PREA AUDIT REPORT ☐ **INTERIM** ■ **FINAL**

ADULT PRISONS & JAILS

NATIONAL PREA RESOURCE CENTER

[redacted]

Auditor Information			
Auditor name: Alberto F Caton			
Address: P. O. Box 582105, Elk Grove, CA 95758			
Email: albertocaton@comcast.net			
Telephone number: 916 714-9570			
Date of facility visit: February 3, 2015			
Facility Information			
Facility name: Maximum-Medium Facility			
Facility physical address: 17645 Industrial Farm Road, Bakersfield, CA 93308			
Facility mailing address: *(if different from above)*			
Facility telephone number: (661) 391-7857			
The facility is:	☐ Federal	☐ State	■ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Prison	■ Jail	
Name of facility's Chief Executive Officer: Lieutenant Thomas Bittle			
Number of staff assigned to the facility in the last 12 months: 61			
Designed facility capacity: 414			
Current population of facility: 373			
Facility security levels/inmate custody levels: K-300, Pro C			
Age range of the population: 18-70			
Name of PREA Compliance Manager: Rhonda Turnbaugh		**Title:**	Sergeant
Email address: turnbaugh@kernsheriff.org		**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 Truxtun Avenue, 5th Floor, Bakersfield, CA 93301			
Mailing address: *(if different from above)*			
Telephone number: (661) 868-3588			
Agency Chief Executive Officer			
Name: Donny Youngblood		**Title:**	Sheriff/Coroner
Email address: sheriff@kenrsheriff.com		**Telephone number:**	(661) 391-7500
Agency-Wide PREA Coordinator			
Name: Kevin Wright		**Title:**	Lieutenant
Email address: wright@kernsheriff.org		**Telephone number:**	661 391-7853

AUDITFINDINGS

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 Kern County Sheriff's Office (KCSO). Director Stone provided information about three cases, one each at the Minimum Facility, Max-Medium and Pre-Trial. 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 PHASE

On February 3, 2015, after departing CRF, the auditor arrived at Agency Headquarters located at 1350 Norris Rd, Bakersfield, CA. The auditor interviewed Human Resources staff and reviewed employee-background-investigation files for clearances and evidence of finger prints remaining on file with the Department of Justice for automatic notification of employee arrest/criminal charges. The auditor proceeded to the agency's Lerdo Complex, site of three of KCSO's jails; there the auditor interviewed Agency Head Designee, Commander Tim Melanson of the Lerdo Facilities Division. Following that interview, the auditor proceeded to Max-Medium Facility for the on-site audit. After introductions, a brief orientation with the PREA Compliance Manager and the watch sergeant, staff took the auditor on a tour of the receiving and booking area where the auditor asked questions about video surveillance and the screening process. The auditor returned to the Intake desk where staff provided inmate rosters and the auditor randomly selected ten inmates for interviews; one inmate was selected from each of the facility's eight dormitories and one from each of the two cell blocks. Facility staff did not identify any lesbian, bisexual, transgender or intersex inmates, nor did staff identify any inmates with disabilities, inmates who alleged sexual abuse or inmates placed in segregated housing due to risk of sexual victimization. The auditor interviewed one inmate staff identified as gay (who did not acknowledge that sexual orientation) and one limited English proficient Spanish-speaking inmate; the auditor is fluent in Spanish and conducted the interview accordingly. The tour continued with entry into the security area where the auditor toured two cell blocks identified as M-1/S-1 and M-2/S-2 and asked impromptu questions of assigned deputies and inmates; the auditor also reviewed unit log books and noted supervisor tour entries. Staff took the auditor to the exercise yard, segregated housing and clinic cells, the infirmary, Medical and Mental Health offices, the inmate education classroom, and the video conference room. The tour continued with the eight dormitories, the workers dorm and attorney visiting rooms. The tour concluded with entry into the facility's Control Room, known as "Duty Office." This office is staffed by a sheriff's aid who controls access gates and monitors numerous video surveillance screens. Following the facility tour, the auditor conducted interviews of the ten inmates selected and departed the facility. On February 4, 2015, the auditor arrived at Max-Medium early enough to interview a few night shift deputies before the end of their shift and continued random staff interviews; a total of ten deputies were interviewed, all from different housing units and from both day and night shifts. The auditor continued with interviews of specialized staff, including a Supervising Deputy, Director of Mental Health, a contract employee, staff who screen inmates for risk of victimization and abusiveness, a classification deputy on supervising inmates in segregated housing, a deputy who would act as first responder and Intake staff. Staff interviews continued with the PREA Compliance Manager, (who also monitors for retaliation), the Facility Manager and the PREA Coordinator. The auditor departed the facility and returned to Agency Headquarters. At Headquarters, the auditor obtained additional information from Human Resources staff, interviewed investigators from Internal Affairs and the Sexual Assault and Abuse Investigation Unit and departed for the day.

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. During the completion of the audit tool, the auditor noted that

DESCRIPTION OF FACILITY CHARACTERISTICS

Kern County Sheriff's Max-Medium Facility opened in 1978 with a rated bed capacity of 408. Max-Medium is a single story square-shaped building with a relatively wide-open design. The administrative offices, inmate visiting, and facility control room are located at the front of the building. The facility is arranged with mostly inmate housing, visiting and other utility spaces forming a perimeter around small free-standing clusters of rooms in the center of the security area. These clusters of rooms provide space for offices, the laundry, supply rooms, medical clinic, infirmary, eight security cells, a multi-purpose room, the inmate classroom, the maintenance shop, and other utility areas. There is a drive-in receiving sallyport where transport vehicles deliver inmates to the booking area which has two holding cells for processing new arrivals.

The facility is managed by a detentions Lieutenant and staffed with10 custody supervisors, 63 detentions deputies and 7 civilian support staff. There are 1-2 medical staff on site at all times, and mental health staff respond from the adjacent Pre-Trial Jail to provide all necessary treatment. A sheriff's aid is assigned to the facility's control room and controls the ingress and egress to the facility, issues duty keys to staff, stores duty weapons, interacts with the public, maintains the facility count, manages the visiting program, and also monitors staff's activities and safety on several surveillance camera monitors. The Sheriff's Aide can view staff from different camera views throughout the facility.

The facility has two dormitory blocks along the right side of the building, each block has four open dorms arranged in a square pattern; each dorm has 11 triple bunks. Two deputies staff two central duty stations in the middle where the four dorms converge; each deputy provides security for two dorms. The deputies have direct visual into the dorms through large 4'x3' windows and can also observe inmate activities through smaller windows that run the length of the unit. There is an inmate worker dormitory with four triple bunks in the back of the building. Max Medium also has two cell-blocks arranged as parallel linear tiers on the left side of the building. Each cell-block has several four and eight-man

SUMMARY OF AUDIT FINDINGS

On February 3, 2015, a Prison Rape Elimination Act (PREA) audit of the Kern County Sheriff's Maximum Medium Facility found that the facility is generally not in compliance with the PREA standards. Of 43 standards in the Adult Prisons and Jails audit tool, the facility exceeded 1 standard, met 22 standards, did not meet 17 standards and 3 did not apply. The facility met or exceeded the standard for 57.5% of the 40 standards that applied. Below is a summary of standards the facility exceeded, standards met, standards not met and standards that did not apply.

******Standards Exceeded******

SCREENING FOR RISK OF VICTIMIZATION AND ABUSIVENESS
115.42 - Use of Screening Information

*****Standards Met*****

PREVENTION PLANNING
115.11 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
115.16 - Inmates with disabilities and inmates who are limited English proficient

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

TRAINING AND EDUCATION
115.32 - Volunteer and contractor training
115.34 - Specialized training: Investigations
115.35 - Specialized training: Medical and mental health care

SCREENING FOR RISK OF VICTIMIZATION AND ABUSIVENESS
115.43 - Protective custody

REPORTING
115.51 - Inmate reporting
115.53 - Inmate access to outside confidential support services
115.54 - Third-party reporting

OFFICIAL RESPONSE FOLLOWING AN INMATE REPORT
115.62 - Agency protection against retaliation

Number of standards exceeded: 1

Number of standards met: 38

0

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

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

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

115.11(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.
115.11(b) - It also 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 as well as sanctions for those found to have violated the policy.
115.11(c) - The Agency's Organizational Chart shows: PREA Coordinator is part of the Detentions Bureau, under the Lerdo Facilities Division and heads the Compliance Section. The PREA Coordinator is a Lieutenant and he has other responsibilities besides PREA; he meets PREA responsibilities only with help from the PREA Compliance Manager. The PREA Coordinator would be better positioned under the Detentions Bureau above all divisions with detention facilities. The agency designated a Sergeant to serve as PREA Compliance Manager on a full-time basis for all of its six facilities. Each facility designated a senior deputy who coordinates PREA compliance matters at their respective facilities under direction from the compliance manager.

Standard 115.12 Contracting with other entities for the confinement of inmates

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

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

Not applicable. The agency does not contract for confinement beds with other agencies.

Standard 115.13 Supervision and monitoring

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

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

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 FM about the requirements of the standards. The agency provided a six-page staffing plan for Max Med The plan was developed to ensure adequate staff to provide a safe environment for inmates and staff and to protect against sexual abuse. The plan reflects staffing under three operational scenarios, normal, limited and restricted.

The facility has a staffing plan that provides for adequate levels of staffing under Normal Operations. There is video monitoring by the Sheriff's Aide (SA) in the Control Room, but no recording. There are eight medium custody dormitories along the right side of the facility (see Max-Med Floor Layout). Four detentions deputies are assigned to these dormitories, each covers two dorms under normal operations. However, under Limited or Restricted operations, the coverage could be reduced to one deputy for four dorms. Under this scenario, that deputy could be out of view of both the camera and other staff if he steps behind the podium towards either pipe chase. The deputy would be in a blind spot if he steps into one these two recessed areas. Installing cameras that cover these four deputy stations would mitigate the blind spot. Also, the SA in Control is, at times, extremely busy performing other duties, and thus distracted from adequate monitoring of the cameras.
115.13(a) - Both the staffing plan and the interview with the Facility Manager, confirm that all 11 items listed in 115.13(a) were considered. The FM indicated that each squad maintains a daily staff roster which he is able to review with supervisors if there are inadequacies and that they would document and notify him of any inadequacies. The FM did not provide any documentation to confirm this practice. Both the aforementioned blind spots under Limited and Restricted Operations and the SA camera monitoring raises safety concerns for both the

Standard 115.14 Youthful inmates

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

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

N/A, The agency does not house youthful inmates.

Standard 115.15 Limits to cross-gender viewing and searches

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

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

115.15(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 facility does not allow cross-gender strip or body cavity searches. The facility does not house female inmates and only male staff conduct strip searches.
115.15(b) - N/A No female inmates at the facility.
115.15(c) - 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 as the inmate being searched and Directive C-1 forbids c-g pat-down searches, except under exigent circumstances. The agency does not allow cross-gender strip or body cavity searches and the facility does not house female inmates.
115.15(d) - Policy P-200, Procedure D, specifies that inmates will not be viewed by non-medical staff of the opposite gender as specified in 115.15d-1 and that staff of the opposite gender are required to announce their presence when entering a housing unit. The policy also addresses requirements of the standard as it relates to documenting notifications in log books and blocking toilet areas visible in security monitors. Ten deputies and 10 inmates interviewed, all reported that inmates are able to shower and toilet without being viewed by non-medical staff of the opposite gender.
115.15(e) - With respect to searching or physically examining transgender or intersex inmates to determine genital status, the policy assigns responsibility for compliance with the standard to medical staff. The policy needs to specifically prohibit these searches for all staff. One of ten deputies interviewed was unaware of this policy.
115.15(f)- 115.15(f) - The facility trained 91% of its employees during the last month of the audit period; therefore, the facility was non-compliant the majority of the audit period. Does not meet standard.

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

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

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

115.16(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 agency provided a copy of its service agreement with Language Line for American Sign Language interpreter services. The agency also uses PREA comic books with illustrations of jail and prison interactions and scenarios where sexual assault is evident. The policy does not include the complete language in 115.16(a) relative to qualified interpreter, i.e.: communicate both "... receptively and expressively using any necessary specialized vocabulary." The Agency Head designee, stated that the agency posted sings in English & Spanish telling inmates how to report abuse and contact counselors using the free hot-line. He also stated that the agency contracted with Language Line for professional interpreter services and that several staff receive bilingual pay and are available to translate for inmates with limited English proficiency. He added that the PREA education video with subtitles will soon be played daily in housing units for inmates who are blind, deaf and hard-of-hearing.
115.16(b) - Policy P-400, Procedure C, specifies that the agency employs multiple staff certified as fluent in Spanish who are available ... Also, that the agency provides interpreter services to LEP inmates via a telephone service. PREA materials are printed in Spanish and other languages and verbally as needed. During random interviews, one inmate requested to be interviewed in Spanish; the auditor is fluent in Spanish and conducted the interview accordingly. The inmate acknowledged receiving PREA information in Spanish said one of the deputies in Intake interviewed him in Spanish and provided the information. He added that the PREA video is played in Spanish in his housing unit.
115.16(c) - The policy does it include the complete language in 115.16(c) relative to "inmate readers or other types of inmate assistance"

Standard 115.17 Hiring and promotion decisions

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

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

115.17(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.
THE CORRECTIVE ACTION STATES THAT Policy P-900, Directive 1, was modified to state: "KCSO shall not hire, promote, or contract with anyone who has engaged, or attempted to engage in sexual abuse in a penal institution or who has been convicted of engaging in non-consensual sexual activity accomplished by force, threats, or other forms of coercion." CORRECTIVE ACTION APPROVED.
115.17(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 that procedures are 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.
115.17(c)(d) - Policy P-900, Procedure A, specifies that the KCSO performs a criminal history records check on all applicants and contacts

Standard 115.18 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.

N/A The facility has not acquired any new structures or made any expansions or installed new video monitoring.

Standard 115.21 Evidence protocol and forensic medical examinations

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

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

115.21(a) - The agency's protocols for conducting administrative and criminal investigations are found in Policies P-500, P-550 and P-600, Also, 8 of 10 deputies interviewed indicated they were familiar with the agency's protocol for obtaining usable physical evidence.
115.21(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."
115.21(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.
115.21(d) - The agency's agreement with Women's Center High Desert includes a long list of services, one of which is victim advocate.
115.21(e) - The WCHD Agreement requires includes the services listed in 115.21(e). See Pg A-2 of WCHD Agreement in "Service Agreements" folder.
115.21(f) - N/A
115.21(g) - N/A
115.21(H) - N/A

Standard 115.22 Policies to ensure referrals of allegations for investigations

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

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

Standard 115.31 Employee training

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

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

115.31(a) - The agency provided a 70-slide Power Point presentation titled Ensuring Inmate's Rights; the training curriculum did not cover mandatory reporting to outside authorities per 115.31(a)(10). Ten deputies interviewed and all acknowledged being trained on all 10 topics listed in 115.31(a). The Pre-Audit Questionnaire reports that 10 of 61 or 16.4% of employees received the 115.31(a) training. Training records include training acknowledgment slips for 5 employees who received training per 115.31 in Jan-Jun '14; no sign-in sheets provided. Auditor is unable to verify that all employees who have contact with inmates received the Ensuring Inmate's Rights PP training. The agency should ensure all employees who may have contact with inmates are trained on all ten elements required by the standard. Does not meet standard.
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. Either way as soon as the information is known, it will be the PREA compliance team that makes the actual report on KCSO's behalf.
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 agency has a process in place where mandatory reporting to outside agencies will be done by the PREA Coordinator. CORRECTIVE ACTION APPROVED.
115.31(b) - Employees are trained to work at any facility with all inmates. Training records reviewed show that 52 of 57 employees were trained in December 2014 and January 2015 on Training Bulletin 14-51, Cross-Gender Pat Searches; the facility has not established that

Standard 115.32 Volunteer and contractor training

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

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

115.32(a) - One contract employee interviewed; she stated she received the training and it included the zero-tolerance policy, how to interact with inmates, how to look for signs of trauma, any verbal comments they might make, how they react to situations, "things they might tell us;" the duty to report; she indicated that in her capacity, she is a mandatory reporter. Training records include 9 sign-in sheets for contractor and volunteer training; also, the curriculum covers the requirements of 115.32(a). Each sign-in sheet has the acknowledgment of understanding clause.
115.32(b) - The training outline includes information about vulnerable inmates, fraternization, the effects of sexual abuse, consequences to abusers, etc. One contract employee interviewed, she indicated that the training included how to interact with inmates, how to look for signs of trauma, any verbal comments they might make, how they react to situations, "things they might tell us;" the duty to report.
115.32(c) - The sign-in sheets for volunteer/contractor training includes the acknowledgment of understanding above the signatures field.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.33(a) - The facility admitted 3,023 inmates over the previous 12 months, but staff could not specify how many received the zero-tolerance policy and information on how to report sexual abuse; the Holding Cell Risk screening does not establish compliance because it was created in Dec 2014. The facility needs to establish a methodology to track how many inmates it provides this information to. The facility provided extensive records of inmate sign-in sheets and participation acknowledgment and understating forms. Does not meet standard.
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. The holding cell risk screening was established in 2013. Email documentation will be provided." Th auditor verified that the informational posters are on the wall in the Intake area and that inmates receive the brochure upon intake. CORRECTIVE ACTION APPROVED.
115.33(b) - The facility reports that 1280 or 42% of inmates received over the past 12 months received the education. Inmate sign-in sheets reflect that the training was provided in October and November 2014. The facility has not demonstrated that it provided the training over a substantial portion of the audit period; also, 42% of inmates trained does not approach the level needed to meet the standard.
THE CORRECTIVE ACTION STATES: "Max inmates will receive comprehensive education within 30 days. However, to provide greater benefit to inmates, Max's goal is to exceed the PREA standard by providing the comprehensive education to within the first or second day after their arrival. In order to accomplish this, the PREA education video is played daily. PREA education has been added to the CJIS education tracking system. Max staff will maintain the computer documentation is made within 30 days of the inmate's arrival." The auditor verified that the education video is played daily in all housing units and inmates receive the information brochure. CORRECTIVE

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.34(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 Detentions Sgt and six Detentions Deputies from Max-Med were trained on Sexual Assault Investigations.
115.34(b) - Policy P-300, Directive A-3, specifies that specialized training for investigators will include: interviewing sexual assault victims 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 conduct sexual assault investigations on staff members. 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.
115.34(c) - Sing-in sheets dated 5/1/14 and 5/29/14 shows a total of 29 employees trained on Detentions Sexual Assault School a 16-hour class.

Standard 115.35 Specialized training: Medical and mental health care

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

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

115.35(a) - Policy P-300, Directive A-4, provides that KCSO will train all Medical and Mental Health staff who work regularly at its facilities on: Detecting sexual assault, preserving physical evidence, responding to victims and how and to whom to report suspicions and allegations of sexual assault. The agency provided a sign-in sheet reflecting that Mental Health staff participated in a two-part PREA Training class, in May and June '14, and several signed training acknowledgment forms reflecting May '14 training on PREA 115.35. Interviewed Medical and MH together and both confirmed that they received training on all 4 topics listed under the standard. Training acknowledgment slips reflect 115.35 PREA training; the lesson plan and PP includes all the required topics in 115.35(a).
115.35(b) - N/A, Medical staff at the facility do not conduct forensic exams.
115.35(c) - The lesson plan and Power Point presentation include the required topics, sign-in sheets and participation and understanding acknowledgment slips reflect that staff received the training last May and June 2014.
115.35(d) - There is a Lesson Plan and PP for Medical and MH titled Ensuring Inmate Health and Safety. There are also several trainee acknowledgment slips for training on 115.32 during May and June 2014.

Standard 115.41 Screening for risk of victimization and abusiveness

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

Auditor discussion, including the evidence relied upon in
determination, the auditor's analysis and reasoning, and
must also include corrective action recommendations wh
recommendations must be included in the Final Report, a
corrective actions taken by the facility.

115.41(a) - The auditor recognizes that the facility currently screens inmates during the intake process; however, the facility has not demonstrated that this practice has been in place a substantial portion of the audit period. In fact, the cases provided as sample are all very recent bookings (mostly Jan '15 and Dec '14). The facility should ensure there are measures in place where it can demonstrate that these screenings are taking place for a substantial amount of new arrivals over the audit period.
THE CORRECTIVE ACTION STATES: "KCSO instituted its full risk screening process for all new arriving inmates to its facilities on July 12, 2014. Max has been consistently and successfully screening its new arriving inmates for almost one year." Policy P-200, Directive B-1 states "Upon intake and upon transfer to another facility, classification staff shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: ...." The policy then goes-on to list the ten items prescribed by the standard. The facility has a process in place where all inmates are screened, during intake, for risk of victimization and abusiveness. CORRECTIVE ACTION APPROVED.
115.41(b) - The facility received some 3,023 inmates during the 12-month audit period and the Pre-Audit Questionnaire reports that zero were screened. The facility should ensure there are measures in place where it can demonstrate that these screenings are taking place for a substantial amount of new arrivals over the audit period and that these screenings are taking place within 72 hours of arrival.
THE CORRECTIVE ACTION STATES: "KCSO instituted its full risk screening process for all new arriving inmates to its facilities on July 12, 2014. Max has been consistently and successfully screening its new arriving inmates for almost one year. A sample of CJIS new bookings shows that the screening is conducted within 72 hrs. in order to make appropriate housing assignments." The auditor verified that the facility has a process in place where all inmates are screened for risk of victimization and abusiveness during the Intake process

Standard 115.42 Use of screening information

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

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

115.42(a) - Policies P-350 and K-300 include provisions regarding the use of risk screening information by classification staff for housing and other program decisions. During the interview, classification staff provided a brief explanation of how they use screening information to inform housing decisions. After entering information, the computerized system assigns housing type based upon case factors. The PREA Compliance Manager explained that answers to PREA questions and the holding cell risk questionnaire are considered, the Screening deputy explained that victims and predators are listed on an Excel spreadsheet to ensure they are not housed together.
115.42(b) - Policy K-100, Page 2, specifies that classification assessments and housing decisions will be made based on information obtained from the inmate or his record. The agency maintains individualized classification information for each inmate in its CJIS system and uses that information to make determinations about that inmate's safety.
115.42(c) - PREA Compliance Manager explained that transgender inmates are assessed by classification based on all current and past booking information and security status to determine the best housing location. There were no transgender or intersex inmates identified for interview.
115.42(d) - Classification conducts 30-day reviews of all inmates, this provides opportunities to review transgender/intersex inmate safety concerns much more frequently than the standard requires.
115.42(e) - Policy P-410, Procedure A, specifies that the Gender Identity Committee will give serious consideration to the inmate's views with regard to his or her own safety. Both PREA Compliance Manager and Screening staff indicated that a transgender inmate's views about safety are given serious consideration; there was no transgender/intersex i/m identified for interview The agency's handling of the transgender inmate case mentioned in 115.41(g) provides some evidence that the agency complies with the standard

Standard 115.43 Protective custody

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

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

115.43(a) - Policy K-400, Procedure B, requires a classification assessment within 24 hours and a review within 30 days documenting concerns for the inmate's safety and articulating why there are no alternative means of housing. The Facility Manager indicated that the agency has a policy prohibiting placing inmates at high risk of sexual victimization in involuntary in segregated housing without first conducting an assessment of all available alternatives. The agency provided a CJIS printout with the facility's handling of a case where the inmate alleged that he was touched inappropriately by inmates in his dormitory. The last page reflects classification staff's deliberations on housing alternatives.
The standard requires an assessment of all available housing before placing an inmate in involuntary segregated housing as protection from victimization; however, if staff are unable to conduct the assessment of housing alternatives immediately, the standard allows placing the inmate in segregated housing for less than 24 hours until the assessment is done. None of the cases provided to the auditor appeared to be involuntary placement in segregated housing; therefore, there is no case the auditor could use to test the agency's compliance with the requirements of 115.43. The auditor, however, believes documentation could improve to make it clear whether or not placement in segregated housing is involuntary. Also, the agency should ensure there is a process in place where individual inmate records can be presented to show compliance with the provisions of 115.43 as it relates to involuntary placement in segregated housing.
115.43(b) - Policy P-410, Dir 1, provides that transgender/intersex inmates will have access to programs, privileges, education or work even while in segregated housing unless safety and security is at stake. If programming is denied, KCSO will document the opportunities that have been limited, the duration and the reasons for the limitations. During the interview, classification staff indicated that inmates in segregated housing have access to programs and privileges, but not work because there is no work program at the facility. Classification

Standard 115.51 Inmate reporting

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

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

115.51(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 lead to retaliation. The inmate brochure lists several alternatives for reporting sexual abuse to both internal and outside sources. Ten deputies interviewed and all provided a variety of alternatives for inmates to report sexual abuse. Ten inmates interviewed, all knew how to report sexual abuse.
115.51(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. 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. Ten inmates interviewed and all knew how to report to outside individuals; all but 2 know they do not have to give their names
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.
115.51(c) - Policy P-450 specifies in the 2nd paragraph that staff shall accept anonymous and third party verbal or written reports of sexual abuse. All ten deputies interviewed indicated they accept reports as specified in the standard and would document promptly. Ten inmates interviewed, 2 were not aware of their right to report sexual abuse in person or in writing; one did not know about having someone else report without giving his or her name.
115.51(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. Ten deputies interviewed, none of them said they would use confidential email; 1 did not know. The agency

Standard 115.52 Exhaustion of administrative remedies

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

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

Standard 115.53 Inmate access to outside confidential support services

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

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

115.53(a) - Policy P-550, Procedure D, specifies that the agency provides addresses for outside victim advocates and a counseling line. The agency also provides access to county immigrant services. The Inmate Education Brochure has both the hot-line number and mailing addresses for Just Detention International and WCHD. Ten inmates interviewed and they had varying levels of knowledge about access to victim services and support.
115.53(b) - Policy P-550, Procedure D, specifies that the agency informs inmates prior to giving them access, of the extent of monitoring and the extent to which reports to will be forwarded to authorities per mandatory reporting laws. The policy includes the language in the standard verbatim. There have been no cases during the audit period where an inmate was given access to confidential support services.
115.53(c) - Personal/Professional Services Agreement between KCSO and Women's Center High Desert effective 12/1/14. The agreement requires among other services, on-site one-on-one counseling, answer incoming calls from inmates, support during investigative interviews, consultation with MH staff as needed, monthly report to PREA compliance staff. The auditor contacted the head of WCHD at the beginning of the pre-audit phase and she confirmed the agreement with the agency.

Standard 115.54 Third-party reporting

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actionsiken by the facili2.2(i)y.

115.54(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 public access areas. 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 115.61 Staff and agency reporting duties

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

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

115.61(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. Dir 9 specifies that the agency is required to report abuse that occurred at another facility. Ten deputies interviewed, all are aware of their duty to report sexual abuse under agency policy.
115.61(b) - Policies P-450 and P-500 do not include the complete language in the standard, specifically as it relates to the only people to whom staff may reveal information related to sexual abuse. Policies P-450 and P-500 should be modified to specify that 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, investigation, and other security and management decisions.

Standard 115.62 Agency protection duties

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

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

115.62(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. Interviews of the agency head designee, Facility Manager and ten deputies could be summarized to all would take immediate action to protect the inmate. Although staff's actions in response to the hypothetical situation are appropriate overall, Policies P-450 and P-500 do not include language for this type of scenario. Both policies should be modified to include required staff response for this type of situation. The auditor realizes that the standard does not require written policy, only immediate action to protect the inmate; therefore, based upon staff's response to the hypothetical situation, the determination is Meets Standard.

Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.67 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.71 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.72 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.73 Reporting to inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.77 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.78 Disciplinary sanctions for inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds

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Standard 115.89 Data storage, publication, and destruction

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

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

115.89(a) - Pol P-700, Dir 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 is approved by PREA Coordinator.
115.89(b) - Pol P-700, Dir 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: "KCSO's PREA Compliance team has prepared its 2014 report for the Max facility that compares and contrasts 2013 to 2014 with respect to its progress at implementing policies and practices to prevent, detect, and respond to sexual abuse in its facilities. This information along with statistical information from incident reports in 2014 will give KCSO a baseline, and a method to accurately examine its PREA program in future years." The auditor verified that the facility's annual report is published on the agency's website. CORRECTIVE ACTION APPROVED.
115.89(c) - Dir 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.
115.89(d) - Dir 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.

Alberto F Caton
Certified PREA Auditor

Auditor Signature

August 10, 2015

Date