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: June 23 2015			
Facility Information			
Facility name: Pretrial Jail Facility			
Facility physical address: 17695 Industrial Farm Road, Bakersfield, CA 93308			
Facility mailing address: *(if different from above)*			
Facility telephone number: (661) 391-7927			
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 Ian Silva			
Number of staff assigned to the facility in the last 12 months: 124			
Designed facility capacity: 1344			
Current population of facility: 1173			
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.

In February, 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. Per the agency's request, the auditor conducted PREA audits of its two remaining facilities, Pretrial Facility located at 17695 Industrial Farm Road, Bakersfield, CA; and Minimum Jail Facility located at 17635 Industrial Farm Road, Bakersfield, CA during the week of June 22, 2015.

PRE-AUDIT PHASE

The auditor provided the notice of upcoming audit to PREA Compliance Manager Sergeant Rhonda Turnbaugh on April 27, 2015. The notice was posted at least six weeks before the scheduled on-site audit. On June 17, 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 agreed to email information about several contacts from inmates at both Minimum and Pretrial, but these were not received.

On June 5, 2015, the auditor received completed pre-audit questionnaires for both facilities scheduled for audit as well as several supporting documents, such as revised policies, training records, male and female inmate education records, incident reviews, inmate notifications, classification history for a random sample of 40 inmates housed at the facility and other relevant documents. With the items received 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 both facilities. 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, a list of specialized staff selected for interviews and a checklist of policies/procedures and additional documents to be reviewed during the on-site audit.

ON-SITE AUDIT PHASE

On June 23, 2015, the auditor arrived at Pretrial Jail Facility with Compliance Manager Sergeant Turnbaugh and following greetings with Facility Manager, Lieutenant Silva the Administrative Sergeant, the Squad Sergeant and a brief entrance meeting, the Compliance Manager took the auditor on a tour of the facility. The tour started at the Intake area where the staff were unable to provide answers to specific questions about the intake process because the facility receives inmates during the night shift and night shift staff were not yet on duty. The auditor noted posters on the walls with PREA information in English and Spanish, then inspected the holding cells and the Receiving Control where a female Sheriff's Aide monitors the video feed from surveillance cameras in the holding cells. The auditor noted that toilets in the holding cells do not have privacy screens and are clearly visible on the monitoring screens in Receiving Control. Like all other agency facilities, all inmate screening information is stored in the CJIS computerized system. The tour continued with the Segregated Housing (C- Pod) where the auditor toured the control booth, reviewed logs, observed inmate use of the shower and asked impromptu questions of the assigned deputy. After returning to the floor area, the auditor asked questions of two inmates on protective custody status, including an inmate who wrote a letter indicating that he had information about inappropriate treatment of inmates at Pretrial. The inmate insisted on relaying his concerns outside of the housing unit; therefore, the auditor placed his name on the list of inmates selected for interviews. The auditor verified that the PREA information posters were on the walls in the pod and the Education video is played. The Compliance Manager took the auditor on tours of three other pods, then she was relieved by the shift sergeant who continued the tour of the remaining three pods including B-Pod (the female pod). The auditor reviewed the log book at each deputy's post for supervisor documentation of rounds, verified that each pod had the PREA information poster on the wall, inspected the showers for privacy as well as the exercise yards. During the tour of the pods, the auditor also visited program areas such as the law library and the laundry. There were no inmate workers at these sites. The Compliance Manager took the auditor to the Infirmary where the auditor viewed inmate consultation in progress, asked impromptu questions of medical staff on duty, toured the medical records room and viewed suicide watch cells. The auditor also toured the facility's Central Control room where the assigned deputy monitors feed from several surveillance cameras in the Infirmary and main corridors to and from the pods. Following the tour, the auditor returned to the staging office and began interviews of 14 deputies selected from each of the seven pods, the Infirmary and from both day and night shifts; after completing the interviews, the auditor remained on-site to observe the intake process as a bus from CRF was expected; however, since the bus did not arrive at the expected time and it had gotten rather late, the auditor departed the facility for the day. The next day, the auditor returned to the facility and interviewed the facility manager. The auditor interviewed the Agency Head designee in February; therefore, for this trip the auditor only requested an updated completed questionnaire. The audit then continued with interviews of specialized staff, followed by interviews of 14 inmates selected randomly from each of the seven pods; the selection included male, female, a transgender inmate, two limited English proficient inmates and an inmate who disclosed prior sexual victimization during screening. After completing the inmate interviews, the auditor departed the facility. The next day, the auditor returned to CRF and Max Medium facilities to verify corrective measures that required on-site verification before completing all activities scheduled for the trip.

POST-AUDIT PHASE

DESCRIPTION OF FACILITY CHARACTERISTICS

The Pretrial Jail facility opened in 1987, with an additional pod coming on-line in 1989. It is the Kern County Sheriff's Office (KCSO) largest detention facility, housing both male and female inmates with a maximum capacity of 1344 inmates. It operates seven pods, a medical infirmary, three classrooms, and multiple support offices. It is managed by a Detentions Lieutenant who oversees 18 supervisory staff, 95 detentions security staff, 2 sheriff's aides, and 9 civilian support staff. There are typically 2-16 mental health staff and 9 medical staff on-site daily. The facility operates on four twelve hour shifts.

Pretrial is a pod designed facility with a central Master Control area. Each pod has six housing units with eight upper level and eight lower double bunk cells. Each pod has a central observation control room which is staffed by one Deputy. Each cell and all dayrooms have intercoms allowing the inmates to communicate with the control room Deputy. The Control Deputy has direct sight of all housing unit dayrooms, cell doors, and the recreation yard. The Deputy can monitor the contact and non-contact Attorney visiting rooms as well as the general non-contact public visiting rooms. On the lower level of the pod, the floor Deputy oversees the sallyport area with views of each unit entrance door, the interview room, and staff office.

Outside of each pod unit entrance are small janitor closets with cleaning supplies that remain locked and each pod has an attached secure warehouse that is used by support staff such as maintenance, or mental health, medical record storage, or as inmate property storage. The facility features numerous other secure work areas which are used by the Chaplain, Librarian, Mental Health Staff, and Medical Supervisor. Additionally, there are three holding cells adjacent to the Master Control room.

The infirmary area contains seven cells for suicide watch inmates, five reverse isolation medical cells, five general medical cells, and a safety cell. Additionally, there are specific rooms that medical staff use for records, pharmacy and treatment supplies, patient treatment room, x-ray room, and dental area. Multiple medical staff and two Deputies staff this high traffic area 24/7.

The receiving / court area is another high traffic area where inmates are received from either the Sheriff's downtown reception facility or from one of the two other facilities at the Lerdo complex. It has an open receiving area, five windowed holding cells, an inmate dress out / x-ray body scanner area, and three small open storage rooms. There is a secure control room area staffed by one Sheriff's aide who oversees inmates in the five holding cells via camera monitors, controls access into the facility, and provides additional security oversight for the one court Deputy, and two search/escort Deputies assigned to the area.

The Master Control Deputy oversees the fire alarm system, tracking of inmate movement, as well as monitoring video cameras of the facility ingress and egress from hallways near the control room area, and the entrance into the receiving and infirmary areas and other points of ingress and egress. The Master Control Deputy also maintains the Facility count and routes all incoming phone calls to the Facility.

The facility features an audio/video surveillance system in some areas. The system is not monitored continuously but retains recordings for an extended period of time. Recordings and/or real time observation video may be viewed by a supervisor or the facility manager.

SUMMARY OF AUDIT FINDINGS

On June 23, 2015, a Prison Rape Elimination Act (PREA) audit of the Kern County Sheriff's Pretrial Jail Facility found that the facility is generally in compliance with the PREA standards. Of 43 standards in the Adult Prisons and Jails audit tool, the facility met 29 standards, did not meet 11 standards and 3 did not apply. The facility met or exceeded the standard for 72.5% 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*****

NONE

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

PREVENTION PLANNING
115.13 - Supervision and monitoring
115.16 - Inmates with disabilities and inmates who are limited English proficient
115.17 - Hiring and promotion decisions
115.18 - Upgrades to facilities and technologies

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

TRAINING AND EDUCATION
115.31 - Employee 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

115.61 - Staff and agency reporting duties
115.62 - Agency protection duties
115.63 - Reporting to other confinement facilities
115.64 - Staff first responder duties.
115.65 - Coordinated response
115.66 - Preservation of ability to protect inmates from contact with abusers
115.67 - Agency protection against retaliation
115.68 - Post-allegation protective custody

INVESTIGATIONS
115.72 - Evidentiary standard for administrative investigations

DISCIPLINE
115.76 - Disciplinary sanctions for staff
115.77 - Corrective action for contractors and volunteers
115.78 - Disciplinary sanctions for inmates

MEDICAL
115.82 - Access to emergency medical and mental health services
115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers

ACTION volunteers

Number of standards exceeded: 0

Number of standards met: 40

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) - DOES NOT MEET STANDARD - 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 with 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. The PREA Compliance Manager does not appear on the agency organizational chart and each facility does not have its own PREA Compliance Manager as the standard requires; instead, each facility has an Administrative Sergeant who is designated to assist the PREA Compliance Manager with compliance issues at their respective facility. The auditor discussed with PREA Coordinator, the requirement of the standards for each facility to have a PREA Compliance Manager and that each facility’s Administrative Sergeant should be designated as PREA Compliance Manager and the current compliance manager could be given some other type of agency-wide PREA title; he agreed and indicated that that should be easy to do.
The PREA appear on the agency Compliance Manager has position as PREA Compliance Manager a Coordinator position facility. the agency organiz Td (ha
CORRECTIVE ACTION: The PREA Coordinator position has itvd (its)Tj 12 24 006 0 04 6 -a 516 0 Td (andd5g 0 Td (has) Tj 17 004 0 72)

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.

115.13(a) - The Kern County Sheriff Jail Facility Staffing Plan Process describes how the agency develops staffing plans for its facilities 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 six-page staffing plan for the Pretrial Facility. 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 Manager explained that the staffing is based on the number of fixed posts and housing unit positions that need to be filled. Staffs for specific functions, like the infirmary officer positions and search/escort positions are added to the staffing numbers. Housing units are generally staffed with two deputies per shift. Inmate safety, including safety from sexual abuse, is considered in determining staffing levels. With regard to the videos, he stated that cameras have been installed in housing areas and plans to install additional cameras are underway. With regard to the staffing plan being documented, he stated that it is an attachment to Policy P-200, Prevention and Detection of Sexual Abuse. The Facility Manager explained how the staffing plan considers each of the 11 items prescribed in the standard. With regard to checking for compliance with the staffing plan, he stated that he monitors the radio traffic, his supervisors will keep me informed, including contacting him during off-hours when significant changes in staffing are called for. Supervisors send him copies of staff rosters and briefings e-mails at the end of each shift which include detail staffing levels.
115.13(b) - Deviations are limited and overtime is used to reduce or eliminate them. The most common reasons for deviations are hospital transports and range qualifications. With respect to the facility documenting all instances of non-compliance with the staffing plan, the Facility Manager replied "Yes" and explained that generally, rosters and logbooks track staffing levels for each shift. Significant changes in staffing levels are also detailed in per-shift briefings called IOI's (Incidents of Interest). He provided a few examples of completed IOIs

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.
115.15(b) - Policy P-200, Directive C-1, states that:

- Cross gender pat-down searches of female inmates by male staff are permitted under exigent circumstances
- Cross gender pat-down searches of females by male staff shall be conducted utilizing the least intrusive methods such as "back of the hand" search techniques as taught by the Defensive Tactics team.

Neither staff nor female inmates interviewed indicated that cross-gender pat-down searches are done. Two female inmates interviewed, when asked if access to programs and out-of-cell activities is ever restricted due to unavailability of female staff to search them, both replied "No." The policy does not require documentation of cross-gender pat-down searches of female inmates. Policy P-200 Directive C-2 should be modified to include the requirement to document cross-gender pat-down searches of female inmates.
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 cross-gender pat-down searches, except under exigent circumstances. The facility does not allow cross-gender strip nor cross-gender body cavity searches. There has not been any cross-gender pat down searches of female inmates; only female staff is assigned to the female pod.
115.15(d) - DOES NOT MEET STANDARD - Policy P-200, Procedure D, states in part "When entering an opposite sex housing unit (Male deputy entering female housing, female deputy entering male housing) deputies are required to announce their presence, have their presence announced, or otherwise ensure inmates are informed they will be or are entering the housing unit." The policy also addresses

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, states in part: KCSO shall provide hearing impaired inmates with TTY devices and/or language interpreters who can interpret effectively, accurately, and impartially, its efforts to prevent, detect, and respond to sexual abuse and sexual harassment, and that KCSO will provide written materials using formats and methods that ensure effective communication with inmates with disabilities. 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 imminent. PREA information is posted throughout inmate areas and there is a Spanish version of each poster; also, the education video is played in Spanish. The auditor determined that there is staff who are bilingual and are able to translate for Limited English Proficient (LEP) inmates. The facility also is able to use their contract with Language Line for interpreter services. One LEP inmate interviewed in Spanish indicated that he received PREA information in his language.
115.16(b) - Policy P-400, Procedure C, states, "KCSO employs multiple staff certified as fluent in Spanish and available to translate for monolingual, Spanish-speaking inmates. KCSO subscribes to Language Line services to provide telephonic interpreter services to LEP inmates in an effective, accurate, and impartial manner. All written materials related to PREA

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, Directive 1 states "KCSO shall not hire, promote, or contract with anyone who has engaged 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. KCSO shall not hire, promote or contract with anyone who has a civil judgment or administrative adjudication against them for engaging in non-consensual sexual activity accomplished by force, threats or other forms of coercion." The auditor randomly selected and reviewed ten files of promotional employees and new hires; every file included a background clearance. The agency did not incorporate past misconduct questions on these PREA issues into its personnel selection process until February 2015; therefore, files of new hires and promotions that preceded that date did not include those questions. All files of hires and promotions since February 2015 included the questions. Additionally, on May 26, 2015, the Sheriff issued a letter to all employees informing them of the agency's commitment to compliance with the provisions of 115.17 and their continuing affirmative duty to disclose misconduct listed in 115.17(a). The letter further informs employees that material omissions or providing materially false information about such misconduct will result in disciplinary action up to and including termination.
115.17(b) - Policy P-900, under POLICY, states KCSO has multiple procedures in place to facilitate the hiring, retention, or promotion of employees. 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. Procedure A states 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. Staff from Human Resources (HR) reported that the agency considers any incidents of

Standard 115.18 Upgrades to facilities and technologies

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

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

115.18(a) - N/A The facility did not add any new construction and did not have any substantial expansion or modification of its physical plant.
115.18(b) - The agency head designee indicated that the agency is increasing monitoring and points out that video surveillance supplements safety, but does not replace staff and that the agency is committed to instituting the use of body cameras inside its detention facilities as it did with patrol deputies. The Facility Manager stated "As funds allow we are putting two cameras in each housing unit to not only act as a deterrent but to identify and prosecute those responsible. Cameras are also being placed in hallways which provide monitoring of staff as well. A $100k expansion is planned for this year." The auditor viewed the facility's video monitoring system in the

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. Fourteen deputies interviewed and all said they knew and understood the agency's protocols for obtaining usable physical evidence if an inmate alleges sexual abuse; they also said they knew who was responsible for conducting sexual abuse investigations. The facility developed a written institutional plan to coordinate actions in response to an incident of sexual abuse among staff first responders, medical, mental health, investigators and facility managers. The institutional plan has been assembled into binders which have been placed in key locations throughout the facility. Each binder has a table of contents, a phone contact section, a security first responder section, non-security first responder section, supervisor section, medical/mental health section, investigation section, search & transportation section, SANE exam section, reporting section and training bulletin section. Also, Policy P-600, Procedure A, lists specific steps for all involved staff to take in the event of a case of sexual abuse; the procedure provides directions for interviewing the victim and preserving evidence for collection by trained staff.
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 those of the publication. The facility's written institutional plan provides a local institutional procedure with protocols that are specific to the institution and derived from the aforementioned policies.
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. Medical staff reported that in the event of a sexual assault, they would examine the inmate, find out when it

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). The Compliance Manager explained that the responsibility for reporting to outside agencies rests with management and that it would never be the responsibility of line staff. Fourteen deputies interviewed and all reported receiving PREA training that involved all ten topics required by the standard. The agency provided 514 employee training acknowledgment slips reflecting that staff received 115.31 training between 2013 and 2014. The agency provided a sign-in sheet indicating that 26 MH employees receive PREA training in May and June 2014; the agency provided employee training acknowledgment slips for Medical staff indicating that they receive 115.35 training in 2015 but no 115.31 training records for Medical staff was provided; other records reflect that 126 of 135 employees received PREA training between 2013 and 2014, but the documentation does not specify whether or not it is 115.31 training. The 514 employee training acknowledgment slips provide evidence of massive employee PREA training between 2013 and 2014; however, the records should be organized in a manner that demonstrates compliance with all standards related to employee training. Training records for staff assigned to a specific facility, should be classified by facility because audits are conducted one facility at a time; then records should be classified by the different classes of employees for whom the standards established training requirements, e.g.: 115.31, all employees; 115.32, volunteers and contractors; 115.34, investigators; and 115.35, medical and mental health. Next, training records should include employee names, work class, date of training, and should clearly reference the specific PREA standard covered by the training and the title of the lesson plan used. Finally, if it is refresher training, the training records should reflect that fact. While the agency may provide training to a variety of employees from different facilities all at once, there should be designated sign-in sheets by facility and by work class. Employee acknowledgment slips should include fields for

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) - DOES NOT MEET STANDARD - The Agency provided a 13-page training outline for instructors and a 35-slide Power Point presentation that includes the Zero-tolerance policy, responsibilities under PREA, role in prevention, evidence preservation, sexual abuse misconduct and many other relevant topics. The training provides scenarios that are specific to a variety of contractor/volunteer level of contact with inmates and includes the agencies Zero-tolerance policy. The questionnaire reports that 8 of 34 or 24% of contract and volunteer employees received the required training. The contract employee interviewed reported receiving training on his responsibilities regarding sexual abuse and sexual harassment prevention, detection, and response, per agency policy and procedure. Training records include nine 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. The facility needs to provide the training required by the standard to the remaining volunteer and contract employees and provide documentation of the training as well as employee acknowledgment forms. CORRECTIVE ACTION: All Contractor's and Volunteer's approved to enter KCSO facilities received the required training in compliance with the standard. The pre-audit questionnaire was taken literally in that 8 of the 34 contractor/volunteers were trained during the 12 month audit period; all others were trained prior to the audit period. The agency provided ten (not nine) sign-in sheets for volunteer/contractor training during the first six months of 2014; the latest sheet in-fact falls within the current audit period and has seven names listed. The auditor is satisfied that the required training has been provided. CORRECTIVE ACTION APPROVED.
115.32(b) - The training outline includes information about vulnerable inmates, fraternization, the effects of sexual abuse, consequences to abusers, etc. The training provides scenarios that are specific to a variety of contractor/volunteer level of contact with inmates 6 0 Td (Cont

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 questionnaire reflects that 8,607 of 11,447 or 75% admitted during the past 12 months received information about the zero-tolerance policy and how to report sexual abuse. The Intake employee interviewed reported that inmates are informed of the Zero-tolerance policy and how to report sexual abuse and that to ensure inmates are educated on the policy, the Intake staff have inmates sign a form acknowledging that they saw and understood the education video. Fourteen inmates interviewed, and all but one reported receiving information about the agency's Zero-tolerance policy and how to report sexual abuse. The facility needs to improve the percentage of inmates who receive this information during intake. The auditor is confident that the facility's current practice includes providing the required information to inmates on the day of arrival.
115.33(b) - The questionnaire reports that 3,031 of 4,042 or 75% of inmates received during the past 12 months, who remained at the facility for 30 days or more, received the comprehensive education within 30 days of arrival. The questionnaire reflects that the facility started showing the video in August 2014 and the computerized inmate signature program began in April 2015. The Intake deputy reported that the education video is played the day of arrival and there are flyers posted in the housing units. Fourteen inmates interviewed and all but one reported being told on arrival about their right not to be sexually abused or harassed and how to report abuse. All but three said they were told about their right not to be punished for reporting sexual abuse. The auditor knows the facility currently shows the video upon arrival and it is shown on a daily basis in the housing units; thus inmates are receiving the education within the required 30 days.
115.33(c) - DOES NOT MEET STANDARD - The agency did not have its inmate education process in place within one year of the effective date of the standards; therefore, no inmates were educated within that time frame. The facility currently plays the Education

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

115.34(a) - The agency provided several training outlines and Power Point presentations used for investigator training, including a 34-slide presentation titled "Interview and Interrogation," a presentation titled Detentions Sexual Assault School, the training outline for a course on Sexual Assault Investigations, etc. The SAAIU investigator stated that he received training specific to conducting sexual abuse investigations in confinement settings. Also, the agency trained Senior Deputies and Sergeants on conducting sexual abuse investigations in confinement settings, See "Detentions Sexual Assault School."
115.34(b) - The SAAIU Investigator reported the following:
• (All SAAIU detectives have received extensive POST training in Sexual Assault investigations and interviews. They were not limited specifically to PREA).
• (All SAAIU detectives have received extensive Miranda, Lybarger and Beheler training. These legal issues are commonly revisited in continued education/training).
• (All SAAIU detectives have been trained and are experienced in evidence collection in relation to Sexual Assault. The training was not specific to jail cells, but included numerous types of conditions and locations where evidence could be collected e.g.: Houses, cars, human bodies, etc.).
• (All SAAIU detectives have experience and POST training in collecting evidence for prosecution and understand the process of Administrative referrals).
The auditor is familiar with the Lybarger warning; it serves the same purpose as the Garrity warning.
115.34(c) - The questionnaire reports that 35 of 35 investigators received the required training. Sing-in sheets dated 5/1/14 and 5/29/14

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) - The questionnaire reports that 11 to 14 Medical employees and 8 to 11 Mental Health employees who work at the facility received the training. Medical and MH personnel interviewed reported receiving training on all four topics prescribed by the standard. Sign-in sheets reflect that MH staff participated in a two-part PREA training in May and June 2014 and several signed training acknowledgment forms for 115.35 training. The lesson plan addresses all four topics prescribed by the standard.
115.35(b) - N/A, Medical staff at the facility do not conduct forensic exams.
115.35(c) - The agency provided employee training acknowledgment forms and a sign-in sheet for Mental Health for a two-part PREA training in May and June 2014, employee training acknowledgment forms showing that medical staff received PREA training in 2014, plus 12 Medical staff acknowledgment forms for 115.35 training in 2015.
115.35(d) - All medical and MH staff are Kern County employees redirected to work at the jails; they are not Sheriff Department employees. The 2014 training acknowledgment forms reflect 115.32 training for medical and the 2015 forms reflect 115.35 training for medical. The agency did not provide record of MH employees receiving 115.32 training. The agency provided 514 employee training acknowledgment slips reflecting that staff received 115.31 training between 2013 and 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) - 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. A classification deputy reported that his office screens inmates upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other inmates. Fourteen inmates interviewed, all but four reported being asked the screening questions and most of those said they were asked the questions during booking at CRF. The facility does not ask screening questions; instead, inmates are asked whether they wish to change any of their answers to the screening questions they were asked at the reception center (CRF) and whether or not they are concerned about their sexual safety. This step down approach requires documentation that the inmates are asked these questions as well as documentation of their responses.
115.41(b) - The questionnaire reports that 11,447 of 11,447 or 100% of inmates received during the past 12 months, who remained at the facility 72 hours or longer, were screened within 72 hours of intake. Policy P-200, Procedure 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." Although the policy does not specifically require Intake screening within 72 hours, it does require the risk assessment to take place upon intake, thus meeting the 72-hour requirement of the standard. The classification deputy indicated that he screens inmates for risk of victimization and abusiveness within 72 hour of arrival. Fourteen inmates interviewed, all but four reported being asked the screeining questions and most of those said they were asked the questions during booking at CRF. The questions in the PREA audit inmate interview protocols were not designed to elicit responses that are consistent with the facility's step-down process; however, the auditor recognizes that inmates are asked the full battery of questions prescribed by the standard at CRF, then they are transferred to another

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. With respect to how the agency uses intake screening information to protect inmates from sexual abuse or being abusive, the Compliance Manager stated: The agency has implemented an extensive risk screening tool that helps to identify those inmates most at risk and those that may be prone to commit abuse. This information is used in addition to all of the other booking information for classification to make the best housing placement in the facility for the inmate. The Screening deputy stated that the information is used to make individualized determinations to ensure the safety of the inmate. The information is also used to make decisions about housing and program assignments. The auditor requested documentation of risk-based housing decisions but did not receive any.
115.42(b) - Policy K-100, under Policy, states classification staff shall use information obtained during the PREA screening process to make individualized determinations about how to ensure the safety of each inmate, and to make or recommend housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. The Screening deputy stated that the information is used to make individualized determinations to ensure the safety of the inmate. The information is also used to make decisions about housing and program assignments. The agency maintains individualized classification information for each inmate in the CJIS system and uses that information to make determinations about the inmate's safety.
115.42(c) - Policy K-300, Procedure C, states in relevant part that Protective Custody (Blue Band): An inmate whose appearance, charges, behavior or risk for sexual victimization requires protection from General Population inmates. This category includes: PREA at

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) - The questionnaire reports that in the past 12 months, no inmates at risk of sexual victimization were held in involuntary segregated housing for one to 24 hours awaiting completion of assessment. Policy K-400, Procedure B, states that inmates administratively segregated at intake due to risk of sexual abuse shall have a complete assessment performed by classification within 24 hours to ensure administrative segregation is necessary and the inmate is housed in the least restrictive housing available. The policy applies the practice to inmates placed in segregated housing from intake. The standard is applicable to any case where an inmate is placed in segregated housing due to high risk of victimization, not only cases placed from intake. The facility manager confirmed that the agency has the policy in question. Documentation should 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 and the policy should be modified to include the provisions of the standard as it relates to any inmate placed in involuntary segregated housing as opposed to inmates placed from intake processing.
115.43(b) - Policy K-400, Procedure B, states that Inmates administratively segregated at intake due to risk of sexual abuse shall have access to programs, privileges, education, and work opportunities to the extent possible. If access is limited, the facility shall document the opportunities limited, the duration of the limitations and the reasons for such limitations. With regard to inmates being placed in segregated housing for protection from sexual abuse or after having alleged sexual abuse, the classification deputy reported that these inmates would have access to programs, privileges, Education and work opportunities depending on level of security, based upon history of violence and mental stability. He also reported that if these program opportunities were restricted, the facility would document the

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. Fourteen deputies interviewed and among them, they provided a variety of options for inmates to privately report sexual abuse and harassment, including calling the hot-line, reporting to a deputy, calling WCHD, telling a relative etc. Fourteen inmate interviewed and most of them indicated they would use the hot-line, tell a deputy, call WCHD, tell a relative, etc. There are PREA posters in English and Spanish in every housing unit with information on how to report sexual abuse; also, the brochure and the education video tells inmates about the various options for reporting, including the hot-line.
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 PREA poster includes the number to report sexual abuse for investigation; the Education brochure indicates that the number in question is used for reporting abuse to the police. Neither the poster nor the brochure tells inmates that they can report and remain anonymous. The Compliance Manager stated that each housing unit has phones that provide inmates with access to a free hot-line that will connect them directly to our local Police Department where they can make an abuse report. All calls are recorded and the Police agency will ensure notification to KCSO in order to respond appropriately. She added that if the inmate makes a report and does not identify themselves BPD will still relay whatever information the inmate does provide and the Pretrial staff will begin an investigation. Fourteen inmates interviewed and ten are aware that they can report sexual abuse to someone who does not work at the facility and seven are aware of their option to report sexual abuse without having to give their names. The information brochure given to inmates includes addresses and phone numbers of outside agencies to whom sexual abuse can be reported

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. Fourteen inmates interviewed: 2 did not know about outside services for dealing with sexual abuse, 10 did not know what kind of services are available, 7 did not know or said the facility did not provide addresses and phone numbers for outside services and 4 did not know when they could talk to service providers. During the walking tour, the auditor noted that each housing unit had posters with PREA information that included the hot-line number for inmates to receive services.
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. Fourteen inmates interviewed; three refused to answer questions about outside services; five did not know if what they say to service providers remain private; five do not know if their conversations could be listened to or shared with someone else and four did not know when are service providers required to report what they tell them. The auditor noted that the PREA Education video is played daily in all housing units and it tells inmates that their conversations with outside providers is kept confidential and the exceptions where it will not.
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 audit 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. Fourteen deputies interviewed and all reported that agency policy requires all staff to immediately report any knowledge, suspicion or information regarding an incident of sexual abuse or harassment in a facility.
115.61(b) - Policy P-450, Directive 2, states that staff shall not reveal any information related to a sexual assault/abuse report to anyone uninvolved in the response and investigation. Policy P-500, Directive 1, states that staff will not discuss details of a sexual assault/abuse report with other staff uninvolved in the response or investigation. All information must be treated confidentially. The policy does not include all of the language in the standard, i.e.: make treatment, investigation, and other security and management decisions. Fourteen deputies interviewed and all indicated they would not share information about an incident of sexual abuse with anyone not involved. 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.
115.61(c) - Policy P-450, Directive 3 states that medical and mental health practitioners shall report knowledge, suspicion, or information regarding sexual assault/abuse, sexual harassment, retaliation, or staff neglect pursuant to this section. Unless precluded by federal, state or local law, Medical and Mental Health staff shall inform inmates of their duty to report sexual abuse and the limits of their confidentiality at the initiation of services. Medical and MH staff reported that they make these disclosures and that they are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official

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) - The questionnaire reports that during the previous 12 months, the facility did not have any case where an inmate was subject to substant
of imminer

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.

115.63(a) - The questionnaire reports that in the past 12 months, the facility did not have any cases where an inmate reported being sexually abused at another facility. Policy P-450, Directive 9, states if KCSO receives information that a sexual assault had occurred at another confinement facility, it has the duty to report the incident to that confinement facility.
• Security staff shall notify the next supervisor in their chain of command
• Section manager shall notify the head of the appropriate agency or jurisdiction where assault/abuse occurred
• Notification shall be made within 72 hours of the allegation
• Section manager shall notify the PREA Compliance manager
• Section manager shall ensure a CJIS incident is written.
115.63(b) - Policy P-450, Directive 9, specifies the agency's duty to report cases of abuse that occurred at other facilities, list specific staff responsibilities and requires notification within 72 hours.
115.63(c) - Policy P-450, Directive 9 provides that the Section manager shall ensure a CJIS incident is written using code 4050 PREA.
115.63(d) - Policy P-450, specifies that all reports of abuse are taken seriously and Policy P-500, Dir 1 specifies that staff will accept any third party report and outlines specific duties and staff's responsibility to investigate all allegations. The Agency Head designee reported that the PREA Coordinator is the point of contact and that it is written into policy; it goes up the chain of command the agency has a customized booking process and these reports are referred to SAAIU for investigation. The Facility Manager stated that he would be notified and he would notify the PREA coordinator and depending on the allegation either one of his Senior Deputies (trained investigators) will investigate or someone from SAAIU. He also reported that there was a case where an inmate received at CRF said he

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.

115.64(a) - The questionnaire reports that in the past 12 months, there were 12 allegations that an inmate was sexually abused; of these allegations, 9 times the first security staff member to respond to the report separated the alleged victim and abuser and in one case staff were notified within a time period that still allowed for the collection of physical evidence. The one time where staff were notified within a time period that still allowed for the collection of physical evidence, the the first security staff member to respond to the report:
• Preserved and protected any crime scene until appropriate steps could be taken to collect any evidence,
• Requested that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating,
• Ensured that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.
Policy P-500, Directive A-1, lists specific steps in response to 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. The auditor interviewed both a security and non-security first responder. The deputy listed all steps prescribed in the standard. Fourteen deputies interviewed and 14 included Step 1, 11 included Step 2, 11 included Step 3 and 12 included Step 4. The auditor reviewed the incident report for the one case where staff were notified within a time period that still allowed for the collection of physical evidence and in that case, the victim reported the sexual assault about three days after the alleged incident; he told the investigator he had already taken a few showers before he reported the assault. Staff still transported him to the local hospital's Sexual Assault Response Team (SART) for a forensic examination. The alleged abuser was also transported to the SART for forensic examination. The incident report reflects that upon receiving the report

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.

115.65(a) - With regard to having a plan to coordinate actions among staff first responders, the facility manager answered "Yes." During the tour, the Compliance Manager provided a copy of the facility's response plan for review. The plan has been assembled into binders clearly labeled and placed in strategically selected locations around the facility. The plan's implementation includes the various staff responders including security, medical, mental health, management, investigations, etc.

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.

115.66(a) - Policy P-200, Directive 2, states that the County collectively bargains with Kern Law Enforcement Association (KLEA), Kern County Detention Officer Association (KCDOA) and Service Employees International Union (SEIU) for issues related to employee pay, leave time, health benefits, uniform allowances. No issues related to employee discipline are negotiated as part of the collective bargaining process. With regard to collective bargaining or other agreements since August 20, 2012, the Agency Head designee stated that there has not been any.
115.66(b) - Not applicable

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.

115.67(a) - Policy P-450, Dir 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 agency developed written PREA Victim Monitoring Instructions and a PREA Victim Monitoring form. The agency developed written PREA Victim Monitoring Instructions and a PREA Victim Monitoring form. The Compliance Manager provided two PREA Victim Monitoring reports for this facility. The reports reflect that the monitoring includes a check of CJIS and interview of the inmate victim; in one case, the first monitoring visit was ten days after the incident and the inmate was released before the second visit; in the other case, the first visit was four and a half weeks after the incident and the monitoring lasted 90 days. In both cases, the monitoring report reflects referral to a victim advocate.

115.67 (b) - Policy P-450, Dir 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 agency uses multiple protection measures, including some of those prescribed by the standard. The policy also states that use of segregated housing for protection shall be in accordance with Policy K-300 and K--400. The Agency Head designee reported that the agency moves inmates, separates the victim from abusers, works with the inmate victim to ensure his or her safety, if the perpetrator happens to be a staff member, that employee is reassigned until the investigation is completed. The Facility Manager stated that the actions are the same, separate the victim from the abuser or harasser by moving one or the other, place a computer "keep-away," and the victim will be monitored for 90 days or more to make sure they are not being retaliated against. The victim can also receive counseling services from our victim advocate. The Compliance Manager, who is responsible for monitoring retaliation, reported that she initiates the contact with the victim and generates the

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

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.

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) - Policy P-700, Directive B-3, states that the Compliance section shall:
•Ensure that data collected is securely retained.
•Remove all personal identifiers prior to making all facility aggregated sexual abuse data available to the public annually on its website.
•Maintain collected sexual assault/abuse data for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise. To ensure the data is securely retained, the PREA Coordinator explained that Classification have access to the data, Medical/MH only has access to information relevant to them; he is the only person who can listen to a call from the hot-line and he would only do that if it is needed for and investigation and with the release of information from the rape crisis program. A PREA report from the website only goes to him.
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 auditor verified that each facility's annual report is available to the public on the agency's website.
115.89(c) - Dir B-3 requires removal of all personal identifiers prior to making data available to the public. The PREA Coordinator reported that annual reports (with aggregated data) do not include personal identifiers. The auditor verified that the reports on the agency's website do not include any personal identifiers.
115.89(d) - Dir B-3 3rd bullet, includes the language in the standard. This is the agency's first year of data collection pursuant to 115.87; therefore, there is no historical data to review.

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

September 25, 2015

Date