PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	March 10, 2020	**To:**	March 12, 2020
AUDITOR INFORMATION			
Name of auditor:	Margaret Capel	**Organization:**	Creative Corrections LLC
Email (b) (6), (b) (7)(C)	[redacted]	**Telephone number:**	479-521[redacted]
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C) [redacted]	**Telephone number:**	202-381-[redacted]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	San Francisco
Field Office Director:	David W. Jennings
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C) [redacted]
Field Office HQ physical address:	215 5th St, Marysville, CA 95901
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Yuba County Jail		
Physical address:	215 5th St, Marysville, CA 95901		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	530-749-7740		
Facility type:	IGSA		
PREA Incorporation Date:	9/12/2018		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C) [redacted]	**Title:**	Captain
Email address:	(b) (6), (b) (7)(C) [redacted]	**Telephone number:**	530-749-[redacted]
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C) [redacted]	**Title:**	Sergeant
Email address:	(b) (6), (b) (7)(C) [redacted]	**Telephone number:**	530-749[redacted]

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NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

Directions: Discuss the audit process to include the date of the audit, names of all individuals in attendance, audit methodology, description of the sampling of staff and detainees interviewed, description of the areas of the facility toured, and a summary of facility characteristics.

The Prison Rape Elimination Act (PREA) audit of the Yuba County Jail was conducted on March 10-12, 2020, by Maggie Capel, U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor. The PREA audit was the first for the Yuba County Jail. The Yuba County Jail contracted with U.S. Immigration and Customs Enforcement (ICE) for the housing of male and female detainees. The audit period covered the previous twelve months from March 10, 2019 – March 10, 2020. The facility's PREA incorporation date is September 12, 2018. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) and Assistant Program Manager, (b) (6), (b) (7)(C) , DOJ and DHS certified PREA Auditors. The Program's Manager role is to provide oversight to the ICE PREA audit process and liaison with the ICE External Reviews and Analysis Unit (ERAU) section during the audit report review process.

The Team Lead, (b) (6), (b) (7)(C), Inspections and Compliance Specialist, ICE/Office of Professional Responsibility (OPR)/ERAU, was the point of contact for this facility. She coordinated the uploading of the facility's completed Pre-Audit Questionnaire (PAQ) as well as facility policies and exhibits to SharePoint. The facility did not provide all of the required policies and supporting documentation prior to the on-site audit for review. The Auditor did review all the facility's supporting documentation and agency and facility policies and procedures that was provided. These documents were to demonstrate the agency's and facility's compliance with the PREA standards. The Auditor forwarded a partial request for additional documentation and questions related to the documents to Team Lead prior to the audit.

The Team Lead forwarded the audit notification poster to the facility. The poster included the dates of the audit, the purpose of the audit, the Auditor's contact information through Creative Corrections LLC, and a statement regarding the confidentiality of any communication received. The facility staff placed posters throughout the facility, including all housing units, and all common areas. The Auditor verified the placement of the audit notification poster during the facility tour, and through detainee and staff interviews. The Auditor did not receive any correspondence from detainees, staff, or third parties regarding this audit.

The on-site visit began on March 10, 2020 at approximately 8:40 a.m. The Team Lead gave a brief introduction and overview of the audit process. In attendance was:

- (b) (6), (b) (7)(C), Team Lead/Inspections and Compliance Specialist, ICE/OPR/ERAU
- (b) (6), (b) (7)(C) , Sergeant, Prevention of Sexual Abuse (PSA) Compliance Manager, Yuba County Jail
- (b) (6), (b) (7)(C) Captain, Yuba County Jail
- (b) (6), (b) (7)(C) Supervisor Detention and Deportation Officer (SDDO), ICE/Enforcement Removal Operations (ERO)

The Auditor provided a listing of documents needed to review and interviews to conduct. The Auditor explained she would probably be working beyond normal working hours. She asked to be notified if any detainee asked to speak with her.

The Auditor, as well as, the PSA Compliance Manager, the Captain, and Team Lead toured all areas of the facility occupied by detainees. County jail inmates are housed with detainees, but detainees are not assigned jobs. Detainees do not enter the commissary, laundry, kitchen, or administrative area. All housing areas were toured, as well as, control centers, intake, and the medical area. During the tour, the Auditor examined logbooks, posted announcements, showers, toilets, changing areas, camera locations, video monitors, and tested the detainee phones to verify detainees were able to contact the designated rape crisis hotline. At the time of the tour, the phones were not working for the PREA hotline. Before the end of the tour the phones had been repaired. Cameras were positioned to allow for easy viewing into the housing areas, but blackout spots were placed on the monitors to prevent viewing into the changing, showering, and toileting areas. Most cameras have tilt, zoom, and pan capabilities. The facility is able to maintain video footage for one year on the jail's main frame. Cameras are monitored in the control booths and the sergeant's office.

The intake area consists of a waiting room and several individual cells that are used for holding, interviews, and dressing out detainees. Intake staff conduct interviews in the holding cells to afford privacy to detainees when answering sensitive questions. Staff reported transgender detainees are housed according to their assigned sex at birth unless the detainee has completed a full transition from one gender to the opposite gender. Medical staff report they are not consulted regarding the housing of transgender detainees. Staff report the detainee's opinion of concerning housing placement is considered.

The housing areas consist of 1 single cell housing area, 4 multiple occupancy cell housing units, 11 open dormitory housing units, 35 segregation cells, and 6 medical unit beds. Modifications were made to R Dorm to provide American Disability Act (ADA) accommodations.

The Pre-Audit Questionnaire (PAQ) stated the facility has a design capacity of 428. The jail is contained in one building in downtown Yuba. The jail does not house juveniles or family units. The total population on the day of the on-site audit was 373 which included 158 male detainees, 10 female detainees, 2 transgender detainees, and no intersex detainees. There were 1,103 detainees booked into the Yuba County Jail in the last 12 months.

The facility employs 79 employees, with security staff working 12-hour shifts from 6:00 a.m. – 6:00 p.m. or 6:00 p.m. to 6:00 a.m. There is a total of 15 medical staff and 3 mental health staff. Health care is provided through a contract with Wellpath.

The PREA allegations spreadsheet, created by ERAU provided to the Auditor prior to the audit, listed four allegations. The facility reported seven allegations on their annual report provided after the on-site visit. Of the seven allegations the facility reported, three of the allegations occurred at the facility, three allegations occurred at another facility, and one allegation reportedly occurred while in law enforcement custody during a transport, but not at a facility. Following the site visit, the Team Lead reviewed the allegations to reconcile the difference in allegation numbers. The difference was three cases, which were reported to the agency and deemed that they did not meet the DHS definition for PREA; therefore, they were not listed on the PREA allegations spreadsheet. The other allegation was reported at an ERO San Francisco Hold Room and the facility reported the incident to ERO. This is the reason the facility did not account for the incident on their annual report. Once reconciled, there were four PREA allegations. Two allegations were detainee-on-detainee and the facility administrative investigations determined the allegations were unfounded. The ERO, Administrative Inquiry Unit (AIU) investigations determined one allegation was unsubstantiated and the other allegation was substantiated. The other two allegations were contractor-on-detainee. One allegation was determined substantiated by AIU and the facility's administrative investigation and the other allegation is still an open case and was not listed in the facility's annual report. The PAQ states the facility completed an investigation into each allegation and five allegations were referred to the appropriate investigative authority. The numbers submitted on the PAQ did not align with the allegations and investigations for the audit period determined PREA related, there were four not five allegations. Two of the cases were criminally investigated by outside agencies with one referred to the District Attorney. The Auditor selected three investigation files for review during the site visit. Of the three files reviewed by the Auditor, one allegation was later determined not to meet the definition for PREA. Two allegations were unsubstantiated, and one was substantiated. Only one of the alleged victims was referred to medical or mental health, and no alleged victim was taken to an outside healthcare facility. All the allegations were reported to Joint Intake Center (JIC) with four referred to AIU for investigation.

Detainee and staff interviews began following the facility tour. The Auditor was provided an office area to conduct interviews. The office allowed for privacy during the interviews. Detainees were randomly selected from each housing area. There were 20 detainees interviewed from the following categories:

- Randomly selected detainees
- Transgender detainee
- Disabled detainees
- Detainees with limited English proficiency (LEP)
- Detainees who had reported abuse at another facility

There were no detainees who identified as gay, lesbian, bisexual, or intersex. There were no detainees who filed a grievance related to sexual abuse and no detainees in segregated housing due to sexual abuse or harassment. The Auditor utilized the Language Services Associates language line provided through Creative Corrections to provide interpretation services for LEP detainees. During the interview, the Auditor showed each detainee the ICE National Detainee Handbook, the facility's Inmate Handbook, and the ICE Sexual Abuse and Assault Awareness PREA pamphlet to confirm they had received these documents when received into the facility.

The Auditor interviewed randomly selected security staff and security supervisors from each shift for a total of 10 security staff interviews. The Auditor also interviewed the Intake Supervisor, two classification staff, a medical staff member, a mental health staff member, the PSA Compliance Manager, an investigator, the Grievance Officer, and the Training Supervisor. Some staff were assigned duties in several areas. For example, Sgt. (b) (6), (b) (7)(C) is the second PSA Compliance Manager and he is also the Grievance Coordinator, Classification Supervisor, and Intake Supervisor.

After completing the on-site visit, an exit briefing was held. The Team Lead opened the meeting and the Auditor provided a summary of the initial audit findings. The following individuals were in attendance:

- (b) (6), (b) (7)(C), Team Lead, ICE/OPR/ERAU
- (b) (6), (b) (7)(C), Sergeant, PSA Compliance Manager, Yuba County Jail
- (b) (6), (b) (7)(C), Captain, Yuba County Jail
- (b) (6), (b) (7)(C), SDDO, ICE/ERO

The Team Lead and the Auditor explained that these were preliminary findings and results may change as documentation and interviews are reviewed. The Auditor reported that each employee interviewed was knowledgeable about PREA and it was apparent from the interviews that employees understood the intent of PREA and their responsibilities in this regard. Detainees reported feeling safe at the facility. There were problems noted with PREA education for detainees while in intake. Only a few detainees reported receiving all of the PREA documents while in intake/booking.

SUMMARY OF AUDIT FINDINGS

Directions: Discuss audit findings to include a summary statement of overall findings and the number of provisions which the facility has achieved compliance at each level: Exceeds Standard, Meets Standard, and Does Not Meet Standard.

The Auditor listed the relevant documentation reviewed for each standard, within the standard narrative.

Number of Standards Exceeded: 0

Number of Standards Met: 17

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.31 Staff training
§115.32 Other training
§115.34 Specialized training: Investigations
§115.51 Detainee reporting
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.64 Responder duties
§115.66 Protection of detainees from contact with alleged abusers
§115.72 Evidentiary standard for administrative investigations
§115.76 Disciplinary sanctions for staff
§115.78 Disciplinary sanctions for detainees
§115.87 Data collection

Number of Standards Not Met: 23

§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.33 Detainee education
§115.35 Specialized training: Medical and mental health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.52 Grievances
§115.63 Reporting to other confinement facilities
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.73 Reporting to detainees
§115.77 Corrective action for contractors and volunteers
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.201 Scope of audits.

Number of Standards Not Applicable: 1

§115.14 Juvenile and family detainees

PROVISIONS

Directions: In the notes, the auditor shall include the evidence relied upon in making the compliance or non-compliance determination for each provision of the standard, 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 the standard. These recommendations must be included in the Corrective Action Plan Final Determination, accompanied by information on specific corrective actions taken by the facility. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable. For any provision identified as Not Applicable, provide an explanation for the reasoning. If additional space for notes is needed, please utilize space provided on the last page.

§115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator.

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

Notes:

Documentation Reviewed:

Yuba County Jail (YCJ) Policy #901 Prison Rape Elimination
Organization chart

(c). YCJ policy #901 states the Yuba County Sheriff Office has zero tolerance for all forms of sexual abuse and sexual harassment and will not tolerate retaliation of any person who reports sexual abuse or sexual harassment or who cooperates with a sexual abuse or sexual harassment investigation. This policy outlines the facility's approach to preventing, detecting, and responding to allegations of sexual abuse and sexual harassment.

(d). The facility employs two Sergeants as PSA Compliance Managers. Policy #901 establishes the duties of the PSA Compliance Managers. These duties include: establishing procedures to comply with the PREA standards; developing staffing plans; developing methods for staff to privately report sexual abuse and sexual harassment; developing protocols for investigating allegations of sexual abuse; ensuring limited English proficiency (LEP) detainees and detainees with disabilities have an equal opportunity to understand and benefit from efforts to prevent, detect, and respond to sexual abuse or sexual harassment; publishing PREA related matters to the facility website; ensuring contractors and others who work in the facility are aware of the zero tolerance policy regarding sexual abuse and sexual harassment; and ensuring information on how to report sexual abuse or sexual harassment allegations is publicly posted at the facility. The PSA Compliance Managers also serves as the point of contact for other agencies to include the agency PSA Coordinator regarding PREA related matters. During the interview with the PSA Compliance Manager, he stated he had sufficient time and authority to oversee the facility's efforts to comply with its sexual abuse prevention and intervention policies and procedures. Although not listed on the organizational chart, the PSA Compliance Manager stated both PSA Compliance Managers currently report to the Jail Captain. When the vacant Lieutenant position is filled the PSA Compliance Managers will report to the Jail Lieutenant, who reports to the Jail Captain.

The facility complies with this standard.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Order C-251 Lockdowns, Head Counts, Safety Checks, and Security Inspections
Pre-Audit Questionnaire (PAQ)
Examples of security staffing rosters
Yuba County Jail Manual and post orders
Pipe reader printout showing security supervisor unannounced rounds
Facility schematic

(a) The YCJ has a design capacity of 428 detainees/inmates. Detainees remain at the facility for an average of 156 days. The facility employs (b)(security staff. Security staff work (b) (7)(E) shifts. Although a formal staffing plan was not submitted, the facility provided shift assignment rosters showing officer post assignments. The Captain stated there is a critical level staffing established for each shift. If there are not enough officers to meet the critical staffing requirement, officers are not relieved from their critical level post until a replacement has been found. To meet critical level staffing the facility utilizes reserve officers and overtime. Critical level staffing requires a same gender officer on the floor in the housing areas and in the control booth to oversee each pod.

The facility has (b)(video cameras installed throughout the facility to include common areas and housing units. Although cameras are not installed in the (b) (7)(E) the Auditor concluded appropriate staffing levels are being adhered to within these areas. All cameras are operational and record 24-hours per day. The video recordings are stored on the facility server for one year. The cameras are monitored in the control center by the control center officers. Shift sergeants also have the capability of monitoring cameras. Some cameras are equipped with pan, tilt, and zoom features. The video monitoring system was updated July 2019.

(b) The comprehensive supervision guidelines are outlined in the Yuba County Jail Manual and post orders. YCJ Order#C-251 requires security officers to make safety checks of detainees at least hourly and to document these checks on the Inmate Hourly Safety Check Sheet. Officers interviewed confirmed these checks are done on an irregular basis at least hourly. Detainees also confirmed that security officers are frequently checking the housing areas. The PSA Compliance Manager reported an annual review of the comprehensive supervision guidelines was completed in 2019 but the former Lieutenant had the annual review documentation and facility staff have been unable to locate the document. The Auditor asked to review the sexual abuse incident reviews, to determine if staff supervision was reviewed and if there were any recommendations, but the PSA Compliance Manager explained although the reviews were conducted and there were no recommendations, the incident reviews were not documented.

Does Not Meet (b): The facility could not provide the annual review of the comprehensive supervision guidelines. The facility must document the review of the comprehensive supervision guidelines annually. The facility must demonstrate compliance through an annual review of the supervision guidelines and provide a copy of the annual review for compliance review.

(c) During interviews, the Captain and the PSA Compliance Manager confirmed when determining adequate levels of detainee supervision and the need for additional video monitoring the facility considers generally accepted correctional and detention practices; judicial findings of inadequacies; the layout of the facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated sexual abuse incidents; recommendations of sexual abuse incident review reports and any other relevant factors, including but not limited to the length of time detainees spend in agency custody.

(d) YCJ Order #C-251 requires security supervisors from each shift to conduct and document unannounced security inspections to identify and deter staff sexual abuse and sexual harassment. These inspections are completed utilizing a patrol wand that is placed on data readers throughout the facility. The data reader sends information to the facility server where the data is stored. This policy also prohibits staff from alerting other staff about the unannounced rounds unless such announcement is related to the legitimate operational functions of the facility. The Captain stated he expected security supervisors to conduct frequent unannounced rounds each shift.

To verify security rounds were completed, the Auditor requested verification of security rounds for January 20, 2020. The PSA Compliance Manager stated there were no documented security rounds for this date and explained that Security Supervisors are required to complete unannounced security rounds with the pipe reader, (b) (7)(E) . There is no other verification of unannounced security rounds being conducted on a daily basis on each shift. The documentation only demonstrated unannounced rounds (b) (7)(E) through the pipe reader.

Does Not Meet (d): Weekly security checks do not meet the standard which requires frequent unannounced security rounds by Security Supervisors. Unannounced security inspections/rounds must be completed and documented daily on each shift, day and night. The facility must demonstrate compliance through documentation of unannounced security rounds by Security Supervisors over a two-week period demonstrating unannounced rounds conducted daily on each shift.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

Documentation Reviewed:

Memorandum dated January 8, 2020 from PSA Compliance Manager

This standard is not applicable. The facility does not house juveniles and family detainees. The facility provided a memorandum from the PSA Compliance Manager stating juveniles are not housed at the facility. The Pre-Audit Questionnaire (PAQ) also stated juveniles are not housed at the facility. This was further confirmed through interviews with security officers. Based on the evidence listed above, observations made during the site visit, and information gathered through interviews the Auditor was able to confirm juveniles are not housed at the facility.

§115.15 - Limits to cross-gender viewing and searches.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Exhibit 6 - Memorandum from the PSA Compliance Manager dated January 8, 2020
YCJ Order C-104 Inmate Sexual Abuse Prevention and Intervention
Exhibit 7 - PREA Resource Video information entitled Guidance in Cross-Gender and Transgender Pat-Searches
Exhibit 7 - Training attendance logs for staff participating in cross-gender and transgender pat searches training

(b, c, d, e, f) The facility does not allow cross-gender searches of any type (pat, strip, body cavity) as evidenced by the facility response to the PAQ and interviews with security staff and supervisors. Every security staff member interviewed confirmed that cross-gender searches of any type are not allowed. This was also confirmed through interviews with detainees. The presence of both male and female officers on each shift is considered critical staffing and the off-going shift will be held over until both male and female security staff are present on the shift. If a cross-gender search occurred, it must be documented on an incident report form and the Strip Search Authorization Log. There have been no incidents of cross-gender searches of any type during this audit period.

(g) YCJ Order C-104 states staff are not to observe detainees who are changing clothing or showering unless there is probable cause or other factors that warrant a strip search. Portable privacy screens are available in every housing unit to allow detainees to shower, change clothing, and perform bodily functions without being viewed by staff of the opposite gender. The Auditor viewed the cameras to determine if the cameras afforded privacy to detainees. The facility has placed blackout spots on the control center monitors in the shower and restroom areas to ensure detainees have privacy while performing bodily functions, bathing, and changing clothing. YCJ Order C-104 also states male personnel needing to enter the living area of the female detainees will announce their presence before entering and only if accompanied by a female staff member. During an emergency situation when a female staff member is not immediately available, a male deputy will notify one of the control rooms and/or the shift supervisor to monitor their movement on the jail's camera system. Only when a supervisor or deputy acknowledges they are monitoring his movement will the male deputy enter the female area without escort. Female deputies and non-sworn female personnel may enter the housing area of the male detainees after they have announced their presence. They will not enter the sleeping area of the male detainees unless escorted by a male deputy. Interviews with staff and detainees confirm that opposite gender staff rarely enter the detainee living areas. Interviews with detainees and the Auditor's observations during the facility tour confirm the female staff are not routinely announcing their presence when entering the male living areas.

Does Not Meet (g): The facility staff are not announcing their presence when entering an opposite gender housing unit. The facility policy and practice must require staff, when entering an area of the opposite gender, to announce their presence. The facility must demonstrate compliance

through an updated policy addressing the language of the standard and documented staff training on the policy change and the requirement of announcing upon entering a housing unit of the opposite gender. The facility must provide the updated policy and documentation of staff training on the updated policy for compliance review.

(h) This section of the standard is not applicable as the facility is not a Family Residential Facility.

(i) Interviews with security staff consistently revealed that the facility does not allow the search or physical examination of a detainee for the sole purpose of determining the detainee's genital characteristics. The Auditor interviewed the transgender detainee who confirmed staff have not searched him for the sole purpose of determining his gender. Medical staff report they are not consulted regarding the housing of transgender detainees.

(j) The facility trains staff in proper search techniques to include searches of cross-gender and transgender detainees. The facility utilizes the training video available through the PREA Resource Center entitled, Guidance in Cross-Gender and Transgender Pat Searches developed by the Moss Group. The facility provided documentation of staff attendance in the training. It is the practice of the facility, when searching a transgender detainee, that the searching officer's gender will be consistent with the detainee's genitalia. If a detainee's gender is unknown, it is determined through means other than a search, such as during conversations with the detainee, by reviewing medical records (if available), or, if necessary, learning such information as part of a broader medical examination conducted in private, by a medical practitioner. If the transgender has male genitalia and breast augmentation, a female officer will search the breast area and a male officer will search the rest of the body. Security staff interviews confirmed this practice. Security staff were consistently able to describe how to search a detainee in a professional, respectful manner and in the least restrictive manner possible.

Does Not Meet (j): It is not appropriate for a transgender or intersex detainee to be searched by both a male and female staff officer, with the male officer searching the parts of the body that are anatomically male and the female officer searching the parts of the body that are anatomically female. A case-by-case determination of the most appropriate staff member to conduct the search is necessary and should take into consideration the detainee's gender expression and the detainee's request for the gender of the staff member to conduct the search. The current practice also conflicts with the training directions provided in the facility's training curriculum (Moss Group, page 41). The facility must demonstrate compliance through documentation of further training to staff on how to conduct proper searches of transgender and intersex detainees as outlined in the training curriculum and ensure the practice is adhered to for compliance review.

§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 8 – Inmate Handbook titled To All Inmates of the Yuba County Jail (English, Spanish)
Exhibit 9 – ICE Zero Tolerance Posters with Reporting information
Exhibit 10 – ERO Language Services handout

(a, b) YCJ policy #901 states the facility ensures that detainees with LEP and/or disabilities have an equal opportunity to understand and benefit from efforts to prevent, detect, and respond to sexual abuse and sexual harassment. This includes, as appropriate, access to interpreter services through Language Line Services, staff interpreters and written materials in formats or through methods that provide effective communication to those with disabilities. The facility's policy language does not include procedures or directives related to accommodations for the disabled or LEP detainees, but the Auditor was able to verify the facility practice through interviews with the Captain, intake staff, detainees, and security staff. For detainees who are deaf or hearing impaired, the facility provides the ICE National Detainee Handbook and the facility's inmate/detainee handbook, to all detainees which outlines the facility rules. Staff explained the ICE National Detainee Handbook is available in 11 different languages other than English; Spanish, French, Haitian Creole, Punjabi, Bengali, Hindi, Arabic, Simplified Chinese, Portuguese, Vietnamese and Russian (the last which was not mentioned by the staff) and can be printed from the internet. The facility also has the ability to remotely access sign language interpreters if necessary. To date, the facility has not received any disabled detainees that require this accommodation. Security staff interviews revealed that detainees who are blind or who have limited vision have access to information about the facility's efforts to prevent, detect, and respond to sexual abuse by listening to the PREA video shown in booking and in the individual housing areas. Security staff reported they would read and explain the PREA information to detainees with limited reading or intellectual skills. The ICE National Detainee Handbook, the facility inmate/detainee handbook, and a PREA pamphlet are to be provided to detainees upon entrance to the facility. The detainees are also provided access to a PREA video in English or Spanish while in booking. Although intake staff stated these materials are provided to detainees upon entrance, the majority of the detainees interviewed stated they did not receive one or more of these handouts and did not watch the video. The Auditor requested verification that PREA information was provided to three LEP detainees. The facility was unable to provide verification that the selected detainees received PREA information at intake. The Auditor interviewed two detainees identified as visually impaired but both detainees were able to read portions of the ICE National Detainee Handbook to the Auditor. The detainees did not need accommodations to read and understand the PREA material, although both stated they had not received written materials or watched the PREA video at intake. Both detainees spoke Spanish and confirmed that interpretation services were provided through bilingual staff at the facility. The accommodations for disabled detainees include use of a Text Telephone (TTY) and sign language interpretation. Staff would also read material to the blind or low vision detainee. The PSA Compliance Manager stated for those detainees who have intellectual, psychiatric, or speech difficulties, the Alta California Regional Center will provide telephonic assistance to explain the PREA material and facility rules to the detainee. The Captain also confirmed that accommodations are provided to detainees with disabilities and to detainees who are LEP. The facility is under a consent decree regarding disabled inmates. The Auditor asked for a summary of the consent decree, but it was not provided to the Auditor.

Recommendation: The facility policy should be expanded to outline the procedures on how to provide effective communication for detainees that are LEP and/or disabled to provide staff written directives for the practices noted during the interviews.

(c) YCF policy #901 states the facility shall not rely on other detainees or prisoners for assistance except in limited circumstances where an extended delay in obtaining an interpreter could compromise the detainee's safety, the performance of first responders duties under this policy, or the investigation of a detainee's allegations of sexual abuse, harassment, or retaliation. The facility provides access to interpretive services through bilingual

staff and through Language Line Solutions. One investigation report indicated a security staff member provided interpretive services for the alleged victim. Interviews with security supervisors and randomly selected security staff confirm staff are aware that minors, alleged abusers, or detainees who have a significant relationship with the abuser are not to be used for interpretation but most staff responded they would not allow another detainee to interpret for an alleged victim even if requested by the victim.

Does Not Meet (c): The facility policy and practice does not allow the detainee to utilize another detainee for interpretation if requested and the agency determines that such interpretation is appropriate and consistent with DHS policy. The facility needs to allow the detainee to utilize another detainee for interpretation if requested and the agency determines that such interpretation is appropriate and consistent with DHS policy. Training needs to be conducted with staff of the practice to ensure compliance with the standard. The facility must demonstrate compliance through removing language from the policy that prohibits a detainee to utilize another detainee for interpretation if requested and the agency determines that such interpretation is appropriate and consistent with DHS policy and through training documentation that staff were trained on the policy change and practice. The facility needs to provide an updated policy and documentation of staff training on the updated policy for compliance review.

Recommendation**:** The facility should expand the policy to address the standard language and provide direction to staff if a detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Office of Personnel Management Policy 5 CFR 731
Executive Order (EO) 10450 Security Requirements for Government Employment
ICE Directive 6-7.0 ICE Personnel Security and Suitability Program
ICE Directive 6.8.0 ICE Suitability Screening Requirements for Contractor Personnel

(a) Agency policy 5 CFR 731 outlines the agency requirements for background investigations of employees. This policy defines the criteria for making suitability determinations. The criteria includes the misconduct or negligence in employment and criminal or dishonest conduct. Executive Order 10450 entitled Security Requirements for Government Employees defines any criminal, infamous, dishonest, immoral, or notoriously disgraceful conduct, habitual use of intoxicants to excess, drug addiction, and sexual perversion as reasons for denial of employment. The background investigation includes verification of employment, education, residence history, and personal references. Investigators conduct an in-person interview with previous employers and process fingerprints for review of the applicant's criminal history. The Auditor received verification of background investigations for the two federal employees assigned to the facility from the ICE Personnel Security Unit. The Auditor was referred to the Captain to review information contained in facility personnel files. The Auditor was not allowed access to personnel files, however, the Captain stated he would verify the information needed from the files. The Auditor spoke with the Captain following the audit and requested information from personnel files for five staff members, two contractors, and one volunteer. The Captain provided information for the five staff members but to date the Auditor has not received background check verification for the volunteer or two contract employees. The Captain confirmed that each employee had received a complete background check to include contact with all previous employers prior to hire and completed the initial PREA training prior to employment.

The Captain confirmed that individuals who have engaged in sexual abuse in a prison jail, holding facility, confinement facility, juvenile facility, or other institutions would not be hired. California law prohibits the disclosure of this information without a signed consent from the applicant. The Captain confirmed that individuals would not be accepted if they refused to allow the investigators to speak with former employers. He also confirmed individuals would not be hired if they had been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt, or implied threats of force or coercion or if the victim did not consent or was unable to consent or refuse or if the individual had been civilly or administratively adjudicated to have engaged in these activities.

(b) The facility did not provide verification that employee applicants are asked about previous misconduct on written employment applications, or interviews for hiring or promotions. The Captain stated applicants are asked directly and on written applications for hire and promotion whether they have a history of sexual abuse, however, no documentation was provided that current employees were asked on written self-evaluations or interviews as part of the review of current employees. The employee signs acknowledging their continuing affirmative duty to disclose misconduct at the time they complete the initial PREA training. Of the five personnel files reviewed, the Captain confirmed each of the selected employees signed acknowledging their continuing affirmative duty to disclose misconduct.

Does Not Meet (b): The facility could not provide documentation that applicants are asked about previous misconduct on employment applications and/or promotion applications and on self-evaluations of current staff. The facility must demonstrate compliance through developing a process and document that employees are asked about misconduct described in provision (b) of the standard and current employees are asked during the promotional process and as part of written self-evaluations. The facility needs to provide examples of five employee files of new hire and one promotional staff file for compliance review in which employees were asked about sexual abuse during the promotional process and as part of written self-evaluations.

(c, d) The Human Resource staff were unavailable for an interview, but the Captain explained the background investigation process for employees, contractors, and volunteers, which included a thorough background investigation which includes in-person interviews with prior institutional employers. He explained that once the employee, volunteer, or contractor is entered into their Human Resource (HR) database, the facility administration will receive formal notification any time the individual is arrested and/or charged with any in-state violations. The Captain confirmed that each of the randomly selected employees received a completed background check prior to hire. The facility does not conduct a separate criminal background check every five years.

Does Not Meet (c): The facility could not provide documentation that initial background checks were completed on new employees who may have contact with detainees. The facility does not complete a background check every five years for facility staff who have contact with detainees. The facility must demonstrate compliance through development of a process for conducting and documenting the initial background checks on new employees and updated background checks every five years for employees who have contact with detainees. The facility needs to provide the process

developed for conducting five-year background checks on all employees that have conduct with detainees and initial backgrounds on all new employees. To demonstrate compliance, the facility needs to submit five employees initial background and their five-year background checks.

Does Not Meet (d): The facility could not provide documentation that initial background checks were completed on volunteers and contractors who may have contact with detainees. The facility needs to provide the process developed for conducting initial backgrounds on volunteers and contracts who may have contact with detainees. To demonstrate compliance, the facility needs to submit five contractors and five volunteer background checks and the process developed to ensure the background checks are completed.

(e) EO 10450 states any deliberate misrepresentations, falsifications, or omissions of material facts are grounds for refusing employment. The Captain confirmed that any of the aforementioned would eliminate the individual from hire.

(f) The Captain explained California law prohibits the release of employee information without a signed authorization from the previous or current employee. He explained the facility would not hire someone who refused to sign authorizing the release of information from previous employers.

§115.18 - Upgrades to facilities and technologies.

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

Documentation Reviewed:

Exhibit 11 – Memorandum to Auditor concerning facility and technology upgrades

(a) The Captain confirmed that he considers the effect of the design, acquisition, expansion, or modification of the facility if acquiring a new facility or planning any substantial expansion or modification of the facility. The facility expanded the shower area in the R-dorm and installed a privacy curtain to afford detainees privacy while showering. The renovation of this shower area does not constitute a substantial expansion or modification to the facility, so this section of the standard is not applicable.

(b) The Captain stated the facility updated the video monitoring system with the addition of [redacted] video monitoring cameras. These cameras now provide video monitoring in areas that did not previously have video recording capabilities and in areas to eliminate blind spots. Observations during the facility tour confirmed that video surveillance is present in all housing areas allowing for continual monitoring of the housing areas. There were no meeting notes, recommendations from incident reviews, or other methods to confirm the facility considered how the technology could enhance its ability to protect detainees from sexual abuse. The Captain confirmed this was considered when determining where to place the additional cameras.

Recommendation: The facility should, when designing or acquiring any new facility and in the planning any substantial expansion or modifications of the existing facility including when installing or updating a video monitoring system, electronic surveillance, or other monitoring technology, maintain written documentation that the facility considered how the such changes may enhance the facility's ability to protect detainees from sexual abuse.

The facility complies with this standard.

§115.21 - Evidence protocols and forensic medical examinations.

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

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
ICE PREA Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention
Exhibit 12 Email from Marina Cavanaugh re: MOU Casa de Esperanza
Exhibit 13 MOU Ridout Regional Hospital
Exhibit 14 Memo – Yuba County sheriff investigates criminal incidents

(a) According to the PAQ, the PSA Compliance Manager, and the Captain, the Yuba County Sheriff's Office conducts investigations of PREA-related incidents for detainees that may rise to the level of criminal prosecution. Administrative investigations are completed by the PSA Compliance Manager, who is the only trained facility investigator at this time. Policy #901 defines the uniform evidence protocol utilized while conducting investigations and procedures for uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative or criminal prosecutions. PREA allegations may also be investigated through OPR or DHS OIG. The agency policy 11062.2 outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection is performed by a partnering federal, state, or local law enforcement agency. OPR coordinates with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS OIG, OPR, or local law enforcement agency, the case is referred to ERO for assignment and completion of an administrative investigation. Interviews with both the Captain and PSA Compliance Manager confirmed the protocols for investigation outlined in Policy #901 were approved by ICE. The facility does not house juvenile detainees, so this portion of the standard is not applicable.

(b, d) The facility utilizes available community resources to provide crisis intervention and counseling and advocacy services for alleged victims. The facility provided an email from the Program Director for Casa de Esperanza, in which she stated the Memorandum of Understanding (MOU) between YCJ and Casa de Esperanza had been forwarded to YCJ. The MOU had not been finalized at the time of the audit. On April 9, 2020, the Auditor spoke with the Deputy Director for Casa de Esperanza. The Deputy Director outlined the services provided to the facility, if requested by the detainee. These services include victim advocacy services, which will provide emotional support, crisis intervention, information, and referrals for detainees during medical exams and investigatory interviews and in-person counseling at the facility. She explained that their facility is working with YCJ to provide direct, confidential hotline services for detainees in the future. The Prosecutor's Office also has victim advocates available to support victims during the legal process.

(c) The facility utilizes available community resources to provide forensic exams. On April 9, 2020, the Auditor spoke with a Registered Nurse in the emergency department of Ridout Regional Medical Center. She explained that a Sexual Assault Nurse Examiner (SANE) is on-call for the emergency room and will conduct the forensic exams for alleged victims of sexual assault from the facility. She stated SANEs are not always available and in this circumstance the alleged victim would be taken to the Bear Clinic in Sacramento, California for a forensic exam by a SANE. She also confirmed that detainees are not charged for the services provided. The facility pays bills for any services provided. The facility provided a copy of the MOU between the facility and Ridsout Regional Medical Center.

(e) Detectives with the Yuba County Sheriff's Office conduct investigations into any incident of sexual assault that may rise to the level of potential criminal prosecution. Because the facility is part of the Yuba County Sheriff's Office, the facility administration maintains good lines of communication with the investigating detectives and the Auditor was able to confirm the Sheriff's Office follows the requirements of 115.21 (a) through (d) through the interview with the Captain and the PSA Compliance Manager.

The facility complies with this standard.

§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Order C-104 Inmate Sexual Abuse Prevention and Intervention
PAQ

(a, d) Policy #901 states the facility will promptly, thoroughly, and objectively investigate all allegations, including third-party and anonymous reports, of sexual abuse or sexual harassment. Staff receiving an allegation of sexual abuse or sexual harassment are required to immediately report this information to the Shift Supervisor. The Shift Supervisor shall ensure the victim is provided medical assistance if necessary. The Shift Supervisor separates the alleged victim from the suspect. A victim who is subjected to sexual abuse or assault is not returned to general population until a reclassification is completed taking into account any increased vulnerability risk due to the sexual assault or sexual abuse. The Shift Supervisor provides notification to specialty investigators, crime scene investigators, and ICE authorities to include the facility Detention Services Compliance Officer (DSCO), SDDO, and the Assistant Field Office Director (AFOD). The AFOD is responsible for notifying the FOD. If the investigation reveals probable cause for criminal prosecution, the case is referred to the District Attorney. The PSA Compliance Manager and the Captain confirmed the investigation process, which includes notification to the appropriate ICE officials, as well as, the Sheriff. There were four PREA allegations during the audit period. The facility conducted administrative investigations on six reported allegations and two were determined not PREA related by the agency. OPR conducted investigations on the four PREA-related allegations, with one case still open. The PAQ states the facility completed an investigation into each allegation and five allegations were referred to the appropriate investigative authority. Two of the cases were investigated by outside agencies.

(b) Policy #901 outlines the responsibilities of the facility investigators and other investigative agencies. All written reports of investigations are held for as long as the alleged abuser is held or employed plus five years. All other data collected pursuant to this policy are securely retained for 10 years. Records are secured in the Sergeant's Office and are only accessible to the PSA Compliance Managers. One of the PSA Compliance Managers is the only trained investigator for the facility. The PSA Compliance Manager and the Captain confirmed the records are stored for 10 years.

(c) The Auditor reviewed the facility's website and verified the facility protocols are posted for the public. The website address is: https://sheriff.co.yuba.ca.us. The ICE website, www.ice.gov/prea provides a PREA overview, PREA policies, reporting options to include addresses and phone numbers, Sexual Abuse and Assault Prevention and Intervention (SAAPI) standards, ICE National Detainee Handbook, ICE PREA poster, and ICE PREA pamphlet.

(e, f) Order C-104 requires all incidents of sexual abuse are promptly reported to the facility's DSCO, the facility's SDDO of detention and the (AFOD). It is a duty of the SDDO or AFOD to contact the FOD in such circumstances. If the incident is potentially criminal, involving another detainee or staff, contractor, or volunteer, the Yuba County Sheriff's Office will conduct a criminal investigation. The PSA Compliance Manager and the Captain confirmed that all notifications are made in accordance with the facility policy. The Auditor reviewed the investigation files for three PREA allegations. The files were reviewed after normal working hours and facility staff were not available at the time for questions. Of the three files reviewed, two files did not indicate whether the JIC, FOD, or AFOD was notified of the incident. Through the review of the Investigation Spreadsheet and the reconciliation of investigation files, the Auditor confirmed all of the allegations were reported to JIC with four forwarded to DHS OPR for investigation.

The Auditor interviewed the PSA Compliance Manager/Investigator again to verify compliance with this standard. The PSA Compliance Manager/Investigator was able to confirm that all allegations were promptly investigated and reported to the appropriate authorities. The PSA Compliance Manager/Investigator has developed a checklist for investigation files which will ensure each element of this standard is addressed.

Recommendation**:** The facility could not demonstrate that all required notifications were made in accordance with the standard and facility policy, however, the Auditor determined notifications were made since the allegations were listed on the PREA allegation spreadsheet created by ERAU. Any allegation of sexual abuse must be reported promptly to the JIC, OPR or DHS OIG, as well as, the appropriate ICE Field Office, and if it is potentially criminal, referred to the appropriate law enforcement agency having jurisdiction. The facility must maintain documentation of an incident notification promptly made to the JIC, OPR, or the DHS OIG, as well as, the appropriate ICE Field Office, and if it is potentially criminal, referral to an appropriate law enforcement agency having jurisdiction.

§115.31 - Staff training.

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

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
PREA Training Power Point for Employees

(a) YCJ Policy #901 states all employees, contractors, and volunteers who may have contact with detainees or prisoners, shall receive facility approved training on the prevention and detection of sexual abuse and sexual harassment within this facility. The Training Manager shall be responsible for developing and administering this training as appropriate, covering at a minimum: the facility's zero tolerance policy; the right of prisoners, detainees and staff members to be free from sexual abuse and sexual harassment and from retaliation for reporting sexual abuse or harassment; the dynamics of sexual abuse and harassment in confinement settings, including which detainees prisoners are most vulnerable; detecting and response to signs of threatened and actual abuse; communicating effectively and professionally with all detainees and prisoners; and compliance with relevant laws related to mandatory reporting of sexual abuse to outside authorities. The PSA Compliance Managers provides the training to employees. The training PREA power point was provided after the on-site visit. The training did not address how to avoid inappropriate relationships, reporting procedures, and limits to reporting of information on a "need to know" basis. The PSA Compliance Manager explained that this was not the only PREA training staff receive but the additional training curriculum was not provided to the Auditor. Overall security staff interviewed were aware of each element of this standard requirement which indicate to the Auditor the staff was provided additional training which included each element of the standard requirement.

Recommendation**:** The facility should expand the policy and training curriculum to include the elements how to avoid inappropriate relationships, reporting procedures, and the limits of the reporting of information on a "need to know" basis. It was apparent through staff interviews the information has been provided but is not reflected in the policy or training curriculum provided.

(b, c) The Auditor requested PREA training verification for five employees. The Captain provided verification for each of the selected employees and confirmed each employee had received PREA training within one year of 2014. Each employee had completed the initial PREA training prior to employment. This training was provided by the facility's PREA incorporation date of September 12, 2018 and prior to assignment in the facility.

The facility complies with this standard.

§115.32 - Other training.

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

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 18 – Memorandum referring Auditor to the Contractor/Volunteer Binder to review sign-in sheets
Training Sign-In Sheets
Wellpath Policy HCD-110-F-06 Response to Sexual Abuse – Yuba CA

(a, b, c) YCJ Policy #901 states that all the facility ensures that all volunteers and contractors who have contact with detainees shall receive approved training on the prevention and detection of sexual abuse and sexual harassment within the facility. The Auditor interviewed two contract healthcare staff and one volunteer, who verified they had received the PREA training. This was also verified through training documentation for the contractors and volunteer provided by the facility.

Each individual interviewed confirmed that they attended the training and each individual was knowledgeable about the facility's PREA policies and their responsibilities in this regard. The training provided to volunteers and contract employees is based on the services they provide and the level of contact they have with detainees. Wellpath provides additional training to healthcare staff, which are facility contract employees. This training includes, but is not limited to the following topics: delineation of health care staff's role in the facility's sexual abuse policy and procedure; role-specific training in the detection and assessment of sexual abuse; effective and professional response to victims and abusers; preservation of physical evidence; how to elicit, receive, and forward reports of allegations or suspicions of sexual abuse; confidentiality requirements; and maintain documentation of training content and attendance. The facility provided verification that these individuals attended the PREA training.

The facility complies with this standard.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Exhibit 8 – Inmate/Detainee handbook (English and Spanish)
Exhibit 9 – ICE Zero-Tolerance Posters (English and Spanish)
Exhibit 19 – Yuba County Jail PREA/SAAPI Pamphlet (English and Spanish)
Exhibit 21 – ICE Sexual Abuse Awareness Information Pamphlet (English and Spanish)
Exhibit 22 – ICE National Detainee Handbook (English and Spanish)

(a) Intake staff explained new detainees receive the ICE Sexual Abuse Awareness Information pamphlet, ICE National Detainee Handbook, the facility's inmate/detainee handbook and view the PREA video while in the intake area. The facility's handbook is available in English and Spanish and the ICE National Detainee Handbook is available in 11 different languages other than English. The PREA pamphlet explains the facility's zero-tolerance policy and provides several methods of reporting sexual abuse or assault. The facility is also to provide each detainee with the facility's inmate/detainee handbook and the ICE National Detainee Handbook in English, Spanish, or a language the detainee understands. The inmate/detainee handbook explains the zero-tolerance policy and options for reporting sexual abuse/assault to the facility or ICE. This handbook also explains that counseling, sexually transmitted disease (STD) testing, and medical treatment will be provided to victims. In addition to the subjects listed in the inmate/detainee

handbook, the ICE National Detainee Handbook provides information regarding retaliation and self-protection. Each of the required orientation education topics for this section are provided to the detainee. Of the 20 random detainees interviewed, 12 detainees reported they did not receive the ICE National Detainee Handbook, 11 detainees reported they did not received the facility's inmate/detainee handbook, 19 detainees reported they did not view the PREA video, and 19 detainees reported they did not receive or could not recall receiving the PREA pamphlet. Some classification officers note in the electronic detainee record that the ICE National Detainee Handbook and/or inmate/detainee handbook was provided to the detainee, but this is not consistently documented.

(b) The facility has the means to provide PREA information to detainees who are visually impaired, deaf, LEP, or for those detainees with developmental or psychiatric disabilities, or detainees with limited reading skills as detailed in standard 115.16. The Auditor requested verification that PREA information was provided to three LEP detainees. The facility was unable to provide verification that the selected detainees received PREA information at intake. As noted above, the majority of detainees interviewed did not receive the ICE National Detainee Handbook, the facility's inmate/detainee handbook, the PREA pamphlet, or watch the PREA video.

Does Not Meet (a)(b): The facility does not consistently provide or document that educational material is provided to detainees while in intake. Documentation of providing the educational material, which would enable the Auditor to confirm that detainees did in fact receive the materials when stating otherwise during interview, was inconsistent and; therefore, did not allow the Auditor to confirm compliance through those means. The detainee education process must address each of the elements outlined in provision (a) of the standard. The facility must be able to demonstrate PREA educational information is provided consistently to all incoming detainees through documentation including LEP detainees and detainees with disabilities. The facility must demonstrate compliance through at least ten detainee files, with at least being five detainees that are LEP or disabled, over a two-month period documenting that the orientation materials are provided to detainees informing them of the all elements listed in this standard provision, and documentation of staff refresher training on providing effective communication of PREA educational information to LEP detainees and detainees with disabilities to provide the consistency of the orientation process for compliance review.

Recommendation: The facility policy should be expanded to outline the procedures on how to provide effective communication for detainees that are LEP and/or disabled to provide staff written directives for the practices noted during the interviews.

(c) The PSA Compliance Manager provided a newly designed Booking Check Sheet as verification of a detainee's participation in the intake process orientation. The intake officer and the detainee sign the Booking Check Sheet. The PSA Compliance Manager also explained the intake officer enters the information into the facility's database if the detainee was provided a facility inmate/detainee Handbook and an ICE National Detainee Handbook.

Does Not Meet (c): The facility was asked to provide Booking Check Sheets for eight detainees. The facility was unable to provide this verification as the requirement to complete the Booking Check Sheet was only recently implemented. The Booking Check Sheet does not document how the information was provided to the detainee i.e. through an interpreter, sign language, or another method if disabled. The facility must demonstrate compliance through the use of the Booking Check Sheet, or another method/documentation, to verify a consistent orientation process. The Booking Check Sheet should be expanded or another method established to document how the information is provided to the detainee including LEP and disabled detainees. Ten detainee files , with at least five being LEP or disabled, containing the Booking Sheet and documentation of the orientation process over a two-month period must be provided for compliance review.

(d) During the facility tour, the Auditor observed PREA posters affixed to the window of each housing area. This poster provides the DHS-prescribed sexual assault awareness notice, the name of the PSA Compliance Manager, and contact information for the National Sexual Abuse Hotline. The Casa de Esperanza is a local organization that provides support services to victims of sexual abuse. These services include providing a victim advocate during the medical exam and the investigation process and supportive in-person counseling services. The name of this organization was not provided on the posters. The standard requires the name of the local organization(s) that can assist detainees who have been victims of sexual abuse be posted in all housing units. It was shared with the Auditor that the facility is working with Casa de Esperanza to provide a hotline for detainees.

Does Not Meet (d): The postings in the housing areas do not provide the name of the local organization that can assist detainees who have been victims of sexual abuse. The facility must demonstrate compliance through developing signage to provide the local organization information to the detainees and provide a copy of the new posting for compliance review.

(e) Intake staff explained that the DHS-prescribed Sexual Assault and Awareness Information pamphlet, is provided to detainees at intake. Of the 20 detainees interviewed, 19 reported they did not receive or could not recall receiving the pamphlet.

Does Not Meet (e): The facility does not make available the DHS prescribed Sexual Assault Awareness Information pamphlet. The facility must demonstrate compliance through a consistent practice of making available the DHS prescribed Sexual Assault and Awareness Information pamphlet to detainees. The facility must provide the method this is accomplished with, documentation for ten detainees over a month period, and documentation of staff refresher training of their duty to distribute and make available the pamphlet for compliance review.

(f) Information about reporting sexual abuse or sexual harassment to the facility and to DHS or ICE Headquarters is provided in the ICE National Detainee Handbook but the Auditor was unable to verify this handbook is provided to detainees at intake or at any other time during detention.

Does Not Meet (f): The facility does not provide detainees with the ICE National Detainee Handbook at intake as directed by policy. The facility must demonstrate compliance through the consistent practice of making available the ICE National Detainee Handbook to all detainees at intake per policy and or in another method for standard compliance. The facility must document the handbook is provided to detainees through the same ten detainee files requested above for compliance review. The facility must also provide refresher training to staff of their duty to distribute and/or make available the ICE National Detainee Handbook in other methods. The facility must provide ten detainee files (same 10 detainee files noted in previous provision) demonstrating providing the ICE National Detainee Handbook at intake or in another method to the detainee and documentation of the staff training must be provided for compliance review.

§115.34 - Specialized training: Investigations.

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

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Agency Training Entitled ICE OPR Investigating Incidents of Sexual Abuse and Assault
National Institute of Corrections (NIC)Training Certificate Entitled Investigating Sexual Abuse in a Confinement Setting

(a, b) YCJ Policy #901 requires investigators assigned to sexual abuse investigations shall also receive training in conducting such investigations in confinement settings. Training shall include techniques for interviewing sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; criteria and evidence required to substantiate a case for administrative action or prosecution referral. There is one trained facility investigator which is one of the PSA Compliance Managers. The facility investigator completed the National Institute of Corrections (NIC) three-hour on-line training course entitled PREA: Investigating Sexual Abuse in a Confinement Setting. The Auditor reviewed the NIC training course and found the curriculum appropriate to meet the elements of the standard. The training includes cross-agency coordination. The Auditor verified the training certificate and other training related documentation is maintained in the facility's training file. The Training Supervisor verified that investigators must complete the NIC investigation training. He added that in the future, all security staff will be required to complete this three-hour course. The PSA Compliance Manager was interviewed concerning his role as the facility investigator. He was knowledgeable about basic investigation procedures and was able to explain the investigation process, the role of external investigators, evidence collection, and other pertinent information regarding investigations. The other PSA Compliance Manager will complete this training soon and assume the role of the second facility investigator.

The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement.

The facility complies with this standard.

§115.35 - Specialized training: Medical and mental health care.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Wellpath Policy HCD-110-F-06 Response to Sexual Abuse – Yuba CA
ICE Health Services Corps (IHSC) training entitled, Sexual Assault and Prevention – PREA
ICE IHSC training entitled, Sexual Abuse Assault Training
Memorandum – No IHSC/USPHS employed at the facility

(a, b) The facility has a contract with Wellpath to provide medical and mental health services to detainees. Healthcare staff are not employed by DHS or the agency. This portion of the standard is not applicable.

(c) Wellpath's policy HCD-110-F-06 states upon hire, and annually thereafter, Wellpath employees receive training and instruction that relates to the prevention, detection, response, and investigation of staff-on-patient and patient-on-patient sexual abuse, as well as how to preserve physical evidence of sexual abuse. This training is an adjunct to the initial and on-going training provided by the facility. Training includes but is not limited to delineation of health care staff's role in the facility's sexual abuse policy and procedure; role specific training in the detection and assessment of sexual abuse; effective and professional response to victims and abusers; preservation of physical evidence; how to elicit, receive, and forward reports of allegations or suspicions of sexual abuse; confidentiality requirements; documentation of training content and attendance will be maintained. The facility provided two health care staff training curriculums, the facility's and Wellpath's. Between the two training curriculums, each element listed above is included. Interviews with mental health and medical staff confirmed health care staff were knowledgeable about their role within the facility as it relates to PREA related matters. Verification of the specialized health care training, as noted in Wellpath Policy HCD-110-F-06 and interviews, was requested following the site visit but not received by the Auditor. The Captain stated the facility provided ERO the facility's policies and procedures, including the policies and procedures ensuring medical staff is trained in procedures for examining and treating victims of sexual abuse during the last ERO inspection (November 13–15, 2019) for review and has not received documentation indicating the review has been completed.

Does Not Meet (c): The Auditor requested verification of specialized training for health care staff. The facility must demonstrate compliance with documentation of medical and mental health specialized training for five healthcare staff.

Recommendation: The agency must complete the policy and procedure review and approve the Wellpath Policy HCD-110-F-06 per the standard language.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Exhibit 25 – Initial Assessment
Exhibit 26 – Computer printout indicating a classification review

Initial Intake Custody Assessment Scales for eight detainees
Intake Custody Assessment Scale form for five detainees with risk factors

(a, b, c, d) The Intake Supervisor explained that the intake staff screen all in-coming detainees for risk of sexual victimization and abusiveness. This is completed as part of the custody assessment via the Intake Custody Assessment Scale. The formal custody assessment provides a custody score and determines a detainee's custody classification and housing placement. The risk assessment portion of the form lists risk factors and check boxes. The following items are listed: medical problem; psychological impairment; mental deficiency; involved in sexual abuse as victim or subject; and LGBTI. A narrative section is provided for criminal history and subject interview. The form does not indicate a section for entering the detainee's assessment of their safety. The custody score can be overridden, if warranted, due to the detainee's risk of victimization or abusiveness. The Auditor asked if classification officers are provided training specific to assessing risk factors for sexual victimization and abusiveness. A classification officer explained there is a classification course all classification officers are required to attend but it does not address how to assess these risk factors when classifying detainees. The facility policies refer to detainees being "at risk" or "high risk" for sexual abuse or sexual abusiveness. If the intention of the risk assessment is to define risk levels according to seriousness, this should be defined to the staff responsible for determining a detainee's risk level. Classification officers are assigned to each shift and are assigned a specific detainee caseload to follow throughout the detainee's holding. The detainees are kept separate from the general population until the intake process is complete. After the intake process is complete, the initial classification and housing assignment based on the custody assessment is determined. According to the Intake Supervisor and random interviews with detainees, this process does not exceed 12 hours.

The Auditor provided the names of eight detainees and requested completed intake forms including the new Booking Check Sheet the facility implemented. The facility was unable to produce documentation of the detainees being screened for risk of sexual victimization and abusiveness as the detainees were admitted prior to implementing the use of the new Booking Check Sheet form. Upon review of the new Booking Check Sheet, the new form does not address the risk screening elements required. The Booking Check Sheet includes documentation of PREA education not risk screening. Furthermore, the Intake Custody Assessment Scale screens for custody security level, not for risk of sexual victimization and abusiveness. The Auditor requested five additional files that demonstrated forms showing the review of risk factors. Four of the five detainees had no other risk factors noted on the Intake Custody Assessment Scale or the Booking Sheet.

Does Not Meet (c)(d): The facility does not assess the detainees at intake on all elements of the provision (c). The Intake Custody Assessment Scale form is a security assessment form and does not address the required information to assess the detainee's risk of sexual victimization or abusiveness, and the new Booking Check Sheet does not address all elements required in the risk screening. The facility must demonstrate compliance through documentation that all the required information in provisions (c) and (d) are addressed in the intake assessment. The facility can update the form to address the assessment information that is required or by another method that captures the required information. The facility needs to provide the documented information for the same ten detainees files requested in 115.33 and documentation of staff training of the process to capture all the elements of the provision for compliance review.

(e) According to classification staff, classification reviews are conducted monthly. The classification officer explained the review process includes an electronic review of incident reports and disciplinary infractions information maintained in the jail record data base. The classification officer stated the narrative portion of PREA incident reports are not available for review by classification officers, as this information is restricted, but the lack of information should signal to the classification officer that a PREA related incident may have occurred. The PSA Compliance Manager explained if new information is received that would affect a detainee's risk factor, the information is passed on to the assigned classification officer to be considered at the next review.

Does Not Meet (e): The current process is not adequate to reassess a detainee's risk of victimization or abusiveness. The facility must demonstrate compliance by allowing the classification officer to review all relevant facility information, which would include the PREA incident reports that classifications officers are currently restricted from viewing, to determine if any factors have changed that might increase or decrease a detainee's risk of sexual victimization or abusiveness or institute a process to allow an individual the facility deems can have access to the information to handle the reassessments. The facility needs to provide the documented reassessments for the same ten detainees files requested in 115.33 (if possible or the initial and reassessment for other detainees), documentation of the new process for allowing staff to view facility information for the reassessment process, and documentation of staff training of the process to capture all the elements of the provision for compliance review.

Recommendation: The facility should as part of the reassessment process conduct interviews with the detainees to obtain direct information from the detainee that may not be included in all relevant facility information, to include PREA incident reports that classification officers are currently restricted from viewing.

(f, g) The Intake/Classification Supervisor confirmed detainees would not be disciplined for refusing to answer questions related to a disability, self-identification as LGBTQI or having previously experienced sexual victimization, or for not sharing concerns about their safety. The facility has implemented appropriate controls to prevent the dissemination of sensitive information gathered through responses to intake assessment questions. This is accomplished through controlled access to detainee records and restricted access to information stored on the facility's computer main frame.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Initial Intake Custody Assessment forms and Reassessments for five detainees with risk factors
Exhibit 27 – Memorandum – No transgender detainees in custody

(a) Detainees receive a custody classification during the intake process, utilizing the Intake Custody Assessment Scale form. This score determines the detainee's housing placement. Information regarding risk factors for victimization or abusiveness may increase or decrease the custody score, thus affecting the housing placement. Detainees are not given work assignments and each housing unit goes to recreation as a unit. The Auditor requested five completed forms showing where risk factors influenced a detainee's housing assignment. Of the five detainee examples provided, each was placed in protective custody due to their crime. Four of the five detainees had no other risk factors noted. The Auditor acknowledges that a detainee's crime may be the sole determining factor for custody decisions, however, this is typically not the case when assessing risk of sexual abusiveness or

victimization. This is usually determined by more than one risk factor but four of the five detainees had no other risk factors checked. From the information provided and interviews with staff, the Auditor was unable to confirm whether risk factors for sexual victimization or abusiveness influence housing decisions.

Does Not Meet (a): The facility is not making housing placements based on the risk of sexual victimization or abusiveness that ensures the safety of each detainee. The Intake Custody Assessment Scale form is a security classification form and does not address information to make informed determinations for the risk of victimization or abusiveness that is to be utilized to make individualized determinations to ensure the safety of each detainee. The facility must demonstrate compliance when determining housing and other activities/assignments that information from a risk assessment that includes all information required under 115.41 (c) and (d) are considered. The facility must provide housing placement decisions that document the consideration of all the information required under 115.41 (c) and (d) with the ten detainee files requested in standard 115.33 for compliance review.

(b) The facility provided a memorandum stating there have been no transgender detainees at the facility for the audit period; however, the PAQ stated there had been two transgender detainees. At the time of the site visit, one transgender detainee was housed at the facility. This detainee had been assigned to general population but was later placed on protective custody due to behavior and management problems caused by the detainee. This detainee assignment to segregation is reassessed monthly by the assigned classification officer.

The Classification Supervisor stated a detainee's genitalia determines housing placement. He explained that a detainee with breast augmentation and a penis would automatically be placed in protective custody. Both classification officers stated the health and safety of the detainee and the detainee's self-identification is considered when making housing placement for transgender detainees. The Health Services Administrator (HSA), stated medical is not consulted regarding transgender detainees. She explained the classification department determines housing. The transgender detainee felt the placement in protective custody was unfair and stated he is being harassed by other detainees. He stated he has expressed these concerns to the mental health staff. The Auditor discussed these concerns with security staff who were aware of the detainee's complaints. Security staff explained they are continually monitoring the cell area to ensure the detainee is not harassed.

Does Not Meet (b): The facility is making placement decisions based solely on the physical anatomy of the detainee and is not consulting with medical or mental health on the assessment or placement. The facility must demonstrate compliance by developing a process to make housing decisions that comply with the standard language which includes not basing the housing placement on the physical anatomy of the detainee. The facility must include in the process that medical and/or mental health staff is consulted as part of the assessment process. The facility must provide a process for housing determination for transgender detainees that meets the standard language and includes a consultation with medical and mental health professionals, as well as, two housing determinations of transgender detainees (if available during the CAP process) for compliance review.

(c) All showers in the housing areas are individual stalls that afford privacy while showering and changing clothes. The toilet areas also have privacy screens. The transgender detainee confirmed he is provided privacy when showering, performing bodily functions, and changing clothes.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Manual Order C-153 – Assignment to Administrative Segregation
Exhibit 28 – Memorandum stating no detainees placed on administration segregation

(a, b) The facility provided a memorandum stating there have been no detainees placed in administrative segregation for a PREA related incident for the audit year. Order #C-153 establishes the criteria and procedures for assigning detainees to administrative segregation. This order requires the classification officer to submit a report to the Classification Supervisor detailing the facts and circumstances that led to the assignment to administrative segregation. The Captain confirmed that the facility considers placement in other housing areas where the detainee would be safe, or the facility will consider a transfer to protect the detainee. The PSA Compliance Manager was unsure if these written procedures were developed in consultation with the FOD.

Recommendation: The procedures are to be developed in consultation with FOD. The facility needs to consult and review the administrative segregation procedures with the FOD and document the process.

(b, c) This order further requires detainees at high risk for sexual victimization shall not be placed in segregated housing unless an assessment of all available alternatives have been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If this assessment cannot be made immediately, the detainee may be held in involuntary housing for less than 24 hours while making the assessment. This assignment is made only until an alternative means of separation from likely abusers can be arranged. Such assignments shall not, ordinarily, exceed 30 days. Detainees placed in administrative segregation for these reasons, have access to programs, activities, visitation, and counsel to the extent possible. If the detainee is restricted from access to programs, privileges, or education the facility documents the opportunities that have been limited; the duration of the limitation; the reasons for such limitations.

(d, e) This order requires the Classification Supervisor or appointed classification officer to conduct a review within 72 hours of the detainee's placement in administrative segregation to determine if continued placement in administrative segregation is still warranted. The standard requires a review, by a supervisory staff member, within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. Although the Classification Supervisor is considered supervisory staff, a classification officer is not considered supervisory staff. The procedures also do not include requirements to notify the FOD no later than 72 hours after the initial placement of a detainee into administrative segregation on the basis of a vulnerability to sexual abuse or assault.

Does Not Meet (d): This order does not require a supervisory staff member to conduct, at a minimum, an identical review after the detainee has spent 7 days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter. The facility needs to update its policy to only allow the Classification Supervisor or appointed supervisory staff to conduct the 72-hour review. The staff must be trained on the

policy changes and ensure staff's understanding of the required practice. The facility needs to provide the updated policy and documentation of staff training on the new policy for compliance review.

Does Not Meet (e): The policy and procedures do not include requirements to notify the FOD no later than 72 hours after the initial placement of a detainee into administrative segregation, on on the basis of a vulnerability to sexual abuse or assault. The facility must demonstrate compliance by expanding the policy to address the language of the standard and documentation of a notification, if available during the corrective action period.

§115.51 - Detainee reporting.

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

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Detainee Handbook
Exhibit 29 Procedures for Legal Calls
Exhibit 30 DHS PREA Poster

(a, b, c) YCJ Policy #901 states detainees or prisoners may make reports to any staff member verbally, in writing, privately, or anonymously for any of the following: sexual abuse; sexual harassment; retaliation by other detainees or prisoners, or staff for reporting sexual abuse or sexual harassment; staff neglect or violation of responsibilities that may have contributed to sexual abuse or sexual harassment. The PSA Compliance Manager, security staff and security supervisors interviewed stated they would accept and document reports of sexual abuse or sexual harassment made verbally, in writing, anonymously, and through a third party. Detainees had mixed responses to questions related to how to report sexual abuse or sexual harassment, with most reporting, at least two or more methods for reporting. The facility's inmate/detainee handbook states detainees can write the following agencies and the correspondence is considered legal mail and will be confidential and free of charge: ICE OPR JIC; Yuba County Probation Victim Witness Assistance Office; and the PSA Compliance Managers at the Yuba County Sheriff's Office. The handbook states outside confidential support is available for victims of sexual abuse and will not be monitored except to the extent, of what is required of mandatory reporting laws. Of the three randomly selected investigation files for review, one file did not indicate the source of the allegation. The remaining two allegations were reported to staff, who promptly reported the allegation for investigation.

The Auditor attempted to call the hotline, but the phones were not working. The phones were repaired the same day. The facility provides a poster in all housing areas that provides the National Sexual Assault Hotline number and states the calls are confidential and calls can be made anonymously.

The facility complies with this standard.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Order F-201 Inmate Grievance Procedure
YCJ Order C-104 Inmate Sexual Abuse Prevention and Intervention
Exhibit 31 - Memo stating no formal grievances
Exhibit 8 Inmate/Detainee Handbook

(a) YCJ Order #F-201 states a grievance can be any complaint regarding jail conditions, procedures, food, failure to accommodate disabilities, or compliance with any portion of the consent decree. The order also outlines procedures for detainees to file a grievance related to sexual abuse. The policy states grievance forms will be provided to detainees within 24-hours of the request. The policy states an inmate (detainee) can file a grievance without submitting it to or referring it to a staff member who is the subject of the complaint. This policy refers the reader to the grievance procedure outlined in the facility's inmate/detainee handbook, which also indicates a detainee can file a grievance related to sexual abuse. Interviews with several staff, including the Grievance Officer, indicated detainees could not utilize the grievance procedure to file sexual abuse allegations. However, the facility's Order F-201 and the facility's inmate/detainee handbook informs that detainees can utilize the grievance process for sexual abuse.

Does Not Meet (a): Detainees must be allowed to utilize the grievance procedure to file complaints related to sexual abuse. The standard also requires detainees to have access to the grievance procedures for filing sexual abuse or harassment allegations. The intent of the standard is to provide prompt, unimpeded access to the grievance procedure. The facility policies that allow staff 24-hours to provide a grievance form to the detainee delays prompt and unimpeded access to the grievance procedure and does not comply with the standard. The facility must demonstrate compliance through the development of a process that allows detainees to file a grievance on sexual abuse promptly and with unimpeded access. The facility must provide the updated process developed, an updated policy allowing detainees prompt and unimpeded access to the grievance process, and documentation of staff training on the updated policy and the updated sexual abuse grievance process for detainees for compliance review.

(b)Neither the facility's order nor the inmate/detainee handbook outline that the facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Interviews with several staff, including the Grievance Officer, indicated detainees could not utilize the grievance procedure to file sexual abuse allegations.

Does Not Meet (b): The facility policy, inmate/detainee handbook, or staff knowledge through interviews indicate that the detainee may file a grievance on sexual abuse without any tiem limits. The facility must educate the staff and detainees that a sexual abuse grievance can be submitted without any timeframe limits. The facility must provide documentation of staff training and information provided to the detainee population that sexual abuse grievances can be submitted without the limitation of any timefarames to demonstrate compliance.

Recommendation: The facility should expand the policy and inmate/detainee handbook to include that all grievances related to sexual abuse can be submitted without the limitations of timeframes.

(c, d) YJC Order F-201 instructs staff to notify the supervisor of any allegations of sexual abuse or harassment and the supervisor is instructed to immediately provide medical attention and to separate the victim from the alleged abuser. The policy states a detainee with an emergency grievance (i.e., one which requires immediate action to avoid injury or continued problems) shall be responded to in an expedited basis. All staff interviewed were able to accurately report what steps they would take if they received a report of sexual abuse.

(e, f) YCJ Order F-201 does not address the standard requirement to send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate FOD at the end of the grievance process. As noted above, the facility's inmate/detainee handbook states there are no time limits on filing a sexual abuse related grievance. The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 30 days of the initial filing of the grievance. Computation of the 30-day time period shall not include time consumed by inmates in preparing any administrative appeal. The detainee shall be permitted to obtain assistance in filing the grievance from third parties to include fellow inmates/detainees, staff, family members, attorneys, and outside advocates. Third parties may also file the grievance for the detainee. If the detainee is not satisfied with the grievance disposition, the detainee may appeal to a Grievance Appeal Board. The detainee can request a hearing on a form entitled Request for Hearing Before Grievance Appeal Board within seven days of the grievance response. Within seven days of receiving the request, the Appeal Board will be convenvened and the hearing conducted. The detainee is given the opportunity to meet with the Board in person and given an opportunity to provide testimony. The Board submits a written disposition of the appeal and a brief explanation of its findings within 72 hours of the completion of the appeal hearing. The facility's inmate/detainee handbook provides instructions on how to contact their consular official and the DHS OIG to confidentially and anonymously report incidents of sexual abuse. The facility provided a memorandum stating no grievances have been filed related to sexual abuse or harassment.

Does Not Meet (e): The policy and practice does not require that all grievances related to sexual abuse and the facility's decisions with respect to such grievances be sent to the appropriate FOD at the end of the grievance process. The facility must demonstrate compliance by developing a process to ensure all grievances related to sexual abuse and the facility's decisions with respect to such grievances be sent to the appropriate FOD at the end of the grievance process and staff need to be trained on the process. The facility needs to provide the updated process with the requirement to notify the FOD, an example of a sexual abuse grievance referred to the FOD, and documentation of staff training of the notification requirement for compliance review.

Does Not Meet (f): The standard requires the facility to issue a decision on the grievance within five days of receipt. This requirement is not addressed in the grievance procedure. The facility must demonstrate compliance through expanding the facility's policy to address the five-day time limit or demonstrate in another manner that a decision on the grievance is made within five days of receipt. The facility must provide documentation that the sexual abuse grievances are issued a decision within five days and documentation that staff are trained on the five-day decision timeframe for compliance review.

Recommendation: The facility should expand the policy to include that all grievances related to sexual abuse and the facility's decisions with respect to such grievances be sent to the appropriate FOD at the end of the grievance process.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

Documentation Reviewed:

YCJ Order C-104 Inmate Sexual Abuse Prevention and Intervention
Exhibit 8 – Inmate/Detainee Handbook
Exhibit 9 – Poster – National Sex Abuse Hotline
Exhibit 12 – Memo re: Rape Crisis Center

(a, b, c) The facility's inmate/detainee handbook states outside confidential support is available for victims of sexual abuse and will not be monitored except to the extent, of what is required of mandatory reporting laws. The National Sexual Abuse Hotline is available to detainees and calls are free and confidential. According to the Deputy Director for Casa de Esperanza, the National Sexual Abuse Hotline forwards the call to their organization and the calls are accepted and handled through their staff. The PSA Compliance Manager and the Deputy Director confirmed they are working on a MOU to allow detainees to make hotline calls directly to Casa de Esperanza. The Deputy Director stated crisis intervention and in-person counseling is provided to detainees who have been victims of sexual abuse. The facility provides the following phone numbers to detainees to call direct for free legal services: America Civil Liberties Union; Central America Resource Center; Community Legal Services in East Palo Alto; Asian Law Caucus; Catholic Charities Immigration Program; and La Raza Centro Legal – San Francisco.

(d) The facility's inmate/detainee handbook provides addresses to ICE OPR, JIC, Yuba County Probation Victim Witness Assistance Office, and Yuba County Sheriff's Department and states correspondence to these agencies are considered legal mail and will be confidential and free of charge. The facility provides numbers to local and national outside resources to include the consular contact information. The Deputy Director for Casa de Esperanza confirmed that advocates from her organization always discuss the limits of confidentiality at the beginning of the session and their role as mandatory reporters.

The facility complies with this standard.

§115.54 - Third-party reporting.

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

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 30 – DHS Poster
Exhibit 32 – ICE Website

(a) According to the PSA Compliance Manager, the facility will accept and investigate all third-party reports of sexual abuse or sexual harassment. Reporting information is provided on the ICE website and the facility's website. The information on the facility's website is under the Jail Info tab and

the About PREA – Background Information page instructs individuals to report by calling the Sheriff's Dispatch or the Jail Supervisor with the numbers provided. YCJ Policy #901 states the PSA Compliance Manager is responsible for ensuring information for involved inmates, detainees, family, community members, and other interested third parties to report sexual abuse or sexual harassment is publicly posted at the facility. During the facility tour, the Auditor noticed there is no information posted for visitors in the jail lobby or visitation area. The Auditor reviewed three investigation files. Of the three investigation files reviewed, none of the reports were received through a third-party.

Recommendation: The facility should ensure information for third-party reporting of sexual abuse is publicly posted at the facility in accordance with facility policy. This will ensure that visitors who do not have access to the facility's website will receive the required information on how to report.

The facility complies with this standard.

§115.61 - Staff reporting duties.

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

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
YCJ Order C-104 Inmate Sexual Abuse Prevention and Intervention

(a, b, c) YCJ Policy #901 states staff members shall accept reports from detainees, prisoners, and third parties and shall promptly document all reports. All staff shall report immediately to the Shift Supervisor any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurs in the facility; retaliation against the detainee or staff member who reports any such incident; and any neglect or violation of responsibilities on the part of any staff member that may have contributed to an incident or retaliation. This policy also states no staff member shall reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment and investigation decisions. YCJ Order C-104 states jail personnel who are made aware of any sexual assault or misconduct may report the incident anonymously or to any supervisor outside their chain of command. The Auditor interviewed 10 security officers and supervisors. All security staff interviewed were aware of their reporting responsibilities if they receive or suspect sexual abuse or harassment. Staff reported they would accept reports from detainees regarding sexual abuse anonymously, in writing, through a third party, or verbally. An incident report is completed for all reports of sexual abuse. The PSA Compliance Manager was unsure if this policy had been reviewed and approved by the agency. The Captain stated the facility provided ICE the policies during the last ICE inspection (November 13 –15, 2019) for review and has not received documentation indicating the review has been completed. The Auditor reviewed three investigation files. Two of the three investigations were promptly reported and investigated. One incident was initially improperly labeled and not processed as a sexual abuse allegation, but was later identified and reported by the SDDO, and investigated by the facility.

Recommendation: The Auditor was unable to verify that the policy was approved by the agency. The agency must review and approve facility policies and procedures per standard language and ensure that the facility specifies appropriate reporting procedures, including a method by which staff can report outside of the chain of command.

(d) The facility does not accept juveniles. The Captain said he is not aware of any California laws that require mandatory reporting of sexual abuse of vulnerable adults.

Recommendation: The facility should research the local and state laws regarding the mandatory reporting of sexual abuse of vulnerable adults.

The facility complies with this standard.

§115.62 - Protection duties.

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

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination

YCJ Policy #901 instructs first responders to separate the parties, the alleged victim and abuser. The Auditor interviewed ten security officers and supervisors from each shift, and each responded that they would immediately separate the alleged victim and abusers. The Captain also explained that employees are expected to move the alleged victim to a safe place, report to the Shift Supervisor, and complete a report.

The Auditor was provided three investigation files for review. It was unclear from this review, what steps were taken to separate the alleged victim from the alleged abuser. These files were reviewed after normal working hours and facility staff were not available for questions so some information may have been missed during the review.

The facility complies with this standard based on policy and staff interviews.

§115.63 - Report to other confinement facilities.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 33 – Sexual Abuse report to another facility

(a, b, c) Policy #901 states upon receiving an allegation that a detainee or prisoner was sexually abused while confined at another facility, the Shift Supervisor shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred. The notification shall be made as soon as possible but no later than 72 hours after receiving the allegation. The Shift Supervisor shall document such notification. Interviews with the Captain and the PSA Compliance Manager confirmed this practice. The facility provided documentation of one incident in which a detainee notified the YCJ staff of a sexual assault allegation which allegedly occurred at another facility. Upon receiving information about the incident, the Shift Supervisor notified the PSA Compliance Manager and contacted the patrol division of the Yuba County Sheriff's Office to take a report. This report was forwarded to the county sheriff's office in which the incident occurred. The facility did not provide documentation that the head of the facility or appropriate office of the agency where the alleged abuse occurred was notified of the incident and within 72 hours.

Does Not Meet (a)(b)(c): The facility could not provide documentation that notifications are made to the head of the facility or appropriate office of the agency where the alleged abuse occurred. The facility must demonstrate compliance that staff are following policy and the standard by notifying the head of the facility or the appropriate office of the agency where the alleged abuse occurred of the allegation reported. The facility needs to provide an example of a notification made to the head of the facility or the appropriate office of the agency where the alleged abuse occurred of the allegation reported within 72 hours and sample documentation of a notification made, if an incident occurs within the corrective action period, for compliance review. The facility must also provide documentation of staff training on the policy requiring the notification to the head of the facility or the appropriate office of the agency where the alleged abuse occurred and documentation of the notification within 72 hours for compliance review.

(d) The Captain explained if a report of sexual abuse that may have occurred at their facility is received from another facility, an investigation would be initiated immediately, and the alleged abuser and victim would be located. If both the abuser and the victim were not at the facility, the case would be referred to the sheriff's detectives. The PSA Compliance Manager also stated that such reports would be reported to the FOD within 72 hours. No such reports have been received during this audit period.

§115.64 - Responder duties.

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

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 34 Memo – No non-security first responders

(a) YCJ Policy #901 requires the first security staff member to respond to a report of sexual abuse or sexual assault to initiate each element of the standard, which are to separate the parties; establish a crime scene to preserve and protect any evidence; identify and secure witnesses until steps can be taken to collect any evidence; and if the abuse occurred within a time period that still allows for the collection of physical evidence, request that the parties not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. A random sampling of security staff from each shift were interviewed and were able to articulate their responsibilities in the event they are the first responders to an allegation of sexual abuse or sexual assault.

(b) The facility provided a memorandum stating the facility does not utilize non-security staff as first responders. However, non-security staff contract health care staff and volunteers stated they would immediately report any allegation of sexual abuse to the Shift Supervisor. The YCF Policy #901 states, if the first responder is not a deputy, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and should then notify a law enforcement staff member. Contract staff said they would ensure the alleged victim was in a safe place, separate from the alleged abuser and they would ensure the detainee did not take any steps that may destroy evidence. The volunteer explained a member of the security team is always present in his groups and he is never alone with detainees. He stated he would not need to separate the victim from the abuser as the security officer would be immediately notified and would take steps to separate the victim and the abuser.

The facility complies with this standard.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 35 – No report to another facility of sexual abuse

(a) The facility utilizes YCJ Policy #901 as the coordinated response in the event of an incident of sexual abuse. This policy outlines the roles of the first responders, the shift supervisor, the investigators, and the administration. This policy does not address the role of medical and mental health staff. The HSA explained the role of medical and mental health staff if an allegation of sexual abuse is received. She explained the detainee would be brought to the medical area and health care staff would immediately provide any necessary first aid. Medical and mental health staff would also provide follow-up services, treatment plans, referrals for continued care, and pregnancy and sexually transmitted disease testing. The HSA explained that none of the incidents alleging sexual abuse required first aid, but each alleged victim was seen by facility health care staff.

The facility also has outside organizations that are part of an incident of sexual abuse that is not included in the policy for coordinated response. The Ridout Regional Medical Center is the hospital emergency room utilized and conducts the forensic exams for alleged victims of sexual assault from the facility. She stated SANEs are not always available, and in this circumstance, the alleged victim would be taken to the Bear Clinic in Sacramento, California for a forensic exam. Also on April 9, 2020, the Auditor spoke with the Deputy Director of Casa de Esperanza who outlined the services provided to detainees, that include victim advocacy services during medical exams and investigatory interviews and in-person counseling at the facility. Also, the Proscutor's Office also has victim advocates available to support victims during the legal process.

Does Not Meet (a): The current plan does not include the roles and responsibilities of medical and mental health staff. The facility must demonstrate compliance by expanding the coordinated response plan to include the roles and responsibilities of medical and mental health. The facility needs to provide the updated coordinated response document that includes all parties as outlined in the standard language for compliance review.

Recommendation: It is recommended the facility include the role of the hospital staff, victim advocacy services, and the Prosecutor's office in the facility policy as part of the coordinated response to allegations of sexual abuse. It is also recommended that a Coordinated Response Plan be created separate from the policy to focus only on the coordinated response of an incident by the first responders, medical and mental health practitioners, investigators, facility leadership, and outside organizations.

(c, d) YCJ Policy #901 states if an alleged detainee or prisoner victim is transferred from the facility to a jail, prison, or medical facility the facility shall, as permitted by law, inform the receiving facility of the incident and the prisoner's potential need for medical or social services, unless the prisoner requests otherwise. The facility provided a memorandum stating there had been no incidents in which a detainee victim was transferred from the YCJ to another facility.

Recommendation: The facility should expand the policy to specifically address facilities covered under 6 CFR part 115.

§115.66 - Protection of detainees from contact with alleged abusers.

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

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination

YCJ Policy #901 states any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees or prisoners and reported to any relevant licensing body. This policy does not address how detainees are protected from staff who are alleged to have committed sexual abuse or the protection of the alleged victim from the contractor or volunteer alleged to have committed sexual abuse, from the point the allegation is received. The Captain explained volunteers or contractors who are alleged to have engaged in sexual abuse are not allowed in the facility until the investigation is complete. The policy also states the Sheriff shall take appropriate remedial measures and consider whether to prohibit further contact with detainees by a contractor or volunteer. The Captain also explained that staff who are alleged to have engaged in sexual abuse, are assigned posts that do not require detainee contact or are placed on leave pending the outcome of the investigation. The Auditor was provided three investigations to review. This Auditor was not able to review all allegations to determine if a staff member, contractor, or volunteer was involved and if the facility took measures to protective the alleged victim from contact with the staff member, contractor, or volunteer. One of the allegations involved a facility contractor and one allegation was an incident that occurred at anther facility involving a contractor.

Recommendation: It is recommended the policy be expanded to address protection of the alleged victim from the staff, contractor, or volunteer alleged to have committed sexual abuse, from the point the allegation is received. The current policy does not address staff. And it is also recommended to expand the policy to document the practice of not allowing in the facility volunteers or contractors who are alleged to have engaged in sexual abuse until the investigation is completed.

The facility complies with this standard.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 36 – Completed investigative file review

(a, b, c) YCJ Policy #901 states all detainees, prisoners, and members who reported sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations shall be protected from retaliation. If any other individual who cooperates with the investigation expresses a fear of retaliation, appropriate measures shall be taken to protect that individual. The Shift Supervisor or the authorized designee shall employ multiple protection measures, such as housing changes or transfers for detainee or prisoner victims or abusers; removal or the alleged abuser from contact with the victims; and emotional support services for detainees, prisoners, or members who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The Shift Supervisor or authorized designee shall identify a staff member to monitor the conduct and treatment of detainees, prisoners, or members who have reported sexual abuse or detainees or prisoners who were reported to have suffered sexual abuse. The staff member shall act promptly to remedy any such retaliation. In the case of prisoners or detainees, such monitoring shall include periodic status checks. The Captain explained that both PSA Compliance Managers are responsible for monitoring for retaliation of detainees, staff, contractors, or volunteers. The PSA Compliance Manager confirmed his responsibilities regarding monitoring for retaliation. He added that monitoring would be done for a minimum of 90 days or longer if necessary. The PSA Compliance Manager stated at this time retaliation monitoring is not documented but he is developing a form for use in the future.

The PSA Compliance Manager provided an audit investigation file review form from one of the completed investigations where he completed retaliation monitoring, which included the dates the retaliation monitoring began and the date it was discontinued. This period was less than 90 days, but the PSA Compliance Manager had properly noted the detainee had been released from custody. However, there was no additional information available to verify retaliation monitoring was being conducted, including other cases monitored, nor did the PSA Compliance Manager during interview, explain the retaliation monitoring method or process he follows to monitor for retaliation. Absent this process or some type of documentation, the Auditor was unable to confirm compliance with this standard.

Does Not Meet (b)(c): The facility had no method to verify monitoring for retaliation was occurring after an allegation. The facility must provide retaliation monitoring for staff and detainees for 90 days after an allegation and document the monitoring. The facility must demonstrate compliance

through a demonstrated method that monitoring for retaliation is occurring for at least 90 days following a report of sexual abuse. The facility needs to provide evidence that monitoring, including multiple protective measures are considered for retaliation, is occurring for compliance review.

§115.68 - Post-allegation protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Manual Order #C-153 Assignment to Administrative Segregation
Exhibit 37 – Memo – No incident using segregation to protect victim

(a, b, c, d) YCJ Manual Order #C-153 states detainees at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If a facility cannot conduct such an assessment immediately, the facility may hold the detainee in involuntary segregated housing for less than 24 hours while completing the assessment. The facility shall assign such detainees to involuntary segregation only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. The PSA Compliance Manager also confirmed detainee victims may be held in administrative segregation for 30 days or less. The standard requires detainee victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. The PSA Compliance Manager also confirmed he completes a reassessment of these detainees prior to returning them to general population. He also stated he notifies the FOD by email whenever a detainee victim has been held in administrative segregation for 72 hours. The facility provided a memorandum to the Auditor stating there have been no incidents in which a detainee was placed segregation for protection from sexual assault, sexual harassment, or retaliation.

Does Not Meet (b): The facility houses detainees in administrative segregation for 30 days or less. The facility must demonstrate compliance through updating the policy and practice that detainee victims shall not be held for longer than five days in any type of administrative segregation pursuant to a PREA allegation, except in highly unusual circumstances or at the request of the detainee. The facility needs to provide the updated policy, documentation of staff training on the new policy and practice, and a detainee file to document the housing period of a detainee in post-allegation protective custody (if a detainee has been placed in protective custody) for compliance review.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination

(a, c) The PSA Compliance Manager conducts the administrative investigations for the facility. He is a trained investigator and his training was verified by the Auditor. The Yuba County Sheriff's Office conducts the criminal investigations. YCJ Policy #901 outlines the responsibilities of the investigators. This policy states investigators shall gather and preserve circumstantial evidence, including any available physical and biological evidence and any available electronic monitoring data interview alleged suspects, witnesses, and victims; review any prior complaints or reports of sexual abuse involving the suspect; conduct compelled interviews only after consulting with the District Attorney as to whether compelled interviews may be an obstacle for subsequent criminal prosecution; assess the credibility of the alleged victim, suspect, or witness on an individual basis and not by the person's status as a detainee or member of the Yuba County Sheriff Department; document in written reports a description of the physical, testimonial, documentary, and other evidence, the reasons behind any credibility assessments, and investigative facts and findings; refer allegations of conduct that may be criminal to the District Attorney for possible prosecution, including any time there is probable cause to believe a detainee or prisoner sexually abused another detainee or prisoner in the facility; and cooperate with outside investigators and remain informed about the progress of any outside investigation. This policy also states no detainee or prisoner who alleges sexual abuse shall be required to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an allegation. The policy also states the department shall retain all written reports from administrative and criminal investigations pursuant to the policy as long as the alleged abuser is held or employed by the department, plus five years. All other data collected pursuant to the policy shall be securely retained for at least 10 years after the initial collection unless federal, state, or local law requires otherwise. The investigation files reviewed followed the investigation policy, protocols, and standard requirements.

(b) This policy also notes administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse. The departure of the alleged abuser or victim from employment or control of this facility shall not be used as a basis for terminating an investigation. The Facility Investigator stated he would complete an administrative investigation into any substantiated or unsubstantiated allegation. The Investigator did not indicate and the policy does not address the standard requirement that administrative investigations are conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity.

Does Not Meet (b): The policy and the interview with the Investigator did not address the standard requirement that administrative investigations are conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. The facility must demonstrate compliance that administrative investigations will be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. The facility needs to provide updated written procedures and policy and documented staff training on the updated policy for compliance review.

(e) The Captain and Facility Investigator both confirmed the departure of the alleged abuser or victim from employment or control of the facility shall not provide a basis for terminating the investigation.

(f) Policy #901 states the facility's investigator will cooperate with outside investigators and remain informed about the progress of any outside investigation. One investigation was referred to the District Attorney for possible criminal charges. The PSA Compliance Manager states he cooperates fully with outside investigators and the District Attorney's office with all investigations. The investigation file did not have any information regarding this communication.

Does Not Meet (f): The facility could not provide documentation that the facility remained informed about the progress of the investigation. The facility must demonstrate compliance of remaining informed about the progress of the investigation. The facility needs to provide documentation of remaining communication with an outside agency during an investigation for compliance review.

§115.72 - Evidentiary standard for administrative investigations.

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

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination

(a) YCJ Policy #901 states all completed investigations shall be forwarded to the Sheriff, or if the allegations may reasonably involve the Sheriff, to the County Administrator. The Sheriff or County Administrator shall review the investigation and determine whether any allegations of sexual abuse or sexual harassment have been substantiated by a preponderance of the evidence. The PSA Compliance Manager is a trained investigator and completes the administrative investigations for the facility. The PSA Compliance Manager and the investigative file reviews confirm the facility does not impose any higher standard than a preponderance of the evidence to substantiate administrative investigations.

The facility complies with this standard.

§115.73 - Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

Documentation Reviewed:

Exhibit 38 – memo – No detainee notified of investigation results

(a) The PSA Compliance Manager stated no detainees were notified of investigation results. This requirement is not addressed in the facility policy.

Does Not Meet (a): The facility and/or agency has not notified detainees of the outcome of the investigations. The agency, per the standard, is required to notify the detainee of the as to the result of the investigation and any responsive action taken. The agency must provide three examples of detainees being notified of the outcome of the investigation, a process developed with the facility for the process to notify detainees, and documentation of agency staff training on the requirement of outcome notifications for compliance review.

Recommendation: It is recommended the facility establish a policy or expand its PREA policy to outline the process of notifying and documenting the notification to the detainee at the completion of an investigation.

§115.76 - Disciplinary sanctions for staff.

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

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 39 – Memo – No incident of staff discipline

(a, b, c, d) YCJ Policy #901 states all personnel shall be subject to disciplinary sanctions up to and including termination for violating this policy. Termination shall be the presumptive disciplinary sanction for members who have engaged in sexual abuse. All discipline shall be commensurate with the nature and circumstances of the acts committed, the member's disciplinary history, and the sanctions imposed for comparable offenses by other members with similar histories. All terminations for violation of this policy, or resignation by members who would have been terminated if not for their resignation, shall be criminally investigated unless the activity was clearly not criminal and reported to any relevant licensing body. The Captain confirmed that the above policy reflects the practice of the facility. To date, there have been no incidents of staff discipline, termination, or resignation in lieu of termination for violation of this policy. There have been no incidents that required notification to a licensing body. The Captain stated the facility provided ERO the policies during the last ERO inspection (November 13 –15, 2019) for review and has not received documentation indicating the review has been completed.

Recommendation: The agency must complete the policy review and approve the facility's policies and procedures per the standard language.

The facility complies with this standard.

§115.77 - Corrective action for contractors and volunteers.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
Exhibit 40 – Memo – No incidents involving volunteer or contractor that required notification to a licensing body

(a, b, c) YCJ Policy #901 states any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees or prisoners and reported to any relevant licensing bodies. The Sheriff shall take appropriate remedial measures and consider whether to prohibit further contact with detainees or prisoners by a contractor or volunteer. The Captain confirmed the above policy is the practice of the facility. He explained that any

allegation of sexual abuse or harassment by a contractor or volunteer would be promptly investigated and referred for criminal investigation if appropriate. The volunteer would be removed from any contact with detainees until the completion of the investigation. A memo was provided stating there were no incidents involving a contract employee or volunteer. However, upon review of the Investigation Spreadsheet, there were two incidents involving contractors, one of the allegations involved a facility contractor and one allegation was an incident that occurred at another facility involving a contractor. Although requested from the facility for review, this Auditor was not able to review the allegation involving the facility contractor to determine if the facility took measures to protect the alleged victim from contact and what corrective action was taken for the substantiated case of the facility contractor given the facility did not provide the documentation.

Does Not Meet (a)(b)(c): The facility did not provide documentation to demonstrate what corrective action was taken for the facility contractor on the substantiated incident. The facility must provide documentation of the corrective action taken including appropriate remedial measures taken consideration whether to provide further contact with detainees, and reporting to any relevant licensing bodies if appropriate for compliance review.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

Documentation Reviewed:

YCJ Manual Order #F-401 Disciplining of Prisoners
Exhibit 41 – Memo – No incident detainee received sanctions for sexual abuse

(a, b, c, d, e, f) Detainees will be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the detainee engaged in detainee-on-detainee sexual abuse or following a criminal finding guilt for detainee-on-detainee sexual abuse. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history and the sanctions imposed for comparable offenses by other detainees with similar histories. The Order F-401 outlines a review by the Shift Supervisor and Jail Supervisor before a disciplinary hearing, appeal procedures and documentation procedures. This policy states the disciplinary process shall consider whether an inmate's mental disabilities or mental illness contributed to his or her behavior, when determining what type of sanctions, if any, should be imposed. The Jail Supervisor must consult with a qualified mental health professional prior to imposing any sanction in order to determine whether the imposed sanction is likely to exacerbate a detainee's mental health symptoms and expose the detainee to an increased risk of danger. The agency may discipline a detainee for sexual contact with staff only upon a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse made in good faith based on a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even in the investigation does not establish evidence sufficient to substantiate the allegation.

The facility provided a memorandum stating there have been no incidents in which a detainee received disciplinary sanctions for sexual abuse. The two detainee-on-detainee allegations, the facility determined one allegation was unsubstantiated and the other unfounded The Captain confirmed the above policies were correct and added the facility may pursue criminal charges as well. He explained the appeal levels range from Sergeant to Under Sheriff. He explained that detainees suffering from a mental illness are referred to mental health for evaluation and the facility implements the recommendations of the mental health staff.

The facility complies with this standard.

§115.81 - Medical and mental health assessment; history of sexual abuse.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Wellpath Policy HCD-110-F-06 Response to Sexual Abuse – Yuba CA
YCJ Policy #901 Prison Rape Elimination

(a, b, c) The HSA explained a risk assessment is completed initially by intake staff. If intake staff identified a sexual abuse victim or abuser, intake staff will immediately refer the detainee to health care staff. For a medical referral, the detainee would be provided a health assessment within two working days. For a mental health referral, the detainee would be provided a mental health evaluation within 72 hours of the referral. The mental health professional explained that medical staff is usually in the intake area when new detainees are received. Medical staff would notify her of the referral, and she would see the detainee the same day if she is on-site, the following day if she is off-site. The Intake Supervisor stated if the risk assessment identifies a victim or abuser, intake staff would immediately refer the detainee to a qualified mental health or medical health professional for follow-up. The Auditor reviewed medical and facility policies but a referral from intake staff for prior victimization or abusiveness was not specifically addressed. The Auditor reviewed the facility policies and this type of referral is not specifically addressed.

The Auditor identified one detainee who had reported a prior history of sexual victimization or abusiveness and requested verification that the detainee was immediately referred to health care staff and verification the detainee was seen by health care staff as outlined in this standard. At the time of this report, this information had not been received.

Does Not Meet (a)(b)(c): The facility did not provide documentation demonstrating detainees that reported prior history of sexual victimization or abusiveness were referred to a qualified medical or mental health professional for follow-up. The facility must demonstrate compliance by immediately referring detainees who disclosed prior victimization and/or perpetrated sexual abuse to medical and mental health for follow-up. The facility needs to provide documentation of referrals and the follow-up by medical and/or mental health services for detainees that reported prior history of sexual victimization or abusiveness for compliance review.

Recommendation: It is recommended the policy be expanded to address the requirement of immediately referring a detainee to medical and/or mental health for follow-up services after disclosing prior sexual victimization or perpetrated sexual abuse.

§115.82 - Access to emergency medical and mental health services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Wellpath Policy HCD-110-F-06 Response to Sexual Abuse – Yuba CA

(a, b) Wellpath's policy HCD-110-F-06 outlines the responsibilities of medical and mental health staff in the event of an incident of sexual abuse. These responsibilities include a baseline history and assessment by medical staff to determine the time and date of the incident and current presenting physical and mental status. Medical staff stabilizes the alleged victim and prepares them for transport for a forensic exam, if applicable. Medical staff communicates with the hospital to conduct the forensic exam and provides the detainee's current treatment, medications, allergies, and any actions or treatment taken related to the assault. Medical staff obtains consent from the detainee for the forensic exam and maximizes the preservation of evidence. Prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases are offered to the victims, as appropriate. Emergency contraception is available for female victims. Following any emergency treatment, medical staff notifies mental health staff of the event and an immediate telephone referral is made. The on-call psychiatrist is contacted if needed. Mental health will assess the need for crisis intervention and provide the services as necessary. Mental health staff offer on-going follow-up services. If the detainee refuses the services, the detainee is informed mental health staff will follow-up in 14 days to determine if the patient is functioning adequately and again offer follow-up services. According to the HSA, these services are provided to the victim at no cost and regardless of whether the victim identifies the abuser or cooperates with the investigation. None of the detainees that reported sexual abuse were still housed at the facility for interviews. Only one of the three investigation files reviewed demonstrated the detainee was seen by medical.

Does Not Meet (a): Of the three investigations reviewed only one detainee was seen by medical. The facility must demonstrate compliance that all detainees who have been victimized by sexual abuse including sexual harassment (the DHS term of sexual abuse includes sexual harassment) are offered emergency medical treatment and crisis intervention services as appropriate. The facility must provide documentation that medical and mental health services were offered for three detainee who have alleged sexual abuse for compliance review.

§115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

Wellpath Policy HCD-110-F-06 Response to Sexual Abuse – Yuba CA
YCJ Policy #901 Prison Rape Elimination

(a, b, c) Wellpath's policy HCD-110-F-06 states continued evaluation and treatment of medical and mental health needs related to sexual abuse will be provided in accordance with the patient's desire for treatment and the community standard of care. Services may be provided through sick call, chronic care clinics, and regular health examinations. After any emergency treatment is provided, health care staff will notify mental health staff of the event. An immediate telephone referral, including after hours, is the preferred referral format in case of an abuse. If after-hours, mental health issues are handled by health care staff at the facility, the evaluating health care staff member will assess the need for immediate crisis-based interventions. The on-call psychiatrist may be contacted for consultation if such is deemed necessary. If needed, a treatment plan will be developed regarding any additional medical follow-up required. Only one of the investigation files reviewed demonstrated the detainee was seen by medical.

Does Not Meet (a): Of the three investigations reviewed only one detainee was seen by medical. The facility must demonstrate compliance that all detainees who have been victimized by sexual abuse including sexual harassment (the DHS term of sexual abuse includes sexual harassment) are offered medical and mental health evaluation and, as appropriate, treatment. The facility must provide documentation that medical and mental health services were offered for a detainee who has been victimized by sexual abuse for compliance review.

(d, e, f) Wellpath's policy HCD-110-F-06 states prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases (e.g. HIV, hepatitis B) are offered to all victims as appropriate. The HSA reported female detainees who suffered sexual abuse are provided with timely and comprehensive information and access to pregnancy related information and services. She added pregnancy and sexually transmitted infection tests are administered as appropriate. Treatment services are provided to the victim at no cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident, according to the HSA.

(g) Wellpath's policy HCD-110-F-06 states if the facility identifies an alleged perpetrator of the abuse (through means such as placement in a segregation unit, issuing a disciplinary report, or filing of criminal charges), a mental health staff member will follow-up with this individual and assess adjustment to his or her current situation. If placed in segregation, mental health staff will continue to monitor adjustment issues at least weekly via the segregation round process. The staff member assigned to this duty shall not be the same person assigned to any on-going follow-up with the victim of abuse. Both the HSA and the Mental health Professional confirmed sexual abuse perpetrators are provided mental health evaluations and treatment. The Auditor was unable to confirm that these services are provided within 60 days of learning of such abuse history.

Does Not Meet (g): The standard requires a mental health evaluation within 60 days of learning of the abuse and the offering of treatment to a detainee-on-detainee abuser. The facility could not demonstrate the referral and evaluation within 60 days, and treatment, if deemed necessary, is occurring. The facility must demonstrate compliance that an attempt to conduct a mental health evaluation of all know detainee-on-detainee abusers, within 60 days of learning of such abuse history, and offer treatment when deemed appropriate by mental health practitioners. The facility needs to provide an example of a mental health evaluation conducted within 60 days on a known detainee-on-detainee abuser for compliance review.

Recommendation: Wellpath's policy does not specify when a mental health professional is required to follow-up with an alleged detainee-on-detainee abuser. The facility and/or Wellpath's policy should be updated to specify when a mental health professional is required to follow-up with an alleged detainee-on detainee abuser.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination
2019 Annual Report of PREA Allegations

(a, b) YCJ Policy #901 states an incident review shall be conducted at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The review should occur within 30 days of the conclusion of the investigation. The review team shall include upper-level management officials and seek input from line supervisors and investigators. The review shall consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI identification status or perceived status; gang affiliation; was motivated or otherwise caused by other group dynamics at the facility; examine the area of the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the staffing level in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff. The team shall prepare a report of its findings including any determination made pursuant to this section and any recommendations for improvement. The report shall be submitted to the Sheriff, and the PSA Compliance Manager. The Sheriff or authorized designee shall implement the recommendations for improvement or shall document the reasons for not doing so.

The Captain and the PSA Compliance Manager reiterated the above policy. The PSA Compliance Manager explained that sexual abuse incident reviews were conducted at the conclusion of each of the investigations during this audit period but there were no recommendations and the reviews were not documented in a report.

Does Not Meet (a): The facility had not completed reviews of unfounded incidents nor prepared written reports for the unsubstantiated and substantiated incident reviews. The facility must demonstrate compliance through the completion of reviews of all incidents and prepare written reports for incident reviews of unsubstantiated and substantiated incidents within 30 days of the conclusion of the investigation. The facility must provide documentation of a review of an unfounded case and written incident review reports for two substantiated and/or unsubstantiated incidents for compliance review.

(c) The facility prepared an annual report of PREA allegations for 2019. This report forwarded to the FOD and agency PSA Coordinator on November 14, 2019. The annual report did not cover a full year and did not include all reported incidents.

Does Not Meet (c): The annual report was completed in November 2019 and did not cover an entire year. By completing the annual review early, one of the cases that occurred within the one year period (December 2019) was not included. The report did not outline the process the facility underwent to improve sexual abuse intervention, prevention, and response efforts and if any recommendations were made from the incident reviews and whether the recommendations were completed. The facility must demonstrate compliance that the annual report includes incidents for the full 12-month audit year and actions taken to improve sexual abuse intervention, prevention, and response efforts and if any recommendations were made from the incident reviews and whether the recommendations were completed. The facility must provide an updated annual report that references the full 12-month audit year and actions taken to improve sexual abuse intervention, prevention, and response efforts and if any recommendations were made from the incident reviews and whether the recommendations were completed for compliance review.

§115.87 - Data collection.

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

Notes:

Documentation Reviewed:

YCJ Policy #901 Prison Rape Elimination

(a) YCJ Policy #901 states the YCJ shall retain all written reports from administrative and criminal investigations pursuant to this policy for as long as the alleged abuser is held or employed by YCJ, plus five years. All other data collected pursuant to this policy shall be securely retained for at least 10 years after the date of the initial collection, unless federal, state, or local laws requires otherwise. According to The PSA Compliance Manager and observed by the Auditor, investigative files are securely stored in the Sergeant's Office and accessible only by the PSA Compliance Managers. Medical and mental health records are securely stored in the Health Services area and accessible only by authorized health care personnel.

The facility complies with this standard.

§115.201 - Scope of audits.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(d) The facility staff allowed the Auditor access to and an opportunity to observe all areas of the facility.

(e) The agency is to provide the Auditor with relevant documentation to complete a thorough audit of the facility. The facility provided minimal relevant documentation during the pre-audit phase. For example, the facility did not provide policy information for standards: 115.13; 115.31; 115.34; 115.35; 115.54; 115.63; 115.67; 115.68; 115.77; and 115.86. The Auditor reviewed the policies provided and found each of these standards were included in the facility's policies and should have been provided during the pre-audit phase of the audit. In addition, supporting documentation was minimal with instructing the Auditor to review the material on-site. All documentation was not available on-site, and the Auditor had to continually ask for further documentation to review for compliance post audit. As the time of the report, the Auditor had not received all documentation requested for compliance review.

Does Not Meet (e): During all phases of the audit, the facility was not accommodating to provide the Auditor with requested documentation needed to ensure compliance with several PREA standards. The facility did not provide the Auditor with relevant documentation to complete a thorough audit of the facility. The facility must demonstrate compliance by providing the Auditor with relevant documentation to complete a thorough audit of the facility including during the Corrective Action Plan (CAP) process.

(i) The Auditor was able to conduct private interviews with detainees.

(j) The Auditor did not receive any confidential information or correspondence from detainees, staff, or third parties.

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AUDITOR CERTIFICATION

Update Audit Findings Outcome Counts by Clicking Button: **Update Outcome Summary**

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	17
Number of standards not met:	23
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	41

I certify that the contents of the report are accurate to the best of my knowledge and no conflict of interest exists with respect to my ability to conduct an audit of the agency under review. I have not included any personally identified information (PII) about any detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.

Margaret L. Capel 9/1/2020

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/1/2020

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/1/2020

PREA Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Corrective Action Plan Final Determination

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Margaret L. Capel	**Organization:**	Creative Corrections, LLC.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(479) 521-(b) (6), (b)

AGENCY INFORMATION	
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)

FIELD OFFICE INFORMATION	
Name of Field Office:	San Francisco
Field Office Director:	David W. Jennings
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	215 5th Street, Marysville, CA 95901
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Yuba County Jail		
Physical address:	215 5th Street, Marysville, CA 95901		
Mailing address: *(if different from above)*			
Telephone number:	(503) 749-7740		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Captain
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(530) 749-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Sergeant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(530) 749-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

Directions: Please provide summary of audit findings to include the number of provisions with which the facility has achieved compliance at each level after implementation of corrective actions: Exceeds Standard, Meets Standard, and Does Not Meet Standard.

The Prison Rape Elimination Act (PREA) audit of the Yuba County Jail was conducted on March 10-12, 2020, by Margaret Capel, U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor for Creative Corrections, LLC of Beaumont, Texas. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, [redacted] and Assistant Program Manager, (b) (6), (b) (7)(C) [redacted] DOJ and DHS certified PREA Auditors.

The Yuba County Jail is operated by the Yuba County Sheriff's Office (YCSO). The facility has a contract with ICE for the housing of adult female and male detainees. The purpose of the March 2020 audit was to determine compliance with DHS PREA Standards. This was the first DHS PREA audit of the facility. The audit period covered the previous twelve months from July 16, 2018 through July 18, 2019. Upon completion of the audit, the Yuba County jail was found to be non-compliant with 22 standards. The facility's Corrective Action Period (CAP) began October 3, 2020 and ended March 3, 2021.

The agency provided the Auditor the Corrective Action Plan (CAP) September 2020 which was reviewed by the Auditor and responses provided to the compliance actions. The 180-day CAP process ending date was March 3, 2021. The facility submitted documentation for the corrective action process on January 15, 2021 through March 3, 2021. A CAP reinspection on-site visit was scheduled to verify full compliance with all the standards. Full compliance with each standard was contingent upon staff and detainee interviews, additional on-site documentation review, and facility observations during the CAP reinspection on-site visit.

The Auditor accompanied by the Assistant Program Manager conducted the CAP reinspection on-site visit on April 27-29, 2021. During the site visit, the Auditors interviewed 16 staff and 5 detainees, toured all areas of the facility accessible to detainees. The Auditors also reviewed 13 employee files, 10 detainee detention files, and reviewed the facility's PREA orientation video and security camera video footage.

Before the start of the CAP reinspection site visit, the Auditor met with agency and facility staff. The Team Lead opened the entry briefing at 8:30 am on the first day of the on-site visit. In attendance were:

(b) (6) [redacted], ICE Supervisory and Detention Officer (SDDO)
(b) (6), (b) (7)(C) [redacted], Assistant Program Manager and DHS PREA Auditor, Creative Corrections (CC)
(b) (6), (b) (7)(C), DHS Certified PREA Auditor, (CC)
(b) (6), (b) (7)(C) Jail Captain
(b) (6), (b) (7)(C), Captain's Assistant
(b) (6), (b) (7)(C), Lieutenant
(b) (6), (b) (7)(C) [redacted], Sergeant, Assistant PREA Manager
(b) (6), (b) (7)(C), Sergeant

The Lead Auditor opened the meeting by thanking the staff for the documentation provided during the CAP period. Briefing introductions were made and the Auditor discussed the audit schedule for the next three days. The Lead Auditor provided an overview of the CAP reinspection on-site visit process and the methodology used to determine PREA compliance. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether these staff are aware of these policies and procedures and the policies are reflected in the daily practices of staff. The Auditor also stated compliance with the PREA standards is determined by a review of the policy and procedures of the facility, observations made during the facility tour, additional on-site documentation review, and conducting staff and detainee interviews.

A tour of the facility was completed by the Auditors and key facility staff. All living units housing ICE detainees were toured, as all areas accessed by ICE detainees to include, program areas, service areas, the control center, segregation, admissions/intake and medical areas. The Auditors reviewed camera locations, phone accessibility, officer post sight lines, detainee postings, showers, restrooms, and changing areas as well as cell inspections. The Auditors spoke informally to detainees and staff regarding facility practices and reviewed logbooks for verification of unannounced security checks. Following the tour, interviews were conducted with a first responder, (5) classification officers (5), the Classification Supervisor, random detainees (5), detention officers (7), a security supervisor, grievance officers (2), intake officers (4), an administrative investigator, a medical professional, a mental health professional, the Acting PSA Compliance Manager, a segregation supervisor, and the Jail Captain.

An exit briefing was conducted by the Lead Auditor at the completion of the on-site audit. The following individuals were in attendance:

(b) (6), (b) (7)(C) [redacted], ICE SDDO
(b) (6), (b) (7)(C), ICE SDDO
(b) (6), (b) (7)(C), Jail Captain
(b) (6), (b) (7)(C), Acting PSA Compliance Manager, Lieutenant
(b) (6), (b) (7)(C) [redacted] Sergeant, Assistant PSA Compliance Manager, Administrative Investigator
(b) (6), (b) (7)(C), Sergeant
(b) (6), (b) (7)(C) [redacted], Assistant Program Manager, CC
Margaret Capel, Lead Auditor, DHS PREA Auditor

The Lead Auditor explained that a final finding for each deficient standard could not be determined until the Auditor reviewed all information gathered through review of documentation, logbooks, and video footage, detainee and staff interviews, and observations made during the facility tour. The Lead Auditor stated she was very impressed with the extensive effort made to come into compliance with the deficient standards. Detainees feel safe and indicated staff are responsive to their needs. Staff were professional and cooperative. The Auditors thanked the staff for the hospitality and cooperation provided by the staff throughout the site visit.

This report is a final report based on the documentation that was submitted for review during the CAP period and information gathered during the on-site visit, for those standards found to be deficient during the facility's PREA audit in March 2020. The report is being completed to detail the facility's current compliance status with the previous 22 deficient standards. On the original report, there were 23 deficient standards listed. Standard 115.16 (a)(b) was not deficient and will not be addressed in this report but subpart 115.16 (c) is correctly listed as deficient. Standard 115.22 was incorrectly listed as deficient on the CAP but was not found deficient in the original report.

Meets Standard (18):

§115.13 - Detainee supervision and monitoring
§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 - Hiring and promotion decisions
§115.33 - Detainee education
§115.35 - Specialized training: Medical and mental health care
§115.41 - Assessment or risk of victimization and abusiveness
§115.42 - Use of assessment information
§115.52 - Grievances
§115.63 - Reporting to other confinement facilities
§115.65 - Coordinated response
§115.67 - Agency protection against retaliation
§115.68 - Post-allegation protective custody
§115.73 - Reporting to detainees
§115.77 - Corrective action for contractors and volunteers
§115.81 - Medical and mental health assessments; history of sexual abuse
§115.82 - Access to emergency medical services
§115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
§115.201 - Scope of audits

The following standards that still Do Not Meet: (4)

§115.15 - Limits to cross-gender viewing and searches
§115.43 - Protective custody
§115.71 - Criminal and administrative investigations
§115.86 - Sexual abuse incident reviews

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence replied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable.

§115.13 - Detainee supervision and monitoring

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

Notes:

(b) The comprehensive supervision guidelines are outlined in the Yuba County Jail Manual and post orders. YCJ Order#C-251 requires security officers to conduct safety checks of detainees at least hourly and to document these checks on the Inmate Hourly Safety Check Sheet. Officers interviewed confirmed these checks are done on an irregular basis and at least hourly. Detainees also confirmed that security officers are frequently checking the housing areas. The PSA Compliance Manager reported an annual review of the comprehensive supervision guidelines was completed in 2019 but the former Lieutenant had the annual review documentation and facility staff have been unable to locate the document. The Auditor asked to review the sexual abuse incident reviews, to determine if staff supervision was reviewed and if there were any recommendations, but the PSA Compliance Manager explained although the reviews were conducted and there were no recommendations, the incident reviews were not documented.

Does Not Meet (b): The facility could not provide the annual review of the comprehensive supervision guidelines. The facility must document the review of the comprehensive supervision guidelines annually. The facility must demonstrate compliance through an annual review of the supervision guidelines and provide a copy of the annual review for compliance review.

Corrective Action Taken (b): The facility provided a memorandum from the Jail Captain stating the Undersheriff had rewritten and reformatted all jail policies in April 2020, which includes the comprehensive supervision guidelines. In accordance with facility policies, an annual review of the policies was completed by the Jail Captain on February 18, 2021. The facility has met substantial compliance with subpart 115.13 (b).

(d) YCJ Order #C-251 requires security supervisors from each shift to conduct and document unannounced security inspections to identify and deter staff sexual abuse and sexual harassment. These inspections are completed utilizing a pipe reader that is placed on data readers throughout the facility. The data reader sends information to the facility server where the data is stored. This policy also prohibits staff from alerting other staff about unannounced rounds unless such announcement is related to the legitimate operational functions of the facility. The Captain stated he expected security supervisors to conduct frequent unannounced rounds each shift.

To verify security rounds were completed, the Auditor requested verification of security rounds for January 20, 2020. The PSA Compliance Manager stated there were no documented security rounds for this date and explained that Security Supervisors are required to complete unannounced security rounds with the pipe reader, only once per week. There is no other verification of unannounced security rounds being conducted daily on each shift. The documentation only demonstrated unannounced rounds once weekly through the pipe reader.

Does Not Meet (d): Weekly security checks do not meet the standards requirement which requires frequent unannounced security inspections to identify and deter sexual abuse of detainees. Facility policy requires that unannounced rounds are to be conducted by security supervisors. Unannounced security inspections/rounds must be completed and documented daily for each shift, day, and night. The facility must demonstrate compliance through documentation of unannounced security rounds by security supervisors per policy requirements over a two-week period demonstrating unannounced rounds are conducted daily on each shift

Corrective Action Taken (d): The facility provided a pipe reader printout of unannounced security inspections by security supervisors for the period of February 14, 2021 through February 28, 2021. The documentation verifies that unannounced security inspections are being conducted consistently on all shifts. Compliance is further supported through interviews with security line staff and supervisors, who all stated unannounced security inspection are documented through the pipe reader. The facility has met substantial compliance for subpart 115.13 (d).

§115.15 - Limits to cross-gender viewing and searches

Outcome: Does not Meet Standard

Notes:

(g) YCJ Order C-104 states staff are not to observe detainees who are changing clothing or showering unless there is probable cause or other factors that warrant a strip search. Portable privacy screens are available in every housing unit to allow detainees to shower, change clothing, and perform bodily functions without being viewed by staff of the opposite gender. The Auditor viewed the cameras to determine if the cameras afforded privacy to detainees. The facility has placed blackout spots on the control center monitors in the shower and restroom areas to ensure detainees have privacy while performing bodily functions, bathing, and changing clothing. YCJ Order C-104 also states male personnel needing to enter the living area of the female detainees will announce their presence before entering and only if accompanied by a female staff member. During an emergency situation when a female staff member is not immediately available, a male deputy will notify one of the control rooms and/or the shift supervisor to monitor their movement on the jail's camera system. Only when a supervisor or deputy acknowledges they are monitoring his movement will the male deputy enter the female area without escort. Female deputies and non-sworn female personnel may enter the housing area of the male detainees after they have announced their presence.

They will not enter the sleeping area of the male detainees unless escorted by a male deputy. Interviews with staff and detainees confirm that opposite gender staff rarely enter the detainee living areas. Interviews with detainees and the Auditor's observations during the facility tour confirm the female staff are not routinely announcing their presence when entering the male living areas.

Does Not Meet (g): The facility staff are not announcing their presence when entering an opposite gender housing unit. The facility policy and practice must require staff, when entering an area of the opposite gender, to announce their presence. The facility must demonstrate compliance through an updated policy addressing the language of the standard and documented staff training on the policy change and the requirement of announcing upon entering a housing unit of the opposite gender. The facility must provide the updated policy and documentation of staff training on the updated policy for compliance review.

Corrective Action Taken (g): The facility provided a memorandum from the Lieutenant to all custodial staff reminding staff of the importance of making cross gender announcements when entering an area in which opposite gender detainees may be changing clothing, while performing bodily functions, or showering. The Lieutenant verified the memorandum was posted in the booking area and the briefing room bulletin board. The facility provided photographs of postings in the detainee housing areas, reminding staff of the cross-gender announcement requirement. The Auditors noted cross gender announcements were made consistently during the facility tour and when Auditors were revisiting areas during the site visit. Detainee and staff interviews indicated cross gender announcements are routinely made when opposite gender staff are entering an area in which detainees may be showering, while performing bodily functions, or changing clothes. The facility has met substantial compliance with subpart 115.15 (g).

(j) The facility trains staff in proper search techniques to include searches of cross-gender and transgender detainees. The facility utilizes the training video available through the PREA Resource Center titled, Guidance in Cross-Gender and Transgender Pat Searches developed by the Moss Group. The facility provided documentation of staff attendance in the training. It is the practice of the facility, when searching a transgender detainee, that the searching officer's gender will be consistent with the detainee's genitalia. If a detainee's gender is unknown, it is determined through means other than a search, such as during conversations with the detainee, by reviewing medical records (if available), or, if necessary, learning such information as part of a broader medical examination conducted in private, by a medical practitioner. If the transgender has male genitalia and breast augmentation, a female officer will search the breast area and a male officer will search the rest of the body. Security staff interviews confirmed this practice. Security staff were consistently able to describe how to search a detainee in a professional, respectful manner and in the least restrictive manner possible.

Does Not Meet (j): It is not appropriate for a transgender or intersex detainee to be searched by both a male and female staff officer, with the male officer searching the parts of the body that are anatomically male and the female officer searching the parts of the body that are anatomically female. A case-by-case determination of the most appropriate staff member to conduct the search is necessary and should take into consideration the detainee's gender expression and the detainee's request for the gender of the staff member to conduct the search. The current practice also conflicts with the training directions provided in the facility's training curriculum (Moss Group, page 41). The facility must demonstrate compliance through documentation of further training to staff on how to conduct proper searches of transgender and intersex detainees as outlined in the training curriculum and ensure the practice is adhered to for compliance review.

Corrective Action Taken (j): The facility provided a copy of the ICE training titled, Cross-Gender, Transgender, and Intersex Searches. The training states, "When operationally feasible, officers conducting a search (of the transgender detainee) must be of the same gender, gender identity, or declared gender as the detainee being searched." The Auditor requested, on three separate dates, for a definition of "operationally feasible" which was not provided. The facility provided a copy of the revised YCJ Policy #D-122, Transgender and Intersex Inmates. The revised policy states, "Strip or visual body cavity searches shall be conducted by custody staff of the gender requested by the transgender person, if available, to search those body parts that are anatomically similar to those of the custody staff who is requested to do the search." The original training stated the transgender detainee with sex change augmentation would be searched by both male and female security staff. The Auditors interviewed seven detention officers and one security supervisor. Three of the eight security staff interviewed stated transgender detainees would be searched by officers of the same gender as the detainee's anatomical genitalia or the detainee would be searched by both male and female officers. There were no transgender or intersex detainees housed at the facility during the site visit.

Does Not Meet: The revised policy allows for custody staff of both genders to search a transgender detainee, which does not meet the standard requirements. The revised policy states, "if available" which is a broader definition than "operationally feasible". Three of the eight security staff interviewed stated transgender detainees would be searched by officers of the same gender as the detainee's anatomical genitalia or the detainee would be searched by both male and female officers. The facility does not comply with standard 115.15(i).

§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient

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

Notes:

(a)(b) The standard subparts (a)(b) were found compliant in the original report but was mistakenly added to the CAP as non-compliant. Therefore, subparts (a)(b) are compliant and will not be addressed in the CAP process.

(c) YCF policy #901 states "the facility shall not rely on other detainees or prisoners for assistance except in limited circumstances where an extended delay in obtaining an interpreter could compromise the detainee's safety, the performance of first responder's duties under this policy, or the investigation of a detainee's allegations of sexual abuse, harassment, or retaliation". The facility provides access to interpretive services through bilingual staff and through Language Line Solutions. One investigation report indicated a security staff member provided interpretive services for the alleged victim. Interviews with security supervisors and randomly selected security staff

confirm staff are aware that minors, alleged abusers, or detainees who have a significant relationship with the abuser are not to be used for interpretation, but most staff responded they would not allow another detainee to interpret for an alleged victim even if requested by the victim.

Does Not Meet (c): The facility policy and practice does not allow the detainee to utilize another detainee for interpretation if requested and the agency determines that such interpretation is appropriate and consistent with DHS policy. The facility needs to allow the detainee to utilize another detainee for interpretation if requested and the agency determines that such interpretation is appropriate and consistent with DHS policy. Training needs to be conducted with staff of the practice to ensure compliance with the standard. The facility must demonstrate compliance through removing language from the policy that prohibits a detainee to utilize another detainee for interpretation if requested and the agency determines that such interpretation is appropriate and consistent with DHS policy and through training documentation that staff were trained on the policy change and practice. The facility needs to provide an updated policy and documentation of staff training on the updated policy for compliance review.

Corrective Action Taken (c): The facility provided a copy of the revised YCJ Policy #D-104 Sexual Abuse and Assault Prevention and Intervention. The revised policy states, "The facility shall take steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse to those who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. This includes the use of a detainee interpreter at the request of the detainee victim. The facility provided a roster of employees with dates the employees completed the required training. During the site visit the Auditors interviewed eight security staff. Five of the security staff reported a detainee could interpret for another detainee, of these five, two noted this would not be allowed when investigating sexual abuse allegations. Three of the officers stated one detainee cannot interpret for another detainee. The facility has met substantial compliance with subpart 115.16 (c).

Recommendation: The facility should provide further training with staff to ensure all staff understands the circumstances in which one detainee can interpret for another detainee.

§115.17 - Hiring and promotion decisions

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

Notes:

(b) The facility did not provide verification that employee applicants are asked about previous misconduct on written employment applications, or interviews for hire or promotions. The Captain stated applicants are asked directly and on written applications for hire and promotion whether they have a history of sexual abuse, however, no documentation was provided that current employees were asked on written self-evaluations or through interviews as part of the review of current employees. The employee signs acknowledging their continuing affirmative duty to disclose misconduct at the time they complete the initial PREA training. Of the five personnel files reviewed, the Captain confirmed each of the selected employees signed acknowledging their continuing affirmative duty to disclose misconduct.

Does Not Meet (b): The facility could not provide documentation that applicants are asked about previous misconduct on employment applications and/or promotion applications and on self-evaluations of current staff. The facility must demonstrate compliance through developing a process and document that employees are asked about misconduct described in provision (b) of the standard and current employees are asked during the promotional process and as part of written self-evaluations. The facility needs to provide examples of five employee files of new hire and one promotional staff file for compliance review in which employees were asked about sexual abuse during the promotional process and as part of written self-evaluations.

Corrective Action Taken (b): The facility provided a memorandum from the facility's Captain explaining that applicants and those staff seeking promotion, complete the Personal History Statement (PHS) form. He further stated there have been no promotions within the last 2 years and 6 months, so the facility is unable to provide examples for those seeking promotions but all applicants for promotion are required to complete the personal history section of this form. The facility provided copies of six completed Personal History Statement forms for new applicants during the CAP process. The Personal History Section of the form asks the applicant questions regarding previous misconduct as required by this standard. During the site visit, the Auditor reviewed 13 employee files. These included a review of seven employees, three newly hired employees, and three contractors. The Auditor reviewed a total of 19 employee files and found two of the files reviewed on-site did not include documentation that the employee was asked about previous misconduct. One of these employees was hired 26 years ago. The facility has met substantial compliance with subpart 115.17 (b).

(c)(d) The Human Resource staff were unavailable for an interview, but the Captain explained the background investigation process for employees, contractors, and volunteers, which included a thorough background investigation which includes in-person interviews with prior institutional employers. He explained that once the employee, volunteer, or contractor is entered into their Human Resource (HR) database, the facility administration will receive formal notification any time the individual is arrested and/or charged with any in-state violations. The Captain confirmed that each of the randomly selected employees received a completed background check prior to hire. The facility does not conduct a separate criminal background check every five years.

Does Not Meet (c): The facility could not provide documentation that initial background checks were completed on new employees who may have contact with detainees. The facility does not complete a background check every five years for facility staff who have contact with detainees. The facility must demonstrate compliance through development of a process for conducting and documenting the initial background checks on new employees and updated background checks every five years for employees who have contact with detainees. The facility needs to provide the process developed for conducting five-year background checks on all employees that have conduct with

detainees and initial backgrounds on all new employees. To demonstrate compliance, the facility needs to submit five employees initial background and their five-year background checks.

Corrective Action Taken (c): The facility provided documentation of the new process developed to ensure five-year background checks are completed. The facility has developed a spreadsheet which includes the due date for the next five-year criminal background checks. The five-year background check is completed during the employee's birth month. A copy of the spreadsheet is forwarded to the PSA Compliance Manager, who is also able to monitor these checks and ensure the checks are completed every five years. The new process is acceptable and ensures proper monitoring of this process by the PSA Compliance Manager. During the CAP process, ICE staff working on the CAP with the facility contacted the Auditor stating the existing policy addressed the five-year background check requirement adequately, but staff was not adhering to the policy. The Auditor stated the facility should review the existing policy with staff and provide verification of this review to the Auditor. The Lieutenant provided a copy of a memorandum sent to affected staff which outlined the requirement for a five-year background check for all employees, contractors, and volunteers. The auditor reviewed 10 employee files while on-site. Of the staff files reviewed, all new hire and five-year background checks were completed. The facility has met substantial compliance with subpart 115.17 (c).

Does Not Meet (d): The facility could not provide documentation that initial background checks were completed on volunteers and contractors who may have contact with detainees. The facility needs to provide the process developed for conducting initial backgrounds on volunteers and contracts who may have contact with detainees. To demonstrate compliance, the facility needs to submit five contractors and five volunteer background checks, and the process developed to ensure the background checks are completed.

Corrective Action Taken (d): The facility provided a memorandum from the Jail Captain explaining that due to the COVID-19 global pandemic volunteers have not been admitted to the facility since March 2020. The facility was unable to provide five completed volunteer background checks. As noted above, ICE Staff working on the CAP with the facility contacted the Auditor stating the existing policy addressed the five-year background check requirement adequately, but staff was not adhering to the policy. The Auditor stated the facility should review the existing policy with staff and provide verification of this review to the Auditor. The Lieutenant provided a copy of a memorandum sent to affected staff which outlined the requirement for a five-year background check for all employees, contractors, and volunteers. The Auditors reviewed three contractor files. Upon review of the background check documentation, the Auditor confirmed all three contractors received their initial background check, and all three contractors were not yet eligible for a five-year background check. The facility has met substantial compliance with subpart 115.17 (d).

§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight

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

Notes:

The Auditor mistakenly labeled this standard as non-compliant. The narrative portion of the standard details the facility's compliance with this standard. The facility is compliant with this standard and this standard will not be assessed in this report.

§115.33 - Detainee education

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

Notes:

(a)(b) The YCJ Policy D-104 states, "The facility shall provide the inmate/detainee notification, orientation, or instruction in formats accessible to all inmates/detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to inmates/detainees who have limited reading skills. The facility shall maintain documentation of inmate and detainee participation in the instruction session. The jail will maintain documentation of an inmates/ detainee's receipt of the ICE National Detainee Handbook, which includes the ICE Sexual Assault and Abuse Awareness pamphlet, and the viewing of the PREA Orientation video. The language and/or manner the information was provided to the detainee will also be documented on the booking report. (ICE Detainees Only)" The facility provided verification the policy revisions were reviewed with staff.

(a) Intake staff explained new detainees receive the ICE Sexual Abuse Awareness Information pamphlet, ICE National Detainee Handbook, the Facility Inmate Handbook and view the PREA video while in the intake area. The Facility Inmate Handbook is available in English and Spanish and the ICE National Detainee Handbook is available in 11 different languages other than English. The PREA pamphlet explains the facility's zero-tolerance policy and provides several methods of reporting sexual abuse or assault. The facility is also to provide each detainee with the Facility Inmate Handbook and the ICE National Detainee Handbook in English, Spanish, or a language the detainee understands. The Facility Inmate Handbook explains the zero-tolerance policy and options for reporting sexual abuse/assault to the facility or ICE. This handbook also explains that counseling, sexually transmitted disease (STD) testing, and medical treatment will be provided to victims. In addition to the subjects listed in the inmate/detainee handbook, the ICE National Detainee Handbook provides information regarding retaliation and self-protection. Each of the required orientation education topics for this section are provided to the detainee. Of the 20 random detainees interviewed, 12 detainees reported they did not receive the ICE National Detainee Handbook, 11 detainees reported they did not received the Facility Inmate Handbook, 19 detainees reported they did not view the PREA video, and 19 detainees reported they did not receive or could not recall receiving the PREA pamphlet. Some classification officers note in the electronic detainee record that the ICE National Detainee Handbook and/or inmate/detainee handbook was provided to the detainee, but this is not consistently documented.

(b) The facility has the means to provide PREA information to detainees who are visually impaired, deaf, LEP, or for those detainees with developmental or psychiatric disabilities, or detainees with limited reading skills as detailed in standard 115.16. The Auditor requested

verification that PREA information was provided to three LEP detainees. The facility was unable to provide verification that the selected detainees received PREA information at intake. As noted above, the majority of detainees interviewed did not receive the ICE National Detainee Handbook, the Facility Inmate Handbook, the PREA pamphlet, or watch the PREA educational video.

Does Not Meet (a)(b): The facility does not consistently provide or document that educational material is provided to detainees while in intake. Documentation that educational material was provided to new detainees and the language and/or format in which it was presented, would enable the Auditor to confirm that detainees receive the required orientation materials. The detainee education process must address each of the elements outlined in provision (a) of the standard. The facility must be able to demonstrate PREA educational information is provided consistently to all incoming detainees through documentation including LEP detainees and detainees with disabilities. The facility must demonstrate compliance through at least ten detainee files, with at least being five detainees that are LEP or disabled, over a two-month period documenting that the orientation materials are provided to detainees informing them of the all elements listed in this standard provision, and documentation of staff refresher training on providing effective communication of PREA educational information to LEP detainees and detainees with disabilities to provide the consistency of the orientation process for compliance review.

Corrective Action Taken (a)(b): The PSA Compliance Manager provided a newly designed Booking Report as verification of a new detainee's participation in the intake orientation. The new form requires intake officer and the detainee to sign the Booking Report. The PSA Compliance Manager also explained the intake officer enters the information into the facility's database if the detainee was provided the facility's Inmate/Detainee Handbook and an ICE National Detainee Handbook. Due to the COVID-19 global pandemic, the facility is not receiving new detainees. To address the requirements of the CAP the facility re-interviewed ten detainees to demonstrate how the facility documents any communication measures taken to effectively communicate with LEP detainees. The facility does not have any disabled detainees at this time. The facility provided verification these new procedures were reviewed by staff. During the on-site visit the Auditor interviewed four intake officers. Each officer reported they would utilize the language line to interpret for detainees who do not speak English or Spanish. The facility has numerous bilingual staff who speak English and Spanish. All intake officers were aware of the requirement to note the language of the handbooks provided to new detainees. When asked where to find ICE National Detainee Handbooks in a language other English or Spanish, half of those interviewed did not know how to access these handbooks and noted they would see their supervisor. Most reported if a handbook was not available in a detainee's language, the intake officer would read the ICE Detainee Handbook to the detainee through an interpreter. The Auditor considered that the intake officers have not admitted a new ICE detainee in several months and none since the new procedures have been implemented. In light of this, the Auditor finds the facility has met substantial compliance with subparts 115.33 (a)(b).

Recommendation: The facility should summarize the required PREA educational information to be read through an interpreter, for those detainees who are not provided a handbook in their language or for detainees who have communication disabilities and cannot read the handbooks. It is not reasonable to expect intake officers to read the full ICE National Detainee Handbook and/or the facility handbook to detainees, directly, or through an interpreter.

Does Not Meet (c): The facility was asked to provide Booking Report for eight detainees. The facility was unable to provide this verification as the requirement to complete the Booking Report was only recently implemented. The Booking Report does not document how the information was provided to the detainee i.e. through an interpreter, sign language, or another method if disabled. The facility must demonstrate compliance through the use of the Booking Report, or another method/documentation, to verify a consistent orientation process. The Booking Report should be expanded, or another method established to document how the information is provided to the detainee including LEP and disabled detainees. Ten detainee files, with at least five being LEP or disabled, containing the Booking Report and documentation of the orientation process over a two-month period must be provided for compliance review.

Corrective Action Taken (c): The facility implemented a new procedure for documenting the educational material provided to incoming new detainees and the format in which the material was presented. The new procedure requires the intake officer to note on the Booking Report the educational material provided to the detainee. The intake officer notes on the form the format or language the material was provided. The intake officer also makes an entry on the facility's database of the handbooks provided and the language of the handbook. The facility informed the Auditor that no additional ICE detainees have been received since the implementation of this new procedures. To demonstrate compliance, the facility provided educational material for the 10 ICE detainees housed at the facility and noted the language of the handbooks provided. There were no disabled detainees assigned to the facility. As noted above, the Auditor interviewed four intake officers. The facility has met substantial compliance with subpart 115.33 (c), but the recommendations provided for subparts (a)(b) also apply to subpart (c).

(d) During the facility tour, the Auditor observed PREA posters affixed to the window of each housing area. This poster provides the DHS-prescribed sexual assault awareness notice, the name of the PSA Compliance Manager, and contact information for the National Sexual Abuse Hotline. The Casa de Esperanza is a local organization that provides support services to victims of sexual abuse. These services include providing a victim advocate during the medical exam and the investigation process and supportive in-person counseling services. The name of this organization was not provided on the posters. The standard requires the name of the local organization(s) that can assist detainees who have been victims of sexual abuse be posted in all housing units. It was shared with the Auditor that the facility is working with Casa de Esperanza to provide a hotline for detainees.

Does Not Meet (d): The postings in the housing areas do not provide the name of the local organization that can assist detainees who have been victims of sexual abuse. The facility must demonstrate compliance through developing signage to provide the local organization information to the detainees and provide a copy of the new posting for compliance review.

Corrective Action Taken (d): During the CAP, the facility provided photographs of the ICE Zero Tolerance poster in English and Spanish, which included the name and phone number for Casa de Esperanza, a local advocacy group that provides a 24-hour hotline and support services to victims of sexual abuse. The facility noted these posters were posted in detainee housing and intake. During the facility tour, the Auditors confirmed these posters were posted in the detainee housing as well as program areas and intake. Detainees cannot call Casa de Esperanza directly from the phones provided in the housing area. Detainees can request to make a private call and will be taken to an individual phone room also utilized for attorney calls. In this room, detainees can contact Casa de Esperanza directly, the calls are not recorded. During the on-site visit, the Auditor called the Casa De Esperanza and confirmed detainees are not required to provide their name or any identifying information. The facility has met substantial compliance with subpart 115.33 (d).

(e) Intake staff explained that the DHS-prescribed Sexual Assault and Awareness Information pamphlet, is provided to detainees at intake. Of the 20 detainees interviewed, 19 reported they did not receive or could not recall receiving the pamphlet.

Does Not Meet (e): The facility does not make available the DHS prescribed Sexual Assault Awareness Information pamphlet. The facility must demonstrate compliance through a consistent practice of making available the DHS prescribed Sexual Assault and Awareness Information pamphlet to detainees. The facility must provide the method this is accomplished with, documentation for ten detainees over a month period, and documentation of staff refresher training of their duty to distribute and make available the pamphlet for compliance review.

Corrective Action Taken (e): As noted in subpart (a)(b), the Booking Report notes that the new detainee was provided the DHS Prescribed Sexual Assault and Awareness Information pamphlet. The Auditors also observed these pamphlets posted in the detainee housing areas. The facility has met substantial compliance with subpart 115.33 (e).

(f) Information about reporting sexual abuse or sexual harassment to the facility and to DHS or ICE Headquarters is provided in the ICE National Detainee Handbook but the Auditor was unable to verify this handbook is provided to detainees at intake or at any other time during detention.

Does Not Meet (f): The facility does not provide detainees with the ICE National Detainee Handbook at intake as directed by policy. The facility must demonstrate compliance through the consistent practice of making available the ICE National Detainee Handbook to all detainees at intake per policy and or in another method for standard compliance. The facility must document the handbook is provided to detainees through the same ten detainee files requested above for compliance review. The facility must also provide refresher training to staff of their duty to distribute and/or make available the ICE National Detainee Handbook in other methods. The facility must provide ten detainee files (same 10 detainee files noted in previous provision) demonstrating providing the ICE National Detainee Handbook at intake or in another method to the detainee and documentation of the staff training must be provided for compliance review.

Corrective Action Taken (f): The corrective action taken for this subpart is addressed in subpart (a)(b). The facility has met substantial compliance with subpart 115.33 (f).

§115.35 - Specialized training: Medical and mental health care

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

Notes:

(c) Wellpath's policy HCD-110-F-06 states upon hire, and annually thereafter, Wellpath employees receive training and instruction that relates to the prevention, detection, response, and investigation of staff-on-patient and patient-on-patient sexual abuse, as well as how to preserve physical evidence of sexual abuse. This training is an adjunct to the initial and on-going training provided by the facility. Training includes but is not limited to delineation of health care staff's role in the facility's sexual abuse policy and procedure; role specific training in the detection and assessment of sexual abuse; effective and professional response to victims and abusers; preservation of physical evidence; how to elicit, receive, and forward reports of allegations or suspicions of sexual abuse; confidentiality requirements; documentation of training content and attendance will be maintained. The facility provided two health care staff training curriculums, the facility's and Wellpath's. Between the two training curriculums, each element listed above is included. Interviews with mental health and medical staff confirmed health care staff were knowledgeable about their role within the facility as it relates to PREA related matters. Verification of the specialized health care training, as noted in Wellpath Policy HCD-110-F-06 and interviews, was requested following the site visit but not received by the Auditor. The Captain stated the facility provided ERO the facility's policies and procedures, including the policies and procedures ensuring medical staff is trained in procedures for examining and treating victims of sexual abuse during the last ERO inspection (November 13–15, 2019) for review and has not received documentation indicating the review has been completed.

Does Not Meet (c): The Auditor requested verification of specialized training for health care staff. The facility must demonstrate compliance with documentation of medical and mental health specialized training for five healthcare staff.

Corrective Action Taken (c): The facility provided a listing of 25 medical and mental health staff and the dates of the specialized training provided. The listing included the date of the next required training and the completion status. The listing showed all staff had received specialized training "on time" or "not yet due". Training certificates were provided for five healthcare staff as requested by the Auditor. The facility provided a spreadsheet which provided the dates of the next required advanced training for all medical and mental health care staff. The facility policy requires the training to be provided annually. The spreadsheet indicates several staff have not received annual training. The Auditor recommends the medical and mental health staff receive the training annually as required by the Wellpath policy. The facility has met substantial compliance with subpart 115.35 (c).

§115.41 - Assessment or risk of victimization and abusiveness
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(c)(d) The Intake Supervisor explained that the intake staff screen all in-coming detainees for risk of sexual victimization and abusiveness. This is completed as part of the custody assessment via the Intake Custody Assessment Scale. The formal custody assessment provides a custody score and determines a detainee's custody classification and housing placement. The risk assessment portion of the form lists risk factors and check boxes. The following items are listed: medical problem; psychological impairment; mental deficiency; involved in sexual abuse as victim or subject; and LGBTI. A narrative section is provided for criminal history and subject interview. The form does not indicate a section for entering the detainee's assessment of their safety. The custody score can be overridden, if warranted, due to the detainee's risk of victimization or abusiveness. The Auditor asked if classification officers are provided training specific to assessing risk factors for sexual victimization and abusiveness. A classification officer explained there is a classification course all classification officers are required to attend but it does not address how to assess these risk factors when classifying detainees. The facility policies refer to detainees being "at risk" or "high risk" for sexual abuse or sexual abusiveness. If the intention of the risk assessment is to define risk levels according to seriousness, this should be defined to the staff responsible for determining a detainee's risk level. Classification officers are assigned to each shift and are assigned a specific detainee caseload to follow throughout the detainee's holding. The detainees are kept separate from the general population until the intake process is complete. After the intake process is complete, the initial classification and housing assignment based on the custody assessment is determined. According to the Intake Supervisor and random interviews with detainees, this process does not exceed 12 hours.

The Auditor provided the names of eight detainees and requested completed intake forms including the new Booking Report the facility implemented. The facility was unable to produce documentation of the detainees being screened for risk of sexual victimization and abusiveness as the detainees were admitted prior to implementing the use of the new Booking Report form. Upon review of the new Booking Report, the new form does not address the risk screening elements required. The Booking Report includes documentation of PREA education and not risk screening. Furthermore, the Intake Custody Assessment Scale screens for custody security level, not for risk of sexual victimization and abusiveness. The Auditor requested five additional files that demonstrated forms showing the review of risk factors. Four of the five detainees had no other risk factors noted on the Intake Custody Assessment Scale or the Booking Sheet.

Does Not Meet (c)(d): The facility does not assess the detainees at intake on all elements of the provision (c). The Intake Custody Assessment Scale form is a security assessment form and does not address the required information to assess the detainee's risk of sexual victimization or abusiveness, and the new Booking Report does not address all elements required in the risk screening. The facility must demonstrate compliance through documentation that all the required information in provisions (c) and (d) are addressed in the intake assessment. The facility can update the form to address the assessment information that is required or by another method that captures the required information. The facility needs to provide the documented information for the same ten detainees files requested in 115.33 and documentation of staff training of the process to capture all the elements of the provision for compliance review.

Corrective Action Taken (c)(d): The facility provided a revised risk assessment that assesses each risk factor required by the standard. Initially the revised risk assessment did not properly assess age as a risk factor. The facility revised the risk assessment to assess age as a risk factor. This revised risk assessment was submitted for the Auditor's review prior to the March 3, 2021 deadline. The facility provided email verification of the submission verifying the submission to ICE, however, the documentation was not provided to the Auditor for review. The Auditor reviewed and accepted the revised risk assessment while on-site since the facility was able to document the CAP submission prior to the deadline. The facility has not received new detainees, so the facility reinterviewed the ten detainees currently housed utilizing the new risk assessment to demonstrate compliance with this standard. The facility has met substantial compliance with subparts 115.41 (c)(d).

(e) According to classification staff, classification reviews are conducted monthly. The classification officer explained the review process includes an electronic review of incident reports and disciplinary infractions information maintained in the jail record data base. The classification officer stated the narrative portion of PREA incident reports are not available for review by classification officers, as this information is restricted, but the lack of information should signal to the classification officer that a PREA related incident may have occurred. The PSA Compliance Manager explained if new information is received that would affect a detainee's risk factor, the information is passed on to the assigned classification officer to be considered at the next review.

Does Not Meet (e): The current process is not adequate to reassess a detainee's risk of victimization or abusiveness. The facility must demonstrate compliance by allowing the classification officer to review all relevant facility information, which would include the PREA incident reports that classifications officers are currently restricted from viewing, to determine if any factors have changed that might increase or decrease a detainee's risk of sexual victimization or abusiveness or institute a process to allow an individual the facility deems can have access to the information to handle the reassessments. The facility needs to provide the documented reassessments for the same ten detainees files requested in 115.33 (if possible or the initial and reassessment for other detainees), documentation of the new process for allowing staff to view facility information for the reassessment process, and documentation of staff training of the process to capture all the elements of the provision for compliance review.

Corrective Action Taken (e): The facility provided a copy of a memorandum authorizing classification officers to have access to applicable reports and documents when assessing or reassessing a detainee's risk of victimization or abusiveness. The facility reviewed

these changes with applicable staff. During the on-site visit, the Auditors interviewed four classification officers. These officers reported they have access to applicable reports (i.e. incident reports, grievances, disciplinary actions, and the like). The facility has met substantial compliance with subpart 115.41 (e).

§115.42 - Use of assessment information

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

(a) Detainees receive a custody classification during the intake process, utilizing the Intake Custody Assessment Scale form. This score determines the detainee's housing placement. Information regarding risk factors for victimization or abusiveness may increase or decrease the custody score, thus affecting the housing placement. Detainees are not given work assignments and each housing unit goes to recreation as a unit. The Auditor requested five completed forms showing where risk factors influenced a detainee's housing assignment. Of the five detainee examples provided, each was placed in protective custody due to their crime. Four of the five detainees had no other risk factors noted. The Auditor acknowledges that a detainee's crime may be the sole determining factor for custody decisions, however, this is typically not the case when assessing risk of sexual abusiveness or victimization. This is usually determined by more than one risk factor, but four of the five detainees had no other risk factors checked. From the information provided and interviews with staff, the Auditor was unable to confirm whether risk factors for sexual victimization or abusiveness influence housing decisions.

Does Not Meet (a): The facility is not making housing placements based on the risk of sexual victimization or abusiveness that ensures the safety of each detainee. The Intake Custody Assessment Scale form is a security classification form and does not address information to make informed determinations for the risk of victimization or abusiveness that is to be utilized to make individualized determinations to ensure the safety of each detainee. The facility must demonstrate compliance when determining housing and other activities/assignments that information from a risk assessment that includes all information required under 115.41 (c) and (d) are considered. The facility must provide housing placement decisions that document the consideration of all the information required under 115.41 (c) and (d) with the ten detainee files requested in standard 115.33 for compliance review.

Corrective Action Taken (a): The facility provided completed risk assessments for the ten detainees currently housed at the facility to demonstrate compliance. The facility has not had any new intakes. The Facility Captain explained although all ICE detainees are now housed in one housing area, should the need arise to provide separate housing for a detainee, another housing unit would be opened for the detainee. The female housing area consists of an open barracks as well as double bunked cells which provides smaller housing for at risk detainees. The facility has met substantial compliance with subpart 115.42 (a).

(b) The facility provided a memorandum stating there have been no transgender detainees at the facility for the audit period; however, the PAQ stated there had been two transgender detainees. At the time of the site visit, one transgender detainee was housed at the facility. This detainee had been assigned to general population but was later placed on protective custody due to behavior and management problems caused by the detainee. This detainee assignment to segregation is reassessed monthly by the assigned classification officer.

The Classification Supervisor stated a detainee's genitalia determines housing placement. He explained that a detainee with breast augmentation and a penis would automatically be placed in protective custody. Both classification officers stated the health and safety of the detainee and the detainee's self-identification is considered when making housing placement for transgender detainees. The Health Services Administrator (HSA) stated medical is not consulted regarding transgender detainees. She explained the classification department determines housing. The transgender detainee felt the placement in protective custody was unfair and stated he is being harassed by other detainees. He stated he has expressed these concerns to the mental health staff. The Auditor discussed these concerns with security staff who were aware of the detainee's complaints. Security staff explained they are continually monitoring the cell area to ensure the detainee is not harassed.

Does Not Meet (b): The facility is making placement decisions based solely on the physical anatomy of the detainee and is not consulting with medical or mental health staff for their assessment or placement recommendations. The facility must demonstrate compliance by developing a process to make housing decisions comply with the standard language which includes not basing the housing placement on the physical anatomy of the detainee. The facility must include in the process that medical and/or mental health staff is consulted as part of the assessment process. The facility must provide a process for housing determination for transgender detainees that meets the standard language and includes a consultation with medical and mental health professionals, as well as, two housing determinations of transgender detainees (if available during the CAP process) for compliance review.

Corrective Action Taken (b): At the time of the on-site visit, there were no transgender detainees housed at the facility. The Auditors interviewed five classification officers to include the Classification Supervisor. Four of the five classification officers stated input from the transgender detainee is considered when making housing decisions. Only two of the five officers interviewed stated medical or mental health would be consulted when making housing decisions for transgender detainees. Medical and mental health staff interviewed stated they are consulted regarding transgender housing decisions. The Facility Lieutenant also stated medical and mental health staff are consulted regarding housing placement of transgender detainees. The facility has met substantial compliance with subpart 115.42 (b).

Recommendation: The facility should provide further training for classification officers regarding the classification and housing decision for transgender detainees, so all staff understand and familiar with the policy protocols.

§115.43 - Protective custody
Outcome: Does not Meet Standard
Notes:

(d)(e) This order requires the Classification Supervisor or appointed classification officer to conduct a review within 72 hours of the detainee's placement in administrative segregation to determine if continued placement in administrative segregation is still warranted. The standard requires a review, by a supervisory staff member, within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. Although the Classification Supervisor is considered supervisory staff, a classification officer is not considered supervisory staff. The procedures also do not include requirements to notify the FOD no later than 72 hours after the initial placement of a detainee into administrative segregation on the basis of a vulnerability to sexual abuse or assault.

Does Not Meet (d): This order does not require a supervisory staff member to conduct, at a minimum, an identical review after the detainee has spent 7 days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter. The facility needs to update its policy to only allow the Classification Supervisor or appointed supervisory staff to conduct the 72-hour review. The staff must be trained on the policy changes and ensure staff's understanding of the required practice. The facility needs to provide the updated policy and documentation of staff training on the new policy for compliance review.

Corrective Action Taken (d): The YCJ Policy D-107 was revised and now states, "If a detainee is placed on administrative segregation, staff shall notify ICE/ERO in writing as soon as possible, but no later than 72 hours after initial placement. Staff shall also notify ICE/ERO when a detainee is released from segregation. A supervisor will conduct a review within 72 hours of a detainee's placement to determine whether segregation is still warranted. The review shall include an interview with the detainee, and the review documented in the detainee's file. A supervisor will conduct an identical review after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter at a minimum." The facility provided a roster of staff and the dates the revised policy was reviewed by staff. The Auditors interviewed five classification officers to include the Classification Supervisor. All reported the classification officer conducts the reviews of detainee victims assigned to protective custody. Classification officers are not considered supervisory staff. The facility does not meet the requirements of this standard subpart 115.43 (d).

Does Not Meet (e): The policy and procedures do not include requirements to notify the FOD no later than 72 hours after the initial placement of a detainee into administrative segregation, on the basis of a vulnerability to sexual abuse or assault. The facility must demonstrate compliance by expanding the policy to address the language of the standard and documentation of a notification, if available during the corrective action period.

Corrective Action Taken (e): The YCJ Policy D-107 Administrative Segregation was revised to and states, "If a detainee is placed on administrative segregation, staff shall notify ICE/ERO in writing as soon as possible, but no later than 72 hours after initial placement. Staff shall also notify ICE/ERO when a detainee is released from segregation." There have been no detainees placed on protective custody during this CAP period and there were no detainees on protective custody during the on-site visit. The facility provided a listing of staff and the dates each reviewed the revised policy. Most classification staff were aware of the requirements to notify ICE within the appropriate time frames. The facility has met substantial compliance with subpart 115.43 (e).

§115.52 - Grievances
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b) YCJ Order #F-201 states a grievance can be any complaint regarding jail conditions, procedures, food, failure to accommodate disabilities, or compliance with any portion of the consent decree. The order also outlines procedures for detainees to file a grievance related to sexual abuse. The policy states grievance forms will be provided to detainees within 24-hours of the request. The policy states an inmate (detainee) can file a grievance without submitting it to or referring it to a staff member who is the subject of the complaint. This policy refers the reader to the grievance procedure outlined in the facility' Inmate/Detainee Handbook, which also indicates a detainee can file a grievance related to sexual abuse. The facility detainee handbook also informs detainees the grievance process. Interviews with several staff, including the Grievance Officer, indicated detainees could not utilize the grievance procedure to file sexual abuse allegations. However, the facility's Order F-201 and the facility's Inmate/Detainee Handbook informs that detainees can utilize the grievance process for sexual abuse.

Does Not Meet (a): Detainees must be allowed to utilize the grievance procedure to file complaints related to sexual abuse. The standard also requires detainees to have access to the grievance procedures for filing sexual abuse or harassment allegations. The intent of the standard is to provide prompt, unimpeded access to the grievance procedure. The facility policies that allow staff 24-hours to provide a grievance form to the detainee delays prompt and unimpeded access to the grievance procedure and does not comply with the standard. The facility must demonstrate compliance through the development of a process that allows detainees to file a grievance on sexual abuse promptly and with unimpeded access. The facility must provide the updated process developed, an updated policy allowing detainees prompt and unimpeded access to the grievance process, and documentation of staff training on the updated policy and the updated sexual abuse grievance process for detainees for compliance review.

Corrective Action Taken (a): The facility revised YCJ Policy #H-100 Inmate Grievances and provided verification that these revisions were reviewed with staff. YCJ Policy #H-100 now states, "Any inmates may file a grievance by submitting a request to any officer or supervisor on the proper grievance form. Grievance forms shall be made readily available to all inmates." During the facility tour, the

Auditors observed grievance forms available to detainees just outside the housing unit. Officers and detainees reported detainees can obtain grievance forms by asking the housing unit or control room officer for a form or obtaining a form from outside the housing unit. There have been no grievances filed related to sexual abuse during the CAP period. The facility has met substantial compliance with subpart 115.52 (a).

(b) Neither the facility's order nor the inmate/detainee handbook outline that the facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Interviews with several staff, including the Grievance Officer, indicated detainees could not utilize the grievance procedure to file sexual abuse allegations.

Does Not Meet (b): The facility policy, inmate/detainee handbook, or staff knowledge through interviews indicate that the detainee may file a grievance concerning sexual abuse without time limitations. The facility must educate the staff and detainees that a sexual abuse grievance can be submitted without time limitations. The facility must provide documentation of staff training and information provided to the detainee population that sexual abuse grievances can be submitted without time limitations to demonstrate compliance.

Corrective Action Taken (b): The revised YCJ Policy #H-100 states, "No time limits shall be imposed on time-sensitive grievances that involve an immediate threat to an inmate's health, safety, or welfare related to sexual abuse." The facility provided the revised policy and verification of the policy review by staff. The facility also provided a copy of the revision to the Facility Detainee Handbook. September 2020. The revised policy was posted on the detainee bulletin boards. Grievance officers, detention officers and detainees were aware there were no time restrictions for filing a grievance related to sexual abuse. There have been no grievances filed related to sexual abuse during the CAP period. The facility has met substantial compliance with subpart 115.52 (b).

(e)(f) YCJ Order F-201 does not address the standard requirement to send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate FOD at the end of the grievance process. As noted above, the facility's Inmate/Detainee Handbook states there are no time limits on filing a sexual abuse related grievance. The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 30 days of the initial filing of the grievance. Computation of the 30-day time period shall not include time consumed by inmates in preparing any administrative appeal. The detainee shall be permitted to obtain assistance in filing the grievance from third parties to include fellow inmates/detainees, staff, family members, attorneys, and outside advocates. Third parties may also file the grievance for the detainee. If the detainee is not satisfied with the grievance disposition, the detainee may appeal to a Grievance Appeal Board. The detainee can request a hearing on a form entitled Request for Hearing Before Grievance Appeal Board within seven days of the grievance response. Within seven days of receiving the request, the Appeal Board will be convened, and the hearing conducted. The detainee is given the opportunity to meet with the Board in person and given an opportunity to provide testimony. The Board submits a written disposition of the appeal and a brief explanation of its findings within 72 hours of the completion of the appeal hearing. The facility's Inmate/Detainee Handbook provides instructions on how to contact their consular official and the DHS OIG to report incidents of sexual abuse confidentially and anonymously. The facility provided a memorandum stating no grievances have been filed related to sexual abuse or harassment.

Does Not Meet (e): The policy and practice does not require that all grievances related to sexual abuse and the facility's decisions with respect to such grievances be sent to the appropriate FOD at the end of the grievance process. The facility must demonstrate compliance by developing a process to ensure all grievances related to sexual abuse and the facility's decisions with respect to such grievances be sent to the appropriate FOD at the end of the grievance process and staff need to be trained on the process. The facility needs to provide the updated process with the requirement to notify the FOD, an example of a sexual abuse grievance referred to the FOD, and documentation of staff training of the notification requirement for compliance review.

Corrective Action Taken (e): The facility revised YCJ Policy #H-100 by adding the statement, "For ICE detainees ICE/ERO/FOD will be notified." The Auditors interviewed two grievance officers who reported ICE would be notified whether a sexual abuse grievance is received and at the end of the grievance process. There have been no grievances filed related to sexual abuse during the CAP period. The facility revised YCJ Policy #H-100 which now reads, "The department shall issue a final decision on the merits of any portion of a grievance alleging sexual abuse within (5) days of the initial filing of the grievance." The facility provided a roster of employees and the dates the employee reviewed this policy. The facility has met substantial compliance with subpart 115.52 (e).

§115.63 - Reporting to other confinement facilities

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

Notes:

(a)(b)(c) Policy #901 states upon receiving an allegation that a detainee or prisoner was sexually abused while confined at another facility, the Shift Supervisor shall notify the head of the facility or the appropriate office of the agency where the alleged abuse occurred. The notification shall be made as soon as possible but no later than 72 hours after receiving the allegation. The Shift Supervisor shall document such notification. Interviews with the Captain and the PSA Compliance Manager confirmed this practice. The facility provided documentation of one incident in which a detainee notified the YCJ staff of a sexual assault allegation which allegedly occurred at another facility. Upon receiving information about the incident, the Shift Supervisor notified the PSA Compliance Manager and contacted the patrol division of the Yuba County Sheriff's Office to take a report. This report was forwarded to the county sheriff's office in which the incident occurred. The facility did not provide documentation that the head of the facility or appropriate office of the agency where the alleged abuse occurred was notified of the incident and within 72 hours.

Does Not Meet (a)(b)(c): The facility could not provide documentation that notifications are made to the head of the facility or appropriate office of the agency where the alleged abuse occurred. The facility must demonstrate compliance that staff are following policy and the standard by notifying the head of the facility or the appropriate office of the agency where the alleged abuse occurred of the allegation reported. The facility needs to provide an example of a notification made to the head of the facility or the appropriate office of the agency where the alleged abuse occurred of the allegation reported within 72 hours and sample documentation of a notification made, if an incident occurs within the corrective action period, for compliance review. The facility must also provide documentation of staff training on the policy requiring the notification to the head of the facility or the appropriate office of the agency where the alleged abuse occurred and documentation of the notification within 72 hours for compliance review.

Corrective Action Taken (a)(b)(c): The facility YCJ Policy #D-104 states, "Upon receiving an allegation that an ICE detainee was sexually abused or assaulted while confined at another facility, the facility administrator shall notify ICE ERO and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The Jail Commander shall notify the detainee in advance of such reporting. The facility shall document that it has provided such notification. The facility where the alleged abuse occurred shall then ensure the allegation is referred for investigation and reported to ICE/ERO (this notification must go directly to the FOD)." The facility also provided a roster of staff with dates staff reviewed the policy. There were no allegations of this type during the CAP period. The facility has met substantial compliance with subparts 115.63 (a)(b)(c).

§115.65 - Coordinated response

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

(a) The facility utilizes YCJ Policy #901 as the coordinated response in the event of an incident of sexual abuse. This policy outlines the roles of the first responders, the shift supervisor, the investigators, and the administration. This policy does not address the role of medical and mental health staff. The HSA explained the role of medical and mental health staff if an allegation of sexual abuse is received. She explained the detainee would be brought to the medical area and health care staff would immediately provide any necessary first aid. Medical and mental health staff would also provide follow-up services, treatment plans, referrals for continued care, and pregnancy and sexually transmitted disease testing. The HSA explained that none of the incidents alleging sexual abuse required first aid, but each alleged victim was seen by facility health care staff.

The facility also has outside organizations that are a part of the facility coordinated response that would assist in an incident of sexual abuse that is not included in the policy for coordinated response. The Rideout Regional Medical Center is the hospital emergency room utilized and conducts the forensic exams for alleged victims of sexual assault from the facility. She stated SANEs are not always available, and in this circumstance, the alleged victim would be taken to the Bear Clinic in Sacramento, California for a forensic exam. Also, on April 9, 2020, the Auditor spoke with the Deputy Director of Casa de Esperanza who outlined the services provided to detainees, that include victim advocacy services during medical exams and investigatory interviews and in-person counseling at the facility. Also, the Prosecutor's Office has victim advocates available to support victims during the legal process.

Does Not Meet (a): The current plan does not include the roles and responsibilities of medical and mental health staff. The facility must demonstrate compliance by expanding the coordinated response plan to include the roles and responsibilities of medical and mental health. The facility needs to provide the updated coordinated response document that includes all parties as outlined in the standard language for compliance review.

Corrective Action Taken (a): The facility revised YCJ Policy #d-100 which now reads, "The facility must use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a custody staff member, criminal investigator, as well as representatives from outside entities that provide relevant services and expertise. The team consist of: Shift Supervisor, PREA Coordinator, Medical Practitioner, Mental Health Practitioner, Victim Advocacy Services Representative, ICE ERO Field Office PSA Coordinator. Staff shall utilize available community resources such as Rideout Hospital or Casa de Esperanza to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse and assault perpetrators to address victims' needs most appropriately." The facility also provided a roster of staff and the dates this policy revision was reviewed with staff. The facility has met substantial compliance with subpart 115.65 (a).

§115.67 - Agency protection against retaliation

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

(b)(c) YCJ Policy #901 states all detainees, prisoners, and members who reported sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations shall be protected from retaliation. If any other individual who cooperates with the investigation expresses a fear of retaliation, appropriate measures shall be taken to protect that individual. The Shift Supervisor or the authorized designee shall employ multiple protection measures, such as housing changes or transfers for detainee or prisoner victims or abusers; removal of the alleged abuser from contact with the victims; and emotional support services for detainees, prisoners, or members who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The Shift Supervisor or authorized designee shall identify a staff member to monitor the conduct and treatment of detainees, prisoners, or members who have reported sexual abuse or detainees or prisoners who were reported to have suffered sexual abuse. The staff member shall act promptly to

remedy any such retaliation. In the case of prisoners or detainees, such monitoring shall include periodic status checks. The Captain explained that both PSA Compliance Managers are responsible for monitoring for retaliation of detainees, staff, contractors, or volunteers. The PSA Compliance Manager confirmed his responsibilities regarding monitoring for retaliation. He added that monitoring would be done for a minimum of 90 days or longer if necessary. The PSA Compliance Manager stated at this time retaliation monitoring is not documented but he is developing a form for use in the future.

The PSA Compliance Manager provided an audit investigation file review form from one of the completed investigations where he completed retaliation monitoring, which included the dates the retaliation monitoring began and the date it was discontinued. This period was less than 90 days, but the PSA Compliance Manager had properly noted the detainee had been released from custody. However, there was no additional information available to verify retaliation monitoring was being conducted, including other cases monitored, nor did the PSA Compliance Manager during interview, explain the retaliation monitoring method, or process he follows to monitor for retaliation. Absent this process or some type of documentation, the Auditor was unable to confirm compliance with this standard.

Does Not Meet (b)(c): The facility had no method to verify monitoring for retaliation was occurring after an allegation. The facility must provide retaliation monitoring for staff and detainees for 90 days after an allegation and document the monitoring. The facility must demonstrate compliance through a demonstrated method that monitoring for retaliation is occurring for at least 90 days following a report of sexual abuse. For compliance, the facility needs to provide evidence that monitoring, including multiple protective measures, are considered for retaliation, for compliance review.

Corrective Action Taken (b)(c): The facility developed a retaliation monitoring form utilized to document retaliation monitoring. Upon completion the form is sent to the PSA Compliance Manager who maintains the records and determines if additional monitoring is required beyond the 90-day period. The facility also provided a completed retaliation log which verified that retaliation monitoring is occurring, and a roster of staff and the dates staff reviewed the new forms. There were no detainee victims at the facility during the site visit to interview. The facility has met substantial compliance with subpart 115.67 (b)(c).

§115.68 - Post-allegation protective custody

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

(b) YCJ Manual Order #C-153 states detainees at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If a facility cannot conduct such an assessment immediately, the facility may hold the detainee in involuntary segregated housing for less than 24 hours while completing the assessment. The facility shall assign such detainees to involuntary segregation only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. The PSA Compliance Manager also confirmed detainee victims may be held in administrative segregation for 30 days or less. The standard requires detainee victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee. The PSA Compliance Manager also confirmed he completes a reassessment of these detainees prior to returning them to general population. He also stated he notifies the FOD by email whenever a detainee victim has been held in administrative segregation for 72 hours. The facility provided a memorandum to the Auditor stating there have been no incidents in which a detainee was placed segregation for protection from sexual assault, sexual harassment, or retaliation.

Does Not Meet (b): The facility houses detainees in administrative segregation for 30 days or less. The facility must demonstrate compliance through updating the policy and practice that detainee victims shall not be held for longer than five days in any type of administrative segregation pursuant to a PREA allegation, except in highly unusual circumstances or at the request of the detainee. The facility needs to provide the updated policy, documentation of staff training on the new policy and practice, and a detainee file to document the housing period of a detainee in post-allegation protective custody (if a detainee has been placed in protective custody) for compliance review.

Corrective Action Taken (b): The facility revised YCJ Policy #D-100 which now reads, "Victims and vulnerable inmates/detainees shall be housed in a supportive environment that represents the least restrictive housing option possible (e.g. in a different housing unit, transfer to another facility, medical housing, or protective custody), and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical or mental health needs of the victim. Victims may not be held longer than 5 days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim. The facility shall notify the appropriate ICE/ERO FOD whenever a detainee victim, or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hours. (See Policy D-106, Section VI, for Administrative Segregation review guidelines)." The facility provided a roster of staff and the dates each staff member completed the revised policy review. There were no detainees placed on protective custody during the CAP period and no detainee victims assigned to protective custody during the on-site visit. The Auditors interviewed five classification officers (one from each shift) and the Classification Supervisor. Classification officers were aware of the review requirements for detainee victims of sexual abuse assigned to protective custody. The facility has met substantial compliance with subpart 115.68 (b).

§115.71 - Criminal and administrative investigations

Outcome: Does not Meet Standard
Notes:

(b) Policy YCJ Policy #D-104 notes administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse. The departure of the alleged abuser or victim from employment or control of this facility shall not be used as a basis for terminating an investigation. The Facility Investigator stated he would complete an administrative investigation into any substantiated or unsubstantiated allegation. The Investigator did not indicate, and the policy does not address the standard requirement that administrative investigations are conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity.

Does Not Meet (b): The policy and the interview with the Investigator did not address the standard requirement that administrative investigations are conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. The facility must demonstrate compliance that administrative investigations will be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. The facility needs to provide updated written procedures and policy and documented staff training on the updated policy for compliance review.

Corrective Action Taken: The facility revised YCJ Policy #D-104 which now reads, "If the allegation involves an ICE detainee, any such investigation shall be coordinated with ICE/ERO." The facility provided a roster of staff and the dates staff reviewed the revised policy. The administrative investigator confirmed administrative investigations are conducted after consultation with DHS. The facility has met substantial compliance with subpart (b).

(f) Policy #901 states the facility's investigator will cooperate with outside investigators and remain informed about the progress of any outside investigation. One investigation was referred to the District Attorney for possible criminal charges. The PSA Compliance Manager states he cooperates fully with outside investigators and the District Attorney's office with all investigations. The investigation file did not have any information regarding this communication.

Does Not Meet (f): The facility could not provide documentation that the facility remained informed about the progress of the investigation. The facility must demonstrate compliance of remaining informed about the progress of the investigation. The facility needs to provide documentation of remaining communication with an outside agency during an investigation for compliance review.

Corrective Action Taken (f): The facility revised YCJ Policy #D-104 which now reads, "When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation via telephonically or email." The facility also provided a roster of staff and the dates staff reviewed this policy revision. The facility provided a copy of correspondence received from the prosecuting attorney's office (in 2019) explaining why criminal charges were not being filed against an alleged detainee perpetrator. There have been no criminal investigations during the CAP period. The Auditor required the facility to document their efforts to remain informed about sexual abuse investigations conducted by outside investigators. Documentation of these efforts provides the Auditor a means for assessing compliance with this standard requirement. Email correspondence between the facility and the criminal investigators provides a means for an Auditor to assess compliance with this standard. Unless telephonic communications are documented, there is no means for the Auditor to assess compliance. The revised policy does not require the telephonic contacts to be documented or another means provided for the Auditor to assess compliance. The facility does not meet the requirements of this standard subpart (f).

§115.73 - Reporting to detainees

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

(a) The PSA Compliance Manager stated no detainees were notified of investigation results. This requirement is not addressed in the facility policy (YCJ Policy #D-104).

Does Not Meet (a): The facility and/or agency has not notified detainees of the outcome of the investigations. The agency, per the standard, is required to notify the detainee about the result of the investigation and any responsive action taken. The agency must provide three examples of detainees being notified of the outcome of the investigation, a process developed with the facility for the process to notify detainees, and documentation of agency staff training on the requirement of outcome notifications for compliance review.

Corrective Action Taken (a): The YCJ Policy #D-104 now reads, "Following an investigation into an inmate's allegation that he or she suffered sexual abuse in an agency facility, the agency shall inform the inmate as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the inmate." The facility provided a roster of staff and the dates the revised policy was reviewed by staff. The facility also provided copies of notification to detainees of the results of the sexual abuse allegation. There were no additional sexual abuse allegations during the CAP period, so the facility provided copies of the investigative outcome notifications to detainee victims from allegations prior to the CAP period. The facility has met substantial compliance with subpart 115.73 (a).

§115.77 - Corrective action for contractors and volunteers

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

(a)(b)(c) YCJ Policy #901 states any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees or prisoners and reported to any relevant licensing bodies. The Sheriff shall take appropriate remedial measures and consider whether to prohibit further contact with detainees or prisoners by a contractor or volunteer. The Captain confirmed the above policy is the practice of the facility. He explained that any allegation of sexual abuse or harassment by a contractor or volunteer would be promptly investigated and referred for criminal investigation if appropriate. The volunteer or contractor would be removed from any contact with detainees until the completion of the investigation. A memo was provided stating there were no incidents involving a contract employee or volunteer. However, upon review of the Investigation Spreadsheet, there were two incidents involving contractors, one of the allegations involved a facility contractor and one allegation was an incident that occurred at another facility involving a contractor. Although requested from the facility for review, this Auditor was not able to review the allegation involving the facility contractor to determine if the facility took measures to protect the alleged victim from contact and what corrective action was taken for the substantiated case of the facility contractor given the facility did not provide the documentation.

Does Not Meet (a)(b)(c): The facility did not provide documentation to demonstrate what corrective action was taken for the facility contractor on the substantiated incident. The facility must provide documentation of the corrective action taken including appropriate remedial measures taken consideration whether to provide further contact with detainees, and reporting to any relevant licensing bodies if appropriate for compliance review

Corrective Action Taken (a)(b)(c): The facility provided documentation regarding the incident involving a contractor. A review of this documentation indicated the contractor did not work for the facility but rather worked for ICE. ICE was notified of the allegation and the contractor was not allowed to enter the facility during the investigation. The facility has met substantial compliance with subparts 115.77 (a)(b)(c).

§115.81 - Medical and mental health assessments; history of sexual abuse

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

(a)(b)(c) The HSA explained a risk assessment is completed initially by intake staff. If intake staff identified a sexual abuse victim or abuser, intake staff will immediately refer the detainee to health care staff. For a medical referral, the detainee would be provided a health assessment within two working days. For a mental health referral, the detainee would be provided a mental health evaluation within 72 hours of the referral. The mental health professional explained that medical staff is usually in the intake area when new detainees are received. Medical staff would notify her of the referral, and she would see the detainee the same day if she is on-site, the following day if she is off-site. The Intake Supervisor stated if the risk assessment identifies a victim or abuser, intake staff would immediately refer the detainee to a qualified mental health or medical health professional for follow-up. The Auditor reviewed medical and facility policies but a referral from intake staff for prior victimization or abusiveness was not specifically addressed. The Auditor reviewed the facility policies, and this type of referral is not specifically addressed.

The Auditor identified one detainee who had reported a prior history of sexual victimization or abusiveness and requested verification that the detainee was immediately referred to health care staff and verification the detainee was seen by health care staff as outlined in this standard. The Auditor did not receive the requested information.

Does Not Meet (a)(b)(c): The facility did not provide documentation demonstrating detainees that reported prior history of sexual victimization or abusiveness were referred to a qualified medical or mental health professional for follow-up. The facility must demonstrate compliance by immediately referring detainees who disclosed prior victimization and/or perpetrated sexual abuse to medical and mental health for follow-up. The facility needs to provide documentation of referrals and the follow-up by medical and/or mental health services for detainees that reported prior history of sexual victimization or abusiveness for compliance review.

Corrective Action Taken (a)(b)(c): The facility developed a referral form to be completed when detainees are assessed to be at risk for sexual victimization or sexual abusiveness. The form adequately documents the referral for services. The facility provided verification of the dates staff reviewed the new form. There were no detainees received during the CAP period who required a referral to mental health or medical staff. The facility has met substantial compliance with subparts 115.81 (a)(b)(c).

§115.82 - Access to emergency medical services

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

(a) Wellpath's policy HCD-110-F-06 outlines the responsibilities of medical and mental health staff in the event of an incident of sexual abuse. These responsibilities include a baseline history and assessment by medical staff to determine the time and date of the incident and current presenting physical and mental status. Medical staff stabilizes the alleged victim and prepares them for transport for a forensic exam, if applicable. Medical staff communicates with the hospital to conduct the forensic exam and provides the detainee's current treatment, medications, allergies, and any actions or treatment taken related to the assault. Medical staff obtains consent from the detainee for the forensic exam and maximizes the preservation of evidence. Prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases are offered to the victims, as appropriate. Emergency contraception is available for female victims. Following any emergency treatment, medical staff notifies mental health staff of the event and an immediate telephone referral is

made. The on-call psychiatrist is contacted if needed. Mental health will assess the need for crisis intervention and provide the services as necessary. Mental health staff offer on-going follow-up services. If the detainee refuses the services, the detainee is informed mental health staff will follow-up in 14 days to determine if the patient is functioning adequately and again offer follow-up services. According to the HSA, these services are provided to the victim at no cost and regardless of whether the victim identifies the abuser or cooperates with the investigation. None of the detainees that reported sexual abuse were still housed at the facility for interviews. Only one of the three investigation files reviewed demonstrated the detainee was seen by medical.

Does Not Meet (a): Of the three investigations reviewed only one detainee was seen by medical. The facility must demonstrate compliance that all detainees who have been victimized by sexual abuse including sexual harassment (the DHS term of sexual abuse includes sexual harassment) are offered emergency medical treatment and crisis intervention services as appropriate. The facility must provide documentation that medical and mental health services were offered for three detainee who have alleged sexual abuse for compliance review.

Corrective Action Taken (a): The facility provided five completed PREA checklists from 2019 for detainee victims indicating the detainees were seen by mental health and medical staff to demonstrate the process. Compliance was further supported through interviews with medical and mental health staff, who confirmed all detainee victims are seen by medical and mental health staff. The facility has met substantial compliance with subpart 115.82 (a).

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

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

Notes:

(a) Wellpath's policy HCD-110-F-06 states continued evaluation and treatment of medical and mental health needs related to sexual abuse will be provided in accordance with the patient's desire for treatment and the community standard of care. Services may be provided through sick call, chronic care clinics, and regular health examinations. After any emergency treatment is provided, health care staff will notify mental health staff of the event. An immediate telephone referral, including after hours, is the preferred referral format in case of an abuse. If after-hours, mental health issues are handled by health care staff at the facility, the evaluating health care staff member will assess the need for immediate crisis-based interventions. The on-call psychiatrist may be contacted for consultation if such is deemed necessary. If needed, a treatment plan will be developed regarding any additional medical follow-up required. Only one of the investigation files reviewed demonstrated the detainee was seen by medical.

Does Not Meet (a): Of the three investigations reviewed only one detainee was seen by medical. The facility must demonstrate compliance that all detainees who have been victimized by sexual abuse including sexual harassment (the DHS term of sexual abuse includes sexual harassment) are offered medical and mental health evaluation and, as appropriate, treatment. The facility must provide documentation that medical and mental health services were offered for a detainee who has been victimized by sexual abuse for compliance review.

Corrective Action Taken (a): The facility provided documentation for five detainee victims from 2019, to demonstrate the process of victims who were offered and/or provided follow-up mental health care. Interviews with medical and mental health staff confirmed detainee victims are offered follow-up medical and mental health care following an alleged incident of sexual abuse. The facility has met substantial compliance with subpart 115.83 (a).

(g) Wellpath's policy HCD-110-F-06 states if the facility identifies an alleged perpetrator of the abuse (through means such as placement in a segregation unit, issuing a disciplinary report, or filing of criminal charges), a mental health staff member will follow-up with this individual and assess adjustment to his or her current situation. If placed in segregation, mental health staff will continue to monitor adjustment issues at least weekly via the segregation round process. The staff member assigned to this duty shall not be the same person assigned to any on-going follow-up with the victim of abuse. Both the HSA and the Mental health Professional confirmed sexual abuse perpetrators are provided mental health evaluations and treatment. The Auditor was unable to confirm that these services are provided within 60 days of learning of such abuse history.

Does Not Meet (g): The standard requires a mental health evaluation within 60 days of learning of the abuse and the offering of treatment to a detainee-on-detainee abuser. The facility could not demonstrate the referral and evaluation within 60 days, and treatment, if deemed necessary, is occurring. The facility must demonstrate compliance that an attempt to conduct a mental health evaluation of all know detainee-on-detainee abusers, within 60 days of learning of such abuse history, and offer treatment when deemed appropriate by mental health practitioners. The facility needs to provide an example of a mental health evaluation conducted within 60 days on a known detainee-on-detainee abuser for compliance review.

Corrective Action Taken (g): The facility provided a copy of Wellpath Policy HCD-110_F-06 Response to Sexual Abuse – Yuba CA. The revised policy now states, "A qualified mental health provider must attempt to conduct a mental health evaluation of all known detainee on detainee abusers, within 60 days of learning of such abuse history, and offer treatment when deemed appropriate. If needed, a treatment plan will be developed regarding any additional medical follow-up. The Jail Lieutenant explained the facility did not provide documentation of a mental health evaluation conducted within 60 days of a known detainee-on-detainee abuser because there were no such incidents during this CAP period. The facility has met substantial compliance with subpart 115.83 (g).

§115.86 - Sexual abuse incident reviews
Outcome: Does not Meet Standard
Notes:

(a) YCJ Policy #901 states an incident review shall be conducted at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The review should occur within 30 days of the conclusion of the investigation. The review team shall include upper-level management officials and seek input from line supervisors and investigators. The review shall consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI identification status or perceived status; gang affiliation; was motivated or otherwise caused by other group dynamics at the facility; examine the area of the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the staffing level in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff. The team shall prepare a report of its findings including any determination made pursuant to this section and any recommendations for improvement. The report shall be submitted to the Sheriff, and the PSA Compliance Manager. The Sheriff or authorized designee shall implement the recommendations for improvement or shall document the reasons for not doing so.

The Captain and the PSA Compliance Manager reiterated the above policy. The PSA Compliance Manager explained that sexual abuse incident reviews were conducted at the conclusion of each of the investigations during this audit period but there were no recommendations, and the reviews were not documented in a report.

Does Not Meet (a): The facility had not completed reviews of unfounded incidents nor prepared written reports for the unsubstantiated and substantiated incident reviews. The facility must demonstrate compliance through the completion of reviews of all incidents and prepare written reports for incident reviews of unsubstantiated and substantiated incidents within 30 days of the conclusion of the investigation. The facility must provide documentation of a review of an unfounded case and written incident review reports for two substantiated and/or unsubstantiated incidents for compliance review.

Corrective Action Taken (a): The facility provided copies of two completed Sexual Abuse Incident Reviews from 2019 and 2020. One review was completed within 30 days of the conclusion of the investigation. The second review did not provide the date the investigation was concluded, so the Auditor was unable to verify the review was conducted within 30-day time. The facility provided no information that after incident review for an unfounded allegation occurred. During the on-site visit, the Auditors explained that, although the standard does not require a written report for unfounded sexual abuse incidents, the incident must be reviewed per the standards requirement. The Auditors recommended the Facility Administrator date and sign the completed administrative investigation, acknowledging a review of the unfounded incident. The facility does not comply with this standard subpart (a).

(c) The facility prepared an annual report of PREA allegations for 2019. This report forwarded to the FOD and agency PSA Coordinator on November 14, 2019. The annual report did not cover a full year and did not include all reported incidents.

Does Not Meet (c): The annual report was completed in November 2019 and did not cover an entire year. By completing the annual review early, one of the cases that occurred within the one-year period (December 2019) was not included. The report did not outline the process the facility underwent to improve sexual abuse intervention, prevention, and response efforts and if any recommendations were made from the incident reviews and whether the recommendations were completed. The facility must demonstrate compliance that the annual report includes incidents for the full 12-month audit year and actions taken to improve sexual abuse intervention, prevention, and response efforts and if any recommendations were made from the incident reviews and whether the recommendations were completed. The facility must provide an updated annual report that references the full 12-month audit year and actions taken to improve sexual abuse intervention, prevention, and response efforts and if any recommendations were made from the incident reviews and whether the recommendations were completed for compliance review.

Corrective Action Taken (c): The facility provided the 2019 annual report, to include the full 12-month period. The annual report included a summary of the substantiated allegations, recommendations for improvement to the facility's sexual abuse prevention and intervention program and corrective action taken by the facility. The facility has met substantial compliance with subpart 115.86 (c).

§115.201 - Scope of audits
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(e) The agency is to provide the Auditor with relevant documentation to complete a thorough audit of the facility. The facility provided minimal relevant documentation during the pre-audit phase. For example, the facility did not provide policy information for standards: 115.13; 115.31; 115.34; 115.35; 115.54; 115.63; 115.67; 115.68; 115.77; and 115.86. The Auditor reviewed the policies provided and found each of these standards were included in the facility's policies and should have been provided during the pre-audit phase of the audit. In addition, supporting documentation was minimal with instructing the Auditor to review the material on-site. All documentation was not available on-site, and the Auditor had to continually ask for further documentation to review for compliance post audit. As the time of the report, the Auditor had not received all documentation requested for compliance review.

Does Not Meet (e): During all phases of the audit, the facility was not accommodating to provide the Auditor with requested documentation needed to ensure compliance with several PREA standards. The facility did not provide the Auditor with relevant

documentation to complete a thorough audit of the facility. The facility must demonstrate compliance by providing the Auditor with relevant documentation to complete a thorough audit of the facility including during the Corrective Action Plan (CAP) process.

Corrective Action Taken (e): The facility provided the Auditor with relevant documentation for each standard. The facility was responsive to the Auditor's request for additional information and clarification. During the on-site visit, the facility ensured staff and detainees were available for interview, the Auditors were provided with comfortable accommodations to conduct both staff and detainee interviews. The facility provided the requested files for review. The facility has met substantial compliance with subpart 115.201 (e).

AUDITOR CERTIFICATION:

I certify that the contents of the report are accurate to the best of my knowledge and no conflict of interest exists with respect to my ability to conduct an audit of the agency under review. I have not included any personally identified information (PII) about any detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.

Margaret L. Capel June 22, 2021
Auditor's Signature & Date

(b) (6), (b) (7)(C) June 22, 2021
Assistant Program Manager's Auditor's Signature & Date

(b) (6), (b) (7)(C) June 22, 2021
Program Manager's Auditor's Signature & Date