assault occurred. Policy P-450, Directive 9 does not specify that the notice must be provided to the head of the facility where the incident occurred. This policy should be modified to require notice to the head of the facility where the incident allegedly occurred. The standard does not require a written policy and the practice complied with the standard as it relates to notifying the facility head.
115.163(b) - Policy P-450, Directive 9, specifies the agency's duty to report cases of abuse that occurred at other facilities and list specific staff responsibilities and requires notification within 72 hours.
115.163(c) - Policy P-450, Directive 9 provides that the Section manager shall ensure a CJIS incident is written using code 4050 PREA.
115.163(d) - Policy P-450, specifies that all reports of abuse are taken seriously and Policy P-500, Directive 1 specifies that staff will accept any third party report and outlines specific duties and staff's responsibility to investigate all allegations. The Commander said the allegation would be referred to the SAAIU for investigation; the Facility Director indicated that it would be investigated by SAAIU immediately.

Standard 115.164 –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.

115.164(a) - Policy P-500, Directive A-1, lists specific steps in response a case of sexual assault. The policy includes all four steps required by the standard among other agency-mandated steps. The policy list specific steps for a variety of scenarios. One deputy interviewed and his response included all four steps required under the standard, except Step 2. There is no non-security personnel assigned to the facility.
THE CORRECTIVE ATION STATES: "KCSO shall ensure all staff understands their responsibilities as a first responder. Online training to be created for staff." The Compliance Manager provided test results for on-line "First Responder" training during the month of May 2015; the test results reflect that all Ridgecrest staff scored 100%. CORRECTIVE ACTION APPROVED.
115.164(b) - Policy P-500, Sexual Assault/Abuse Security Response Plan does not include the procedure for non-security first responder. Policy P-500 should be modified to include a procedure for non-security first responder. Neither of the two deputies interviewed included all four steps required under 115.164(a).
Additional training on staff responder duties is needed to ensure security staff is prepared to respond according to the requirements of the standard in the event of an actual case sexual assault.
THE CORRECTIVE ACTION STATES: "None, PREA standard requirement has been met through training provided. Additionally, contracted staff such as teachers or volunteers do not have access to KCSO policies. KCSO taught this responsibility to non-security first responders, specifically - power point slide #50 in the Medical and Mental Health training. Power point slide #32 in the Contractor / Volunteer training.
Training given also taught KCSO requirements on reporting sexual abuse." The Compliance Manager provided test results for on-line "First Responder" training during the month of May 2015; the test results reflect that all

Ridgecrest staff scored 100%. CORRECTIVE ACTION APPROVED.

Standard 115.165 –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.

115.165(a) – Policy P-500, Security Response; P-550, Medical and MH response and Policy P-600, Administrative and Criminal Investigations. Between the three policies, the agency addressed the response for the various disciplines; however, an agency or facility response plan would list the steps for staff of all disciplines in a coordinated manner and allow responders to know what to expect from staff of the other disciplines and see the big picture of the coordinated response. The facility maintains binders with specific produces for lockups derived from agency policy. The Facility Director said the response would be the same as he explained for Q11; he added victim advocate services, MH and forensic exam. The facility should ensure its coordinated response includes mandatory notifications to the designated local or state services agency under mandatory reporting laws.
115.165(b) – There have been no such cases at this facility. Facility Director indicated that in the event the inmate victim is transferred to another confinement facility or medical facility for treatment, the agency would inform the receiving facility of the incident and the victim's potential need for social services. A facility coordinated response plan should include the provision of the standard to not notify the receiving confinement agency of the incident if the detainee so requests. There have been no cases to test the facility's compliance or non-compliance with the standard.

Standard 115.166 - Preservation of ability to protect detainees 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.

115.166(a) - Policy P-200, Directive 2, Collective Bargaining Agreements does not include the provisions of the standard relative to the agency or any other governmental entity responsible for collective bargaining not entering into an agreement that limits the agency's ability to remove an alleged staff abuser from contact with inmates pending outcome of investigation. The Commander indicated that the current agreement has been in place since July 2012 and it does not include any reference to employee assignments.

Standard 115.167 - 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.

115.167(a) - Policy P-450, Directive 7, provides that it is agency policy to protect all inmates and staff who report sexual assault/abuse or sexual harassment or cooperate with sexual assault/abuse or sexual harassment investigations from retaliation by other inmates or staff. The standard requires that the policy designate which staff members of departments are charged with monitoring retaliation. Policy P-450 does not designate which staff members or departments are charged with monitoring retaliation. Policy P-450 should be modified to designate the position and department/section charged with monitoring retaliation. Does not meet standard.
CORRECTIVE ACTION: Policy P-450, Directive 7, has been modified to include the following: "PREA Manager assigned to the compliance section shall monitor the conduct and treatment of;
-Inmates or staff who reported sexual assault/abuse
-Inmates who were reported to have suffered sexual assault/abuse"
CORRECTIVE ACTION APPROVED.
115.167 (b) - Policy P-450, Directive 7, provides that the agency protects inmates and staff who reported abuse from retaliation by: Classification changes, housing or facility transfers, staff reassignment or victim advocates services. The policy also states that use of segregated housing for protection shall be in accordance with Policy K-300 and K--400. During interviews the Commander, the Facility Director and the PREA Compliance Manager (monitors retaliation) all provided responses that are consistent with the requirements of the standard. The Facility Director indicated that he monitor's retaliation as well.
115.167(c) - Policy P-450, Directive 8, specifies that for at least 90 days following a report, the agency monitors the conduct and treatment of victims of abuse as well as inmates and staff who reported sexual abuse and lists six items that are monitored: inmate disciplinary reports, housing changes, program changes, negative performance reviews, staff reassignment, periodic status checks of inmates. The Facility Director stated that he would make housing and classification changes refer to victim advocate services, and re-assign staff if necessary; monitors the conduct and treatment of inmates/staff who reported or were reported to have suffered sexual assault/abuse.
115.167(d) - Policy P-450 does not include a provision for protecting any other individual who cooperated with an investigation and expresses fear of retaliation. Although the standard does not require written policy on protecting other individuals who cooperate with an investigation if they express fear of retaliation, only that the agency take appropriate measures to protect that individual from retaliation, Policy P-450 should be modified to include the requirement to protect other individuals, including witnesses and third party reporters from the community if they express fear of retaliation.

Standard 115.171 - 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.

115.171(a) - Policy P-600, 1st paragraph, specifies that as a law enforcement agency, KCSO shall promptly, thoroughly and objectively investigate all reports of inmate sexual assault or retaliation occurring in its facilities, including third party reports. The policy lists specific requirements for each type of investigation. Both investigators

IA and SAAIU indicated that they start investigations immediately and conduct them thoroughly and objectively.
115.171(b) - Agency Detentions Investigators participated in a 16-hour class on Detentions Sexual Assault School in May 2014. No training records have been provided for SAAIU investigators and the curriculum did not include Garrity warning. Because agency policy specifies that any allegation of staff sexual abuse will be investigated by SAAIU, the requirement for training that includes Garrity warning only applies to SAAIU investigators. During the interview, the SAAIU investigator indicated that his training included Garrity warning.
115.171(c) - Policy P-600, Directive 4, requires investigators to gather and preserve direct and circumstantial evidence including DNA and electronic monitoring and interview victims and witnesses and review prior reports of abuse involving the victim and alleged abuser. During interviews, investigators listed most of the investigative tasks listed in the standard. Although the standard does not require investigators to document their review of prior complaints involving the perpetrator, if it is not documented, the agency would not be able to show compliance. The agency should establish investigative measures to ensure this review for prior complaints and reports involving the perpetrators are conducted as part of the investigative process.
115.171(d) - Policy P-600, Directive 4, says "The agency shall attempt to conduct interviews of any suspected perpetrator(s) in accordance with all laws and statues as to not hinder potential criminal prosecution." The standard says "When the quality of the evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution." The language in Directive 4 implies the agency will attempt to conduct interviews in accordance with the law and not hinder potential criminal prosecution. This suggests the agency will interview perpetrators first and check with prosecutors later. The standard requires the agency to consult with prosecutors before interviewing perpetrators if it appears the case might be good enough for referral to prosecuting authorities. Directive 4 should be modified to be consistent with the language in the standard.
CORRECTIVE ACTION: The policy was revised to state "KCSO will not conduct any compelled interviews until after all criminal proceedings are completed, or the District Attorney has declined to file the complaint." CORRECTIVE ACTION APPROVED.
115.171(e) - Directive 4, includes the entire language of 115.171(e) verbatim and both investigators indicated they evaluate credibility on an individual basis.
115.171(f) - Directive 4, includes the entire language of 115.171(f) verbatim with one exception; the policy adds "or if there were policy violations" at the end of the language in 115.171(f)(1). This additional language does not conflict with provisions of the standard. The Internal Affairs investigator stated that IA Determines whether other staff failed to report misconduct or policies were violated by inaction. He asserted that he documents investigations in written reports including statements from victim, witnesses, subject staff, evidence, video surveillance, etc.
115.171(g) - Directive 4, includes the entire language of 115.171(g) verbatim. The SAAIU Investigator stated that his investigations include a complete and thorough report; he documents evidence, photographs video, etc. suspect, victim and witness statements; injuries to any involved party; disposition. i.e., suspect arrested, no suspect identified, sent to DA
115.171(h) - Directive 4, includes the entire language of the standard. The SAAIU Investigator indicated that they refer cases when there is probable cause to believe a crime was committed.
115.171(i) - Directive 4, states that "The agency shall retain all written reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years." There were no cases old enough to test compliance with this standard.
115.171(j) - Directive 4, includes the entire language of 115.171(j) verbatim and both investigators indicated they would continue the investigation given the scenario presented in the standard.

Standard 115.172 - 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.

115.172(a) - Policy P-600, second paragraph provides that "No standard higher than a preponderance of the evidence shall be used in determining whether allegations of sexual abuse or sexual harassment are substantiated in administrative investigations." The SAAIU stated that he uses a preponderance of the evidence for administrative and probable cause for criminal. The Internal Affairs investigator stated that he uses probable cause to refer a case for criminal prosecution. The PREA Compliance Manager indicated that investigators have not been documenting their determination of whether the allegations are substantiated, unsubstantiated or unfounded. Policy P-600 should be modified to require sexual assault/abuse investigators to document their determination of whether the allegations are substantiated, unsubstantiated or unfounded.

Standard 115.176 - 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.

115.176(a) - Policy P-900, Procedure C, specifies that staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse/harassment policy. There have been no cases of staff discipline since the effective date of the standard.
115.176(b) - Policy P-900 does not include the language in 115.76(b). The agency has not had any employee disciplinary action related to sexual abuse during the audit period. Policy P-900 should be modified to include the language in the standard that specifies termination as the presumptive disciplinary sanction for staff who engaged in sexual abuse.
115.176(c) - Policy P-900, Procedure C, does not include the provision in the standard for employee disciplinary sanctions to be commensurate with "the staff member's disciplinary history and the sanctions imposed for comparable offenses by other staff with similar histories." Policy P-900 should be modified to include the missing provisions of the standard.
115.176(d) - Policy P-900, Procedure C, does not include the provision in the standard to report terminations to law enforcement agencies if the activity is criminal. Policy P-900 should be modified to include the missing provisions of the standard.
The auditor recognizes that the standards in question do not require written policy, only compliance with the standard; however, if the agency has written policy that conflicts with provisions of the standards, the agencies practices are likely to conflict with provisions of the standard as well.

Standard 115.177 - 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.

115.177(a) - Pol P-900, Procedure E, specifies that KCSO shall terminate the services of any contractor or volunteer for any substantiated allegation of sexual abuse on an inmate. The two bullet statements that follow, state:
-Any contractor or volunteer who engages in sexual abuse of an inmate shall be prohibited from contact with inmates and shall be reported to law enforcement agencies. Such conduct shall be reported to relevant licensing bodies.
-In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the facility shall take appropriate remedial measures, and shall consider whether to prohibit all further contact by the contractor or volunteer with inmates.
Policy P-900, Procedure E, should be modified to eliminate the conflicting language with regard to terminating versus prohibiting contact with inmates.
115.177(b) - The agency's policy is in the second bullet above. The Facility Director stated that contractors are not used for lockups, but they would be prohibited from contact with inmates and will be reported to licensing bodies and/or referred for prosecution. With respect to remedial measures, he said: termination of the contract or terminate the volunteer service.

Standard 115.178 - Referrals for prosecution for detainee-on-detainee 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.

115.178(a) - Policy P-100 4th paragraph, specifies that inmate-on-inmate sexual abuse or retaliation for reporting or cooperating with an investigation will be investigated and referred for prosecution when appropriate. The Facility Director stated that Investigation is launched per policy and findings sent for review for prosecution; victim is removed from the threat area and policy is followed to safeguard the victim's health and potential for retaliation.

Standard 115.182 - Access to emergency medical 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.

115.182(a) – The Facility Director stated that detainees receive timely unimpeded access to emergency medical care and that medical aid is provided/summoned as soon as injuries are discovered requiring medical aid to respond. First aid is administered to the staff member's ability and training.

115.182(b) - Policy P-550; 2nd paragraph states "KCSO shall provide free community level medical and mental health services to all sexual abuse victims with or without cooperation in any subsequent investigation." The policy does not include language in 115.182(b), specifically "whether the victim names the abuser" The policy should be modified to include the missing language.

Standard 115.186 –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.

115.186(a) - Pol P-700, Procedure A states "The facility shall conduct an incident review at the conclusion of every sexual abuse investigation, including allegations not substantiated, unless the allegation has been determined to be unfounded." The agency provided their two-page Incident Review Form. The agency has not yet conducted an Incident Review and there have not been any incidents at this facility.
115.186(b) - The facility has not had any incidents of sexual abuse during the audit period.
115.186(c) - Pol P-700, Procedure A states "The review team shall include the PREA coordinator, section manager, with input from line supervisors, investigators, and medical or mental health practitioners." The Facility Director stated that the facility has an Incident Review Team that consists of upper level management officials with input from investigators and supervisors.
115.186(d) - The auditor interviewed the Facility Director and the PREA Coordinator; the PREA Coordinator also answered questions as a representative of the Incident Review Team.
The Facility Director, when asked "How does the team use the information from the sexual abuse incident review? He stated that the team uses the information to identify inadequacies in policy/staffing levels, review monitoring capabilities and the physical layout for barriers that can be remedied and recommend the need for change to the PREA Compliance Manager and the Section Manager. He also stated the team would:
(a) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the lockup;
(b) Examine the area in the lockup where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(c) Assess the adequacy of staffing levels in that area during different shifts;
(d) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff
The PREA Coordinator, when asked whether the facility would prepare a report of its findings from the sexual abuse incident reviews, including any determinations per 115.186(d) 1 – 5, and any recommendations for improvement, he indicated the facility would and that the reports would be forwarded to him for review. He said he would use the information to identify processes, policies, structural or video monitoring changes, the team also considers whether staffing changes are needed and the extent to which those changes need to be considered to prevent further cases,
With respect to the Incident Review Team, the PREA Coordinator indicated the team would:
-Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility
-Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse
-Assess the adequacy of staffing levels in that area during different shifts

-Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff
115.186(e) – The facility has not had any incidents since the effective date of the PREA Standards; however, management installed cameras and made other changes in response to the 2011 incident that involved staff misconduct.

Standard 115.187 - 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.

115.187(a) & (c) - Policy P-700, Procedure B, requires the KCSO Compliance Section to "Collect accurate, uniform data for every allegation of sexual assault/abuse at all KCSO custody facilities using a standardized instrument and set of definitions." The agency provided the USDOJ Survey of Sexual Victimization Incident Form and Training Bulletin dated 12/3/14 with information on the agency's new PREA Reporting Form. The also agency provided the Annual Report for this facility.
115.187(b) - Pol P700, Procedure B, states that the agency aggregates the data at least annually. The annual report includes data from prior and current year 2013 and 2014.
115.187(d) - Procedure B, states that the Compliance Section shall: "Maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual assault/abuse incident reviews." The data maintained and reviewed by the agency is not collected from all incident-based sources required by the standard; specifically there is not incident review data. The agency should conduct incident reviews and aggregate this data at least annually. Does not meet standard.
THE CORRECTIVE ACTION STATES: "None, [Ridgecrest] jail did not have any incident reports, or investigation files from which to conduct incident reviews during the audit period 2014 or the prior 2013 period.
The PREA incident review team will conduct reviews of any future sexual abuse incidents." The auditor verified that the agency implemented it incident review process in March 2015. CORRECTIVE ACTION APPROVED.
115.187(e) - N/A The agency does not contract with private facilities for beds.
115.187(f) - N/A The USDOJ has not requested any data from the agency.

Standard 115.188 - 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.

115.188(a) - The agency is just getting started with its data collection and review program. The PREA Coordinator indicated that his office recently began working with IT on a process to manage data access. Without incident review data, the data collected and aggregated is not complete according to the standard. The data was not collected and aggregated pursuant to the requirements of 115.187; specifically, the data does not include Incident

Review data. Does not meet standard.
THE CORRECTIVE ACTION STATES: "The PREA compliance team and facility manager have evaluated the overall implementation methods to keep inmates safe which were not available in 2013. There were no incident reports in 2013 or 2014 to compare. A facility report has been drafted to publish to the public website in compliance with PREA standards." The auditor verified that the substation's annual report and the agency-wide annual report are published on the agency's website. CORRECTIVE ACTION APPROVED.
115.188(b) - The annual report includes prior and current year data; however, the required comparison between current year data and corrective actions, and those from prior years should be addressed even if there is no data or corrective action to compare. The report should also include an assessment of the agency's progress in addressing sexual abuse. The auditor recognizes that there were no incidents at this facility in 2014; however, the annual report should address all issues required by the standards. This would ensure the document starts with a compliant format and continues to address all issues required by the standard going forward. Does not meet standard.
THE CORRECTIVE ACTION STATES: "The PREA compliance team in conjunction with the facility manager have prepared and published the first annual report for the Ridgecrest jail. The report examines its purpose for the public and articulates methods implemented to keep inmates safe that were not available in 2013. There were no incidents to compare in 2013 and 2014." The agency's website has a revised annual report dated May 18, 2015; the report points out that there has been no incidents in the past two years and that there are no changes required. CORRECTIVE ACTION APPROVED.
115.188(c) - The last page of the annual review includes name and signature for the Commander, the PREA Coordinator and the Facility Director and the full report is available on the agency's website.
115.188(d) - The agency recently issued its first annual report for this facility and there is no data to be redacted.

Standard 115.189 - 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.

115.189(a) - Pol P-700, Directive B-3, states that the Compliance Section shall "Ensure that data collected is securely retained." Access is limited to PREA Coordinator, PREA Compliance Manager, and classification deputies. All releases of this data require approval by the PREA Coordinator.
115.189(b) - Pol P-700, Directive B-3, states that the Compliance Section shall "Remove all personal identifiers prior to making all facility aggregated sexual abuse data available to the public annually on its website." http://www.kernsheriff.com. The agency recently posted the facility's first annual report to the website; therefore, the agency/facility was not in compliance with the standard during the audit period. The agency should make sure there is a current annual report with aggregated data and that it is available to the public on the agency's website. Even if there is no data, the agency should have the report available to the public reflecting that there is no data because there were no incidents. Does not meet standard.
THE CORRECTIVE ACTION STATES: "The PREA compliance team in conjunction with the facility manager have prepared and published the first annual report for the Ridgecrest jail. The report examines its purpose for the public and articulates methods implemented to keep inmates safe that were not available in 2013. There were no incidents to compare in 2013 and 2014." The agency's website has a revised annual report dated May 18, 2015. CORRECTIVE ACTION APPROVED.
115.189(c) - Directive B-3 requires removal of all personal identifiers prior to making data available to the public. The current annual report does not include any personal identifiers.

115.189(d) - Directive B-3 3rd bullet, includes the language in the standard.

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.

A.F. Caton

ALBERTO F CATON
Certified PREA Auditor
Adult Facilities

August 10, 2015
Date