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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

August 2025

Special Review of the California Department of Corrections and Rehabilitation's Response to Incarcerated-Person-on-Incarcerated-Person Allegations Under the Prison Rape Elimination Act

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August 21, 2025

Mr. Jeffrey Macomber
Secretary
Department of Corrections and Rehabilitation
P.O. Box 942883
Sacramento, CA 94283-001

Dear Mr. Macomber:

Enclosed is the Office of the Inspector General's (the OIG) report titled *Special Review of the California Department of Corrections and Rehabilitation's Response to Incarcerated-Person-on-Incarcerated-Person Allegations Under the Prison Rape Elimination Act.* California Penal Code section 6126, subdivisions (b) and (c) authorize the OIG to initiate reviews of the California Department of Corrections and Rehabilitation's (the department) policies, practices, and procedures. In this review, we assessed departmental responses to 74 of 288 (26 percent) alleged violations of the Prison Rape Elimination Act (PREA) that were investigated and closed from March 2024 through August 2024. The 74 cases we reviewed were reviewed by prison Institutional PREA Review Committees (review committees) from March 1, 2024, through August 31, 2024. While violations of PREA may be alleged against prison employees, this special review assessed only the department's investigation of allegations made against incarcerated people.

During our assessment, we reviewed departmental responses to PREA allegations at three different stages: identification, investigation, and institutional oversight and review. We broadly assessed whether prison staff and management properly identified and initiated required protocols in response to PREA allegations, whether the investigations were timely and in compliance with department policy, and whether prisons adequately conducted incident reviews in compliance with departmental policy.

We found several concerning issues in the department's handling of the PREA allegations and investigations we reviewed. Prison staff and supervisors did not always complete required duties when they were notified of PREA allegations, and alleged victims were not always offered medical or mental health treatment, including forensic examinations to collect and preserve physical evidence. Furthermore, departmental staff did not always offer alleged victims support persons or advocates as required by departmental policy.

In addition, almost all the investigations of PREA allegations we reviewed were inadequate for one or more reasons. We found that investigators did not perform one or more investigative procedures in 91 percent (67 of 74) of the cases we reviewed. In some cases, investigators did not collect sufficient evidence or interview alleged victims, alleged suspects, or potential witnesses. We also found that some of the investigative reports we reviewed lacked basic facts and contained

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errors and inconsistencies. Moreover, some investigators had not received required specialized PREA training as required by law and departmental policy.

In nearly all incidents we reviewed, we found significant inadequacies that review committees missed or failed to address. Consequently, we found that review committees did not provide proper oversight to ensure PREA investigations were adequate and complete. By failing in their oversight role, review committees generally did not ensure departmental staff followed either federal and state law, or departmental policy and guidelines when responding to PREA allegations.

Following publication, we request the department provide its status on implementing our recommendations at intervals of 60 days, six months, and one year from the special review report date.

Respectfully submitted,

Amarik K. Singh
Inspector General

Contents

Illustrations

Figures

Tables

Terms Used in This Report	
Abusive Sexual Contact	Contact of any person without his or her consent, or by coercion, or contact of a person who is unable to consent or refuse AND intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person.
Forensic Medical Examination	An examination provided by a nurse who has specialized training to conduct sexual assault evidentiary exams. The nurse is trained in the medical, psychological, and forensic examination of sexual assault victims and may provide expert testimony if a case goes to trial. The examination consists of an explanation of the process, the incarcerated person's consent, discussion of the incident and when/how it occurred, and a detailed physical examination that will include evidence collection and photographs.
Institutional PREA Review Committee	A committee comprised of executive, custody, and medical staff at each prison tasked with conducting incident reviews of all PREA allegations with substantiated and unsubstantiated investigation outcomes.
Locally Designated Investigator (Investigator)	The prison's Investigative Services Unit investigator or other designated prison staff who have been trained to conduct investigations into allegations of sexual violence and/or staff sexual misconduct.
Nonconsensual Sex Acts	Contact of any person without his or her consent, or by coercion, or contact of a person who is unable to consent or refuse AND contact between the penis and vagina or the penis and the anus including penetration, however slight; or contact between the mouth and the penis, vagina, or anus or penetration of the anal or genital opening of another person by the hand, finger, or other object.
Prison Rape Elimination Act (PREA)	Federal legislation that established a "zero tolerance" standard for prison rape. Subsequent standards required state, local, or federal agencies with direct responsibility for the operation of any facility that confines incarcerated people to have a written policy mandating zero tolerance toward all forms of sexual abuse or harassment. PREA also required agencies to outline their approach to preventing, detecting, and responding to sexual abuse and misconduct.
Sexual Harassment	Repeated and unwelcomed sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by an incarcerated person toward another incarcerated person.
Substantiated	An allegation that was investigated and determined to have occurred.
Unfounded	An allegation that was investigated and determined not to have occurred.
Unsubstantiated	An allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether the event occurred.
Victim Advocate	A person engaged in any office, hospital, institution or center commonly known as a rape crisis center whose primary purpose is the rendering of advice or assistance to victims of sexual assault and who has received a certificate evidencing completion of a training program in the counseling of sexual assault victims issued by an approved counseling center.
Victim Support Person	Any person of the alleged victim's choosing present at any medical or evidentiary or physical examination and which could include another incarcerated person, friend, or family member including a registered domestic partner.

Source: The Department Operations Manual and the department's *Specialized PREA Training for Locally Designated Investigator's Participant Workbook.*

Introduction

California Penal Code section 6126(b) authorizes the Office of the Inspector General (the OIG) to initiate a review of the California Department of Correction's (the department) policies, practices, and procedures. In this review, we assessed departmental responses to 74 of 288 (26 percent) alleged violations of the Prison Rape Elimination Act (PREA) that were investigated and closed from March 2024 through August 2024. The 74 cases we reviewed were reviewed by the prison Institutional PREA Review Committees (review committee or IPRC) from March 1, 2024, through August 31, 2024.[1] While violations of PREA may be alleged against prison employees, during this review we assessed only the department's investigation of allegations made against incarcerated people.

During our assessment, we reviewed departmental responses to PREA allegations at three different stages: identification, investigation, and institutional oversight and review. We broadly assessed whether prison staff and management properly identified and initiated required protocols in response to PREA allegations, whether the investigations were timely and in compliance with departmental policy, and whether prisons adequately conducted incident reviews in compliance with departmental policy. To accomplish this, we reviewed PREA case documentation, met with prison staff, and analyzed the results of PREA investigations. We also attended review committee meetings to assess whether departmental staff complied with regulations, procedure, and applicable laws.

Background

"It is the policy of the CDCR [the department] to provide a safe, humane, secure environment, free from sexual misconduct. CDCR shall maintain a zero tolerance for sexual misconduct in its institutions, community correctional facilities, conservation camps, and for all offenders under its jurisdiction. Sexual misconduct between offenders and by staff towards offenders is strictly prohibited.

Source: Departmental policy memorandum dated November 2, 2006, titled "Prison Rape Elimination Act – Zero Tolerance Policy."

1. Each prison is required to conduct an incident review of every sexual violence allegation, including allegations that have not been substantiated. An incident review is not required for allegations that have been determined to be unfounded. Only two investigations we reviewed that went to IPRC were determined to be unfounded, but 48 allegations determined to be unfounded were closed during our review period. Therefore, our case review was not inclusive of all unfounded investigation outcomes, and it is likely most allegations determined to be unfounded are not reviewed by IPRCs.

Prison rape and other forms of sexual misconduct including unwanted touching and verbal harassment, have historically been problems affecting the safety and security of incarcerated populations in America's prisons, including those in California. To combat rape in prisons nationwide, Congress enacted the Prison Rape Elimination Act (PREA) in 2003.[2] This historic legislation established a "zero tolerance" standard for rape in prisons in the United States.[3]

PREA also created the National Prison Rape Elimination Commission which drafted national standards for eliminating prison rape.[4] The Department of Justice published the final PREA Standards in the Federal Register on June 20, 2012, and they became effective August 20, 2012.[5] Under federal law, a state whose Governor does not certify full compliance with the standards is subject to the loss of five percent of any Department of Justice grant funds that it would otherwise receive for prison purposes, unless the Governor submits an assurance that the five percent will be used only for the purpose of enabling the State to achieve and certify full compliance with the standards in future years.[6] In addition, any correctional accreditation organization that seeks Federal grants must adopt accreditation standards regarding sexual abuse that are consistent with the national standards.[7]

PREA standards require the department to have written policies mandating zero tolerance toward all forms of sexual abuse and harassment and outlining its approach to preventing, detecting, and responding to such conduct.[8] The executive summary of the federal rules emphasized that the success of the PREA standards in combating sexual abuse in prisons depended on effective leadership but acknowledged that effective leadership could not be directly mandated. Instead, the federal standards were intended to foster a change in prison culture by institutionalizing policies and practices that were generally not outcome-based but rather focused on policies and procedures to reduce and ameliorate bad outcomes. Furthermore, while the standards were intended to include a variety of best practices, they did not incorporate every avenue of combating sexual abuse.[9] The federal act is the foundation of the department's response to PREA allegations and its zero-tolerance policy for sexual misconduct in California prisons.[10]

2. 34 United States Code Annotated (U.S.C.A.) section 30301, et seq.
3. 34 U.S.C.A. section 30302.
4. 34 U.S.C.A. section 30306(a) and (d).
5. 34 U.S.C.A. section 30307(a); 28 *Code of Federal Regulations* (C.F.R.) Part 115.
6. 34 U.S.C.A. section 30307(e).
7. 34 U.S.C.A. section 30308(b).
8. 28 C.F.R. section 115.11(a).
9. Executive Summary signed by the Attorney General on May 16, 2012, pp. 2–3.
10. The department's operations manual (DOM) Section 54040.2.

The Sexual Abuse in Detention Elimination Act of 2005 is also foundational to combating sexual misconduct in California prisons.[11] Like PREA, the Sexual Abuse in Detention Elimination Act requires the department to ensure that its protocols for responding to sexual abuse include providing the safest possible housing options to incarcerated people who experience repeated abuse,[12] implement thoughtful, confidential standards of physical and mental health care to reduce the impact of sexual abuse,[13] and ensure specific procedures are performed in the investigation and prosecution of sexual abuse incidents.[14] Consequently, the department established policy and procedures and required all staff to receive training related to the prevention, detection, response, and investigation of sexual misconduct in California prisons.[15]

Sexual misconduct can include three different forms of abuse that are specifically prohibited by PREA standards and departmental policy: nonconsensual sexual acts, abusive sexual contact, and sexual harassment.[16] Under PREA standards and departmental policy, *nonconsensual sexual acts* are generally defined as unwilling or forced sexual contact or penetration, such as rape.[17] *Abusive sexual contact* is generally defined as unwanted touching directly or through the clothing of the genitalia or other intimate parts of a person in a sexual manner.[18] Finally, *sexual harassment* is generally defined as unwelcome conduct that does not involve physical contact, such as unwanted sexual advances.[19] Collectively, we refer to any claims of sexual misconduct as *PREA allegations* in this report. While PREA allegations can be made against prison employees, as we explained in the introduction, this report assesses only the department's response to allegations made against incarcerated people in State prisons.

The OIG plays an important role in combating sexual violence in California prisons because it has the authority to receive confidential letters regarding sexual abuse, inspect institutions and interview all incarcerated people, and investigate reports of the mishandling of incidents of sexual abuse.[20] The OIG forwards allegations of rape and sexual assault made against staff and incarcerated people to the department for review. In 2024, the OIG referred 538 PREA allegations against staff and incarcerated people to the department for processing.

11. Cal. Penal Code section 2635, et seq.
12. Cal. Penal Code section 2637.
13. Cal. Penal Code section 2638.
14. Cal. Penal Code section 2639.
15. DOM Sections 54040.1; 54040.4.
16. 28 C.F.R. section 115.6; DOM Sections 54040.1–3.
17. 28 C.F.R. section 115.6; DOM Sections 54040.3.
18. 28 C.F.R. section 115.6; DOM Sections 54040.3.
19. 28 C.F.R. section 115.6; DOM Sections 54040.3.
20. Cal. Penal Code Section 2641.

Reporting a PREA Allegation

The first steps prison staff take when responding to PREA allegations are critical to preserving evidence and facilitating thorough investigations, and PREA standards require that the department provide multiple ways for incarcerated people to report PREA allegations.[21] A victim may report a PREA allegation by informing departmental staff verbally or in writing; utilizing the incarcerated person appeals process; utilizing departmental or OIG sexual assault hotlines; or informing a third party who in turn reports the allegation to the department or the OIG.[22] Departmental staff must immediately and confidentially report PREA allegations to the appropriate supervisors when they become aware of them.[23] In addition, departmental staff must complete an incident report if they witness a suspected PREA violation or receive a PREA allegation.[24]

Staff who initially respond to the PREA allegation must take the alleged victim to a private, secure location and request they not shower, remove clothing without custody supervision, use restroom facilities, or consume any liquids.[25] In addition, staff are required to refer alleged victims for medical or mental health evaluations.[26]

Custody supervisors have significant responsibilities when they are notified of PREA allegations. Custody supervisors must assign alleged victims a custody escort who will remain with the alleged victims throughout the medical exam process, whenever possible.[27] Custody supervisors must also ensure that purported crime scenes are secured and ensure a log of all persons entering the crime scene area is maintained.[28] Finally, custody supervisors must arrange housing alternatives for the alleged victims and consider their risk of sexual victimization while assessing appropriate housing placement.[29] To assist custody supervisors with responding to PREA allegations, departmental training and guidelines include a checklist identifying all actions they are required to complete.[30]

21. 28 C.F.R. section 115.51.
22. DOM Section 54040.7.
23. 28 C.F.R. section 115.61(a)–(b); DOM Section 54040.7.
24. DOM Section 54040.7.
25. 28 C.F.R. section 115.64(a); DOM Section 54040.8.
26. 28 C.F.R. section 115.83; DOM Section 54040.7.
27. DOM Section 54040.8.1.
28. DOM Section 54040.8.1
29. DOM Section 54040.10.
30. See Appendix B.

Investigations of PREA Allegations Committed by Incarcerated Offenders

PREA standards require the department to have a policy in place governing the conduct of investigations and ensure that a prompt, thorough, and objective investigation is completed for all allegations of sexual abuse and sexual harassment occurring in its prisons.[31] To do this, prison authorities assign locally designated investigators (investigators) who are specifically trained to investigate PREA allegations.[32] Departmental policy and training mandates that investigators use standard fact-finding techniques including interviewing alleged victims, suspects, and potential witnesses.[33] Investigators should record interviews when possible and objectively assess the reliability of victims, suspects, and witnesses on an individual basis.[34] Investigators should also review available evidence from the audio-video surveillance system and departmental records, such as movement logs and phone calls.[35] Investigators may collect evidence from crime scenes, as well as from alleged victims' and suspects' clothing and bodies.[36] Finally, departmental staff log and store any physical evidence specialized nurses collect during forensic medical examinations.[37]

The department has established guidelines for investigators to follow while questioning PREA victims about the specific details of their allegations. In part because of the sensitive nature of the allegations, alleged victims have a right to an advocate and a support person of their choosing present during their forensic medical examinations and investigatory interviews.[38] However, support people may be excluded from the forensic medical examinations or investigatory interviews if their presence would be detrimental.[39] The department or a medical provider excluding a support person or advocate from a forensic medical examination must document their reasons for doing so.[40] Likewise, the investigator or district attorney excluding a support person from

31. 28 C.F.R. section 115.22(d); 115.71(a).

32. 28 C.F.R. section 115.71(b); DOM Sections 54040.3; 54040.8.1.

33. DOM Sections 54040.7.3, 54040.8.1 and 54040.12; Cal. Dept. of Corrections and Rehabilitation, *Specialized PREA Training for Locally Designated Investigators Participant Workbook* – Version 1.0, Approved May 2020, pp. 23–24 (hereafter abbreviated as *Specialized PREA Training*).

34. 28 C.F.R. section 115.71(e); *Specialized PREA Training*, pp. 29 and 47–48.

35. *Specialized PREA Training*, pp. 30–35.

36. *Specialized PREA Training*, pp. 30–35.

37. *Specialized PREA Training*, pp. 30–35.

38. 28 C.F.R. section 115.21(e); DOM Section 54040.8.2.

39. DOM Section 54040.8.2.

40. DOM Section 54040.8.2.

investigatory interviews must document their reasons, but they must also notify alleged victims about the exclusion prior to the interview.[41]

The time frame of when an incarcerated person reports a PREA allegation affects the steps investigators take when collecting and processing evidence. Custody supervisors are required to secure alleged victims, named suspects, and crime scenes, if feasible, for forensic processing.[42] Custody supervisors must also transport suspects and willing victims to forensic medical examinations if the alleged incident occurred less than 72 hours before it was reported and involved nonconsensual sex acts.[43] When a PREA allegation involves abusive sexual contact, such as unwanted touching, prison staff must generally consult with a specialized nurse to determine if a forensic medical examination is warranted.[44]

Table 1. When Custody Supervisors Must Arrange Forensic Examinations for Alleged PREA Violations Reported Within 72 Hours of the Incident

Allegation Type	Policy Requirement
Sexual Harassment	Neither the alleged victim nor the alleged suspect will receive a forensic examination.
Abusive Sexual Contact	Consult with a nurse about whether the alleged victim or suspect should receive a forensic examination. An alleged victim may refuse a forensic examination, but the refusal should be video recorded.
Nonconsensual Sex Acts	The alleged victim and suspect shall receive a forensic examination. An alleged victim may refuse a forensic examination, but the refusal should be video recorded.

Source: The Department Operations Manual Section 54040.12.1.

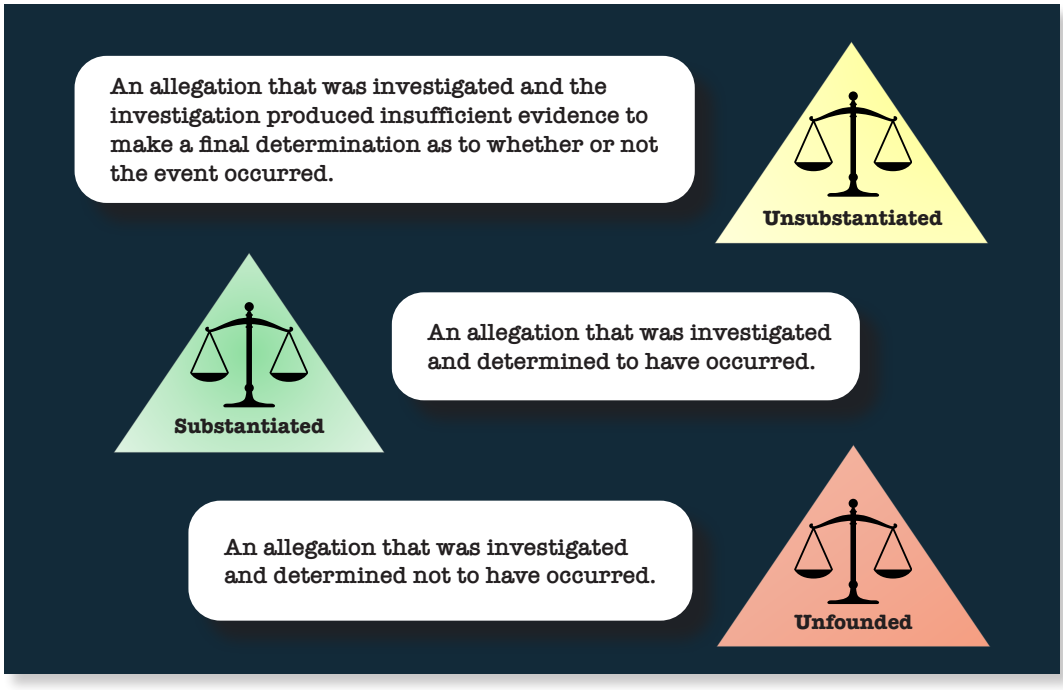
When custody staff are notified of a PREA violation more than 72 hours after the alleged incident, custody supervisors must also consult with a specialized nurse, for abusive sexual contact and nonconsensual sex act allegations to determine whether a forensic medical examination would provide additional evidence.[45] If so, departmental staff will transport the alleged victim for the examination. While an alleged victim may refuse a forensic medical examination, departmental policy states all refusals should be video recorded.[46]

41. DOM Section 54040.8.2.
42. DOM Sections 54040.8.1; 54040.11.
43. DOM Section 54040.12.1.
44. DOM Section 54040.12.1.
45. DOM Section 54040.12.2.
46. DOM Section 54040.12.1–2.

When completing investigations of alleged PREA violations, investigators reach one of three conclusions using a "preponderance of the evidence" standard: substantiated, unsubstantiated, or unfounded.[47] Investigators conclude an allegation is substantiated if they determine the alleged violation occurred, while a conclusion of unfounded means investigators determined the alleged violation did not occur.[48] If investigators cannot determine whether an alleged PREA violation occurred, it is deemed unsubstantiated.[49] Generally, investigations without any independent witnesses or other evidence (video footage, forensic medical examinations, etc.) result in determinations that the allegations are unsubstantiated, even if an alleged victim reported in detail that the incident occurred.

Figure 1 below explains the three outcomes that can result from an investigation.

Figure 1. Possible Outcomes Resulting From an Investigation



Source: Adapted from a graphic in the California Department of Corrections and Rehabilitation's publication titled *Specialized PREA Training for Locally Designated Investigator's Participant Workbook*.

47. *Preponderance of the evidence* is the burden of proof standard which determines guilt based on the more convincing evidence and its probable truth or accuracy, and not in the amount of evidence. A preponderance of the evidence determines what is more likely to have occurred. Sources: *Specialized PREA Training* and DOM Section 54040.12.5.

48. 28 C.F.R. section 115.5.

49. 28 C.F.R. section 115.5.

The Institutional PREA Review Committee Incident Review Process

PREA standards require prisons to conduct incident reviews at the conclusion of every sexual abuse investigation, including where the allegations have not been substantiated.[50] To accomplish this, the prison's PREA compliance manager schedules PREA allegations for review by the prison's review committee within 60 days of the date of discovery of the allegation, or within 30 days of closure of the investigation, whichever is sooner.[51] While incident reviews are not required if investigators determine PREA allegations to be unfounded, wardens may nevertheless request the case be reviewed.[52]

Review committees are normally composed of the prison's warden or a designee, and a variety of custody and medical staff.[53] Generally, review committees are responsible for considering whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, and respond to sexual abuse.[54]

Figure 2 below outlines roles and responsibilities of the review committee.

Figure 2. Roles and Responsibilities of the Institutional PREA Review Committee

The Institutional PREA Review Committee 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; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.
- Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
- If the staffing plan was not complied with, this fact shall be documented during this review and addressed in the corrective action plan.
- Assess the adequacy of staffing levels in that area during different shifts.
- Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.
- Prepare a report of its findings and any recommendations for improvement.
- Determine a plan to correct findings and document in the report.
- Document implementation of the Action Plan or reasons for not doing so.
- Submit the report to the warden for final review.

Source: Department Operations Manual, Section 54040.17.

50. 28 C.F.R. section 115.86.
51. 28 C.F.R. section 115.86(b); DOM Section 54040.17.
52. 28 C.F.R. section 115.86(a); DOM Section 54040.17.
53. 28 C.F.R. section 115.86(c); DOM Section 54040.17.
54. 28 C.F.R. section 115.86(d)(1); DOM Section 54040.17.

Review committees generally oversee PREA allegations from initial reporting through the conclusion of the investigations. As part of the review process, the committees must judge whether staff's actions prior to, during, and subsequent to the reporting of the allegation were in compliance with regulations, departmental procedure, and applicable law.[55] Review committees must also determine if follow-up action is necessary and consider changes to policies and procedures to better prevent, detect, and respond to sexual misconduct in the prisons.[56]

Sexual Abuse and Misconduct Statistics in California Prisons

The department has a zero-tolerance policy for sexual misconduct in its prisons and is committed to providing a safe, humane, secure environment, free from sexual violence and sexual harassment. Nevertheless, allegations of sexual misconduct are still common in departmental facilities.

Since 2018, the department reports having received over 3,000 PREA allegations made against incarcerated people. As reported by the department, Tables 2 through 4 on the next page provide a six-year summary of PREA allegations made against incarcerated people by allegation type, and the outcome of departmental investigations into the allegations.

The OIG analyzed 74 PREA allegations reviewed by prison review committees from March 1, 2024, through August 31, 2024. Figure 3 on page 11 provides a breakdown of the 74 PREA allegations we analyzed in this special review. Of the cases we reviewed, 46 alleged nonconsensual sex acts, 26 alleged abusive sexual contact, and two alleged sexual harassment.

55. DOM Section 54040.17.

56. 28 C.F.R. section 115.86(d)(1); DOM Section 54040.17.

Table 2. Incarcerated-Person-on-Incarcerated-Person Nonconsensual Sexual Acts

Outcome	2018	2019	2020	2021	2022	2023
Substantiated	3	7	8	4	3	5
Unsubstantiated	204	162	137	161	138	124
Unfounded	58	59	71	53	21	29
Ongoing investigation	3	9	6	9	19	85
Total	**268**	**237**	**222**	**227**	**181**	**243**

Source: The department's Prison Rape Elimination Act Annual Report – Calendar Year 2023.

Table 3. Incarcerated-Person-on-Incarcerated-Person Abusive Sexual Contact

Outcome	2018	2019	2020	2021	2022	2023
Substantiated	8	5	3	4	6	7
Unsubstantiated	131	118	89	131	137	141
Unfounded	39	39	36	20	15	12
Ongoing investigation	1	6	1	6	14	81
Total	**179**	**168**	**129**	**161**	**172**	**241**

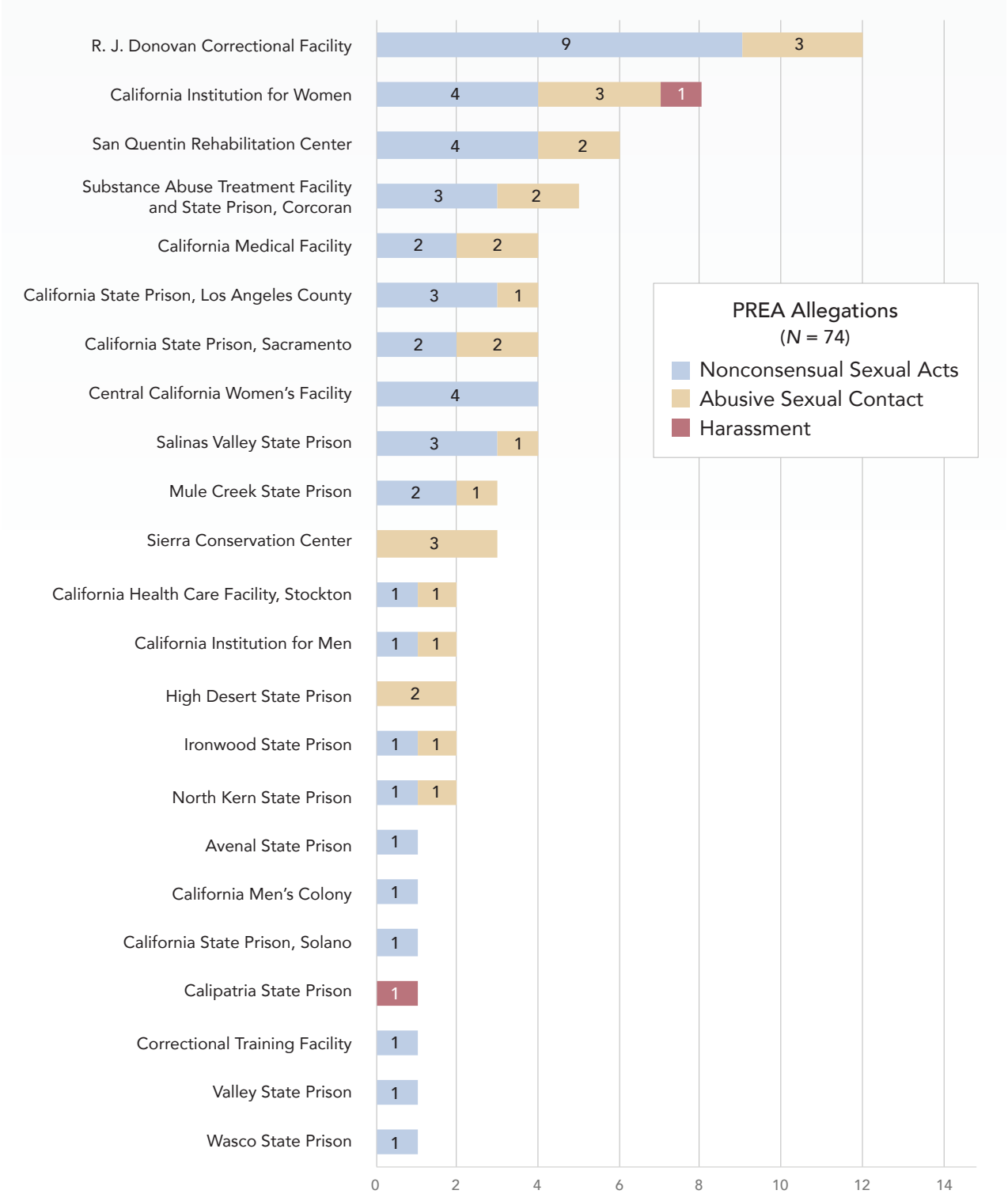
Source: The department's Prison Rape Elimination Act Annual Report – Calendar Year 2023.

Table 4. Incarcerated-Person-on-Incarcerated-Person Abusive Sexual Harassment

Outcome	2018	2019	2020	2021	2022	2023
Substantiated	10	1	6	13	2	12
Unsubstantiated	83	71	91	93	82	66
Unfounded	32	16	23	14	13	7
Ongoing investigation	0	0	2	12	26	72
Total	**125**	**88**	**122**	**132**	**123**	**157**

Source: The department's Prison Rape Elimination Act Annual Report – Calendar Year 2023.

Figure 3. PREA Allegations, by Prison, Reviewed by Institutional PREA Review Committees From March 2024 Through August 2024



Source: The OIG's analysis of incarcerated-person-on-incarcerated-person PREA allegations reviewed by the PREA Review Committee from March 1, 2024, through August 31, 2024.

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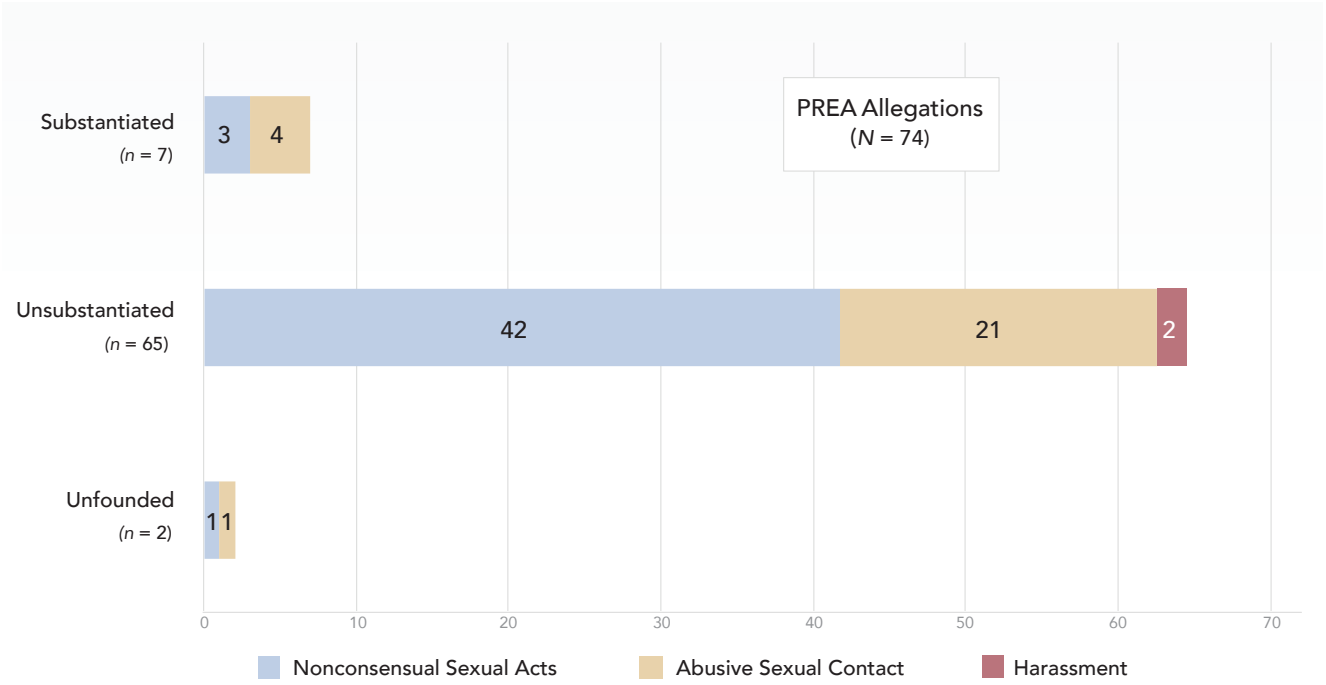
Review Results

We found several concerning issues in the department's handling of the PREA allegations and investigations we reviewed. Prison staff did not always appropriately report or document PREA allegations when they were initially received, and alleged victims were not always offered medical or mental health treatment. In addition, we found investigators did not perform one or more investigative procedures in all but six cases we reviewed. In some cases, investigators did not: collect sufficient evidence; interview alleged victims, suspects, or potential witnesses; or review available audio-video surveillance system footage. Investigators also did not always video or audio record interviews with alleged victims or suspects. The department also failed to offer alleged victims a support person or advocate as required by departmental policy. Moreover, some investigators had not received required specialized PREA training.

We found that review committees missed or failed to address any of the inadequacies that we identified in 67 out of the 74 (91 percent) investigations we analyzed. Review committees did not provide proper oversight to ensure PREA investigations were adequate and complete. By failing in their oversight role, review committees generally did not ensure departmental staff followed either federal and state law, or departmental policy and guidelines when responding to PREA allegations.

Investigators substantiated 9 percent (7 of 74) of the PREA allegations we reviewed, meaning they determined the allegations were more likely than not to have occurred based on a preponderance of the evidence. However, investigators overwhelmingly determined there was insufficient evidence to make a final determination as to whether the majority of PREA allegations made occurred, finding 88 percent (65 of 74) of the allegations to be unsubstantiated, and three percent (2 of 74) of the allegations to be unfounded. Figure 4 below shows the type of allegations and the investigation outcomes for the 74 incidents we reviewed.

Figure 4. Investigation Outcomes of PREA Incidents the OIG Reviewed



Note: An incident review is not required for allegations that have been determined to be unfounded. Therefore, the only unfounded allegations we analyzed were those reviewed by review committees.

Source: The OIG's analysis of PREA allegations made against incarcerated people reviewed by the PREA Review Committee from March 1, 2024, through August 31, 2024.

Figure 5 on the next page further details that 43 percent (32 of 74) of the PREA allegations we reviewed were reported less than 72 hours after the incidents, while 57 percent (42 of 74) were reported over 72 hours after the alleged incidents. The oldest, a case involving alleged nonconsensual acts, was reported 19.5 years after the alleged incident occurred. In general, it is more difficult for the department to thoroughly investigate and reach supportable determinations on PREA allegations made more than 72 hours after the incident reportedly occurred.

Figure 5. PREA Allegation Reporting Times After Incidents

Source: The OIG's analysis of PREA allegations made against incarcerated people reviewed by the PREA Review Committee from March 1, 2024, through August 31, 2024.

Chapter 1. Prison Staff Did Not Always Perform Required Procedures When Notified of PREA Allegations

We found that prison staff generally recognized and responded when an incarcerated person or third party reported PREA allegations. However, in three percent (2 of 74) of incidents we reviewed, the alleged victims stated they had previously reported their PREA allegations to departmental mental health or medical staff. Although investigators were assigned to the allegations, none determined whether the incarcerated people had previously reported these incidents or, if they had, why the allegations had not been investigated.

Prison staff also incorrectly classified the PREA allegations in two cases we reviewed. In the first incident, investigators incorrectly classified an allegation that the PREA suspect allegedly digitally penetrated the victim as abusive sexual contact, which does not involve penetration, instead of a nonconsensual sex act, which does. The investigative report only included information related to unwanted touching and did not contain any information on the alleged digital penetration. Consequently, the investigator may not have addressed the allegation at all. In addition, the specialized nurse making the determination on whether a forensic examination was warranted may not have known that the victim alleged he was digitally penetrated. Ultimately, the specialized nurse did not recommend the alleged victim receive a forensic examination. In the second incident, prison staff incorrectly classified an allegation that an incarcerated person climbed on top of another incarcerated person and asked for sexual favors as sexual harassment instead of abusive sexual contact, a more severe form of sexual misconduct.

Staff and Supervisors Did Not Always Complete Required Duties When They Were Notified of PREA Allegations

To assist staff in fulfilling their responsibilities under law and policy, the department created a PREA initial contact guide[57] and trained staff[58] to implement specific procedures upon receipt of a PREA allegation.[59] It is critical that staff follow departmental guidance because many of the instructions contained in the PREA initial contact guide are intended to preserve physical evidence in compliance with law and departmental policy.[60] For example, staff are required to request that a PREA victim not shower, use the restroom, consume liquids, or remove clothing without

57. 28 C.F.R. 115.31; DOM Section 54040.8; Appendix C.

58. 28 C.F.R. 115.31; DOM Section 54040.4.

59. 28 C.F.R. 115.61; DOM Section 54040.7.

60. 28 C.F.R. 115.64(a); Cal. Penal Code section 2639(c); DOM Section 54040.8.1.

custody supervision, to preserve potential evidence for forensic medical examinations.[61]

However, in the cases we reviewed, we found documentation that staff had taken steps to preserve physical evidence in only 21 percent (four of 19) of incidents alleging nonconsensual sex acts that were reported within 72 hours. Therefore, even if the allegations of nonconsensual sex acts were timely reported and investigated, the probability that physical evidence would have been recovered during forensic medical examinations was likely reduced.

We recognize that the procedures detailed in the PREA initial contact guide may not be warranted or necessary to preserve evidence of allegations of nonconsensual acts reported long after the incident. The instructions may also not be warranted or necessary in allegations of abusive sexual contact or harassment. However, unless staff document that they followed—or document why they did not follow—the procedures outlined in the PREA initial contact guide, management cannot determine if staff followed departmental policy intended to preserve critical physical evidence.

The department created procedures for custody supervisors to follow upon receipt of PREA allegations and trained the supervisors on the procedures.[62] These procedures are intended to, among other things, preserve physical evidence during investigations. However, as was the case with the PREA initial contact guide, we found that supervisors did not always follow the steps outlined in the custody supervisor checklist. For example, custody supervisors did not document taking any measures to secure crime scenes[63] in 42 percent (eight of 19) of nonconsensual sex act allegations we reviewed that were reported less than 72 hours after the incident.

In addition to securing crime scenes, the custody supervisor checklist itemizes many other steps supervisors must take in response to PREA allegations. We analyzed the documentation in the 74 incidents we reviewed to determine if either custody supervisors or investigators took necessary steps to comply with departmental policy, even if a completed checklist was in the case file. Table 5 below illustrates the number of violations of select itemized policy requirements we found on the custody supervisor checklist.

61. 28 C.F.R. 115.64(a); Cal. Penal Code section 2639(c); DOM Sections 54040.8 and 54040.11.

62. DOM Sections 54040.4, 54040.8.1; Appendix B.

63. 28 C.F.R. section 115.71(c); DOM Section 54040.8.1.

Table 5. Case Review Summary for Custody Supervisor Duties

Selected Extracts From the PREA Custody Supervisor Checklist	Cases Without Evidence That Duties Were Completed	Percentage of Cases in Which Duties Were Not Completed	Effect of Noncompliance
Obtain briefing from the initial contact person.	18	24%	Absent the briefing, it would be difficult to gather additional information from the initial contact person, if necessary.
Ensure a timeline is initiated.	7	9%	It may be difficult to understand the sequencing of events to support the investigation and compliance with PREA protocols.
Ensure victim is secured (Ensure no visual or physical contact occurs between victim and suspect(s)).	8	11%	Risk of continued sexual victimization or abuse.
Secure the suspect(s), if identify is known.	12	16%	Risk of continued sexual victimization or abuse.
Review incarcerated person's offender profile to determine if a staff assistant is needed.*	20	27%	Without staff assistance, the incarcerated person may not be able to communicate effectively to provide critical information for the investigation.
Complete the Victim of Sex Crimes form.	21	28%	The form has the victim acknowledge that his or name will become a matter of public record, unless he or she requests otherwise. If staff fail to provide this form, the victim may not be aware of their right to confidentiality.

* The staff assistant provides support for basic communication to incarcerated people with special accommodation or adaptive support needs.

Source: The OIG's review of 74 PREA incidents.

Like the instructions contained in the PREA initial contact guide, the steps itemized in the custody supervisor checklist are critical to both preserve evidence and ensure PREA investigations are complete and thorough.[64] Therefore, unless staff document that they completed the required steps, management cannot verify compliance with departmental policy.

Staff Did Not Always Ensure Alleged PREA Victims Received Required Mental Health or Medical Evaluations, Including Forensic Examinations

As we explained above, departmental staff are required to preserve physical evidence when responding to PREA allegations, particularly when the incident is alleged to have occurred less than 72 hours before it was reported.[65] Consequently, unless the incarcerated person alleged only harassment, departmental policy requires staff to either transport suspects and willing victims for forensic medical examinations[66] or consult with a specialized nurse to determine if an examination is warranted.[67] We found that staff generally complied with policy but failed to do so in 19 percent (six of 32) of incidents alleged to have occurred less than 72 hours before they were reported.

In one incident, an incarcerated person alleged he was forced to perform nonconsensual sex acts and reported it the same day. However, an investigator closed his investigation approximately 24 hours later, ". . . due to the time lapse in the date of the allegation and the date the alleged incident was reported." We did not find any information in the PREA case record or the investigative report that supported the investigator's conclusion. Therefore, the investigative report was inaccurate—a problem we discuss in greater detail later in this report—and the alleged victim was not transported for a forensic medical examination as required by departmental policy.

The remaining five incidents reported less than 72 hours after the PREA violations allegedly occurred involved allegations of abusive sexual contact. Staff did not consult with a specialized nurse to determine if a forensic medical examination was necessary in three of those cases as departmental policy requires, and we could not determine if staff did so in the other two cases.

Even if a PREA violation is reported more than 72 hours after the incident allegedly occurred, staff are required to consult with a specialized nurse to determine if a forensic medical examination is

64. 28 C.F.R. section 115.71(a); DOM Section 54040.8.1.

65. 28 C.F.R. section 115.64(a); Cal. Penal Code section 2639(c); DOM Section 54040.8–9, 54040.12.1.

66. 28 C.F.R. section 115.21; DOM Sections 54040.12.1 and 54040.12.2.

67. DOM Sections 54040.12.1 and 54040.12.2.

warranted unless the incident involved only harassment.[68] However, we found that staff failed to consult with a specialized nurse in 50 percent (21 of 42) of the allegations reported more than 72 hours after the incident allegedly occurred. Of those incidents, 13 alleged nonconsensual sex acts and eight alleged abusive sexual contact.

Investigators often made the decision not to contact a specialized nurse based on the amount of time that had passed between the alleged incident and the date the PREA allegation was reported. For example, when allegations were reported weeks, months, or years after the incident, investigators did not consult with a specialized nurse. However, the responsibility of making those determinations rests with trained medical professionals under departmental policy.[69]

In addition to forensic medical examinations, PREA standards and departmental policy require staff to refer alleged victims for medical and mental health evaluations.[70] We found that the department met this requirement in nearly all cases we reviewed. However, alleged victims did not immediately receive a medical evaluation or mental health referral in seven incidents we reviewed. The delays ranged between two and eight days after the incidents were reported.

Departmental Staff Did Not Offer Alleged PREA Victims a Victim-Support Person or a Victim Advocate in Nearly Half the Cases We Reviewed

Incarcerated people, like all victims of sexual assault or other misconduct, suffer significant trauma and may need support to guide them through the investigatory process. To assist alleged PREA victims in prisons, the law generally and departmental policy give victims the right to the assistance of both a support person of their choosing and a professional victim advocate who is specially trained to assist victims of sexual assault.[71] Victim advocates reduce survivors' trauma in the following ways:

- Advocates increase survivors' wellness and help them cope with the trauma of sexual abuse.
- Survivors are likely to feel more comfortable with the investigation if they have an advocate.
- Survivors who feel comfortable and supported are more likely to participate in the investigative process, which increases the likelihood of a successful investigation.

68. DOM Section 54040.12.2.

69. DOM Section 54040.12.2.

70. 28 C.F.R. section 115.82; DOM Sections 54040.7 and 54040.9.

71. 28 C.F.R. section 115.21(d)–(e); Cal. Penal Code section 679.04(a); DOM Section 54040.8.2.

In violation of departmental policy, custody staff offered a victim support person or advocate in only 43 of the 74 PREA incidents (58 percent) we reviewed. In addition, in three cases, investigators did not offer alleged victims the services of a support person or advocate until after they were interviewed, even though one of the purposes of a victim support person and advocate is to assist and support victims during the interview process. By not offering a support person or advocate, victims may be less forthcoming or willing to participate in PREA investigations.

Chapter 2. Almost All Investigations of PREA Allegations We Reviewed Were Inadequate for One or More Reasons

Overall, we found one or more deficiencies in 67 of the 74 PREA investigations we reviewed (91 percent), including: investigators failing to conduct interviews or conducting inadequate interviews; investigators failing to secure, collect, or consider evidence; and investigators submitting poorly written investigative reports. We also found eight PREA investigations were not conducted by an investigator specifically trained to conduct PREA investigations, as required by standards and departmental policy.[72]

Investigators Did Not Conduct Timely Interviews, or Did Not Conduct Interviews at All

Investigators must conduct thorough interviews once they identify alleged PREA victims, PREA suspects, and potential witnesses.[73] However, in three incidents we reviewed, investigators assigned to conduct investigations at the prisons where the incidents allegedly occurred did not interview the alleged victims. The investigators instead relied only on memoranda produced at the prisons where the incarcerated people were housed when they made the allegations. Because PREA allegations must be investigated where the incidents allegedly occurred,[74] the memoranda investigators relied on were likely initial preliminary interviews with the alleged victims. Therefore, investigators at the prisons where the alleged incidents occurred likely needed additional evidence to make supportable determinations on the merits of the allegations.

In addition, investigators did not interview the PREA suspects in 12 of the 74 (16 percent) incidents we reviewed. In 26 cases (35 percent), investigators made no attempt to identify witnesses and, therefore did not interview anyone who may have been able to corroborate or refute the PREA allegations. By not interviewing the alleged victims, those accused of violating PREA, or potential witnesses, investigators may not have received all relevant facts and detailed information necessary to support their determinations.

Investigators conducted untimely interviews in at least seven incidents (9 percent) we reviewed. When notified of a PREA allegation that occurred at another prison, PREA standards and departmental policy require prison staff to notify the prison where the incident occurred as soon as possible, but no later than 72 hours—or three days—after receiving the

72. 28 C.F.R. section 115.71(c); Cal. Penal Code section 2639(b); and DOM Section 54040.12.

73. 28 C.F.R. section 115.71; Cal. Penal Code section 2639(b); and DOM Sections 54040.8.1, 54040.12; *Specialized PREA Training*, pp. 12 and 47–54.

74. 28 C.F.R. section 115.63; DOM Section 54040.7.4.

allegation.[75] However, in one case we reviewed, the prison that received multiple PREA allegations from one alleged victim did not forward the complaints to the prison where the incidents occurred until four days later. To make matters worse, the investigator at the prison where the incidents allegedly occurred did not interview the alleged victim for an additional 17 days, took as long as 30 days to interview identified witnesses, and took 54 days to interview a registered nurse for case information. Ultimately, the investigator did not complete all interviews until almost two months after the alleged PREA victim reported the incidents.

Investigators in six other incidents (8 percent) we reviewed delayed interviewing alleged victims and suspects between six and 41 days. The longer it takes to conduct interviews, the less likely it is that individuals will accurately remember the specific details vital to PREA investigations.

Investigators Generally Did Not, but Should, Record All Interviews of Alleged PREA Victims or Suspects

Departmental training instructs investigators to video or audio record interviews of alleged PREA victims as soon as appropriate.[76] The training particularly emphasizes the importance of conducting victim interviews and states that recording statements can be an excellent investigative tool.[77] Some of the advantages of recording interviews are to:

- Provide more detail than handwritten notes.
- Enable investigators to be more attentive during the interview.
- Assist investigators in synopsizing details.
- Protect the interviewer should a complaint or misunderstanding arise.
- Convey the victim's immediate response to prosecutors and jurors.

We believe the department would benefit from recording all interviews, including those with suspects and witnesses, for the same reasons emphasized in the departmental training and for the reasons we state below. It is troubling that investigators did not either video or audio record any interviews in 70 percent (52 of 74) of the PREA investigations we reviewed. Investigators video recorded one or more interviews in only nine cases (12 percent), and audio recorded interviews in only 17 cases (23 percent).

75. 28 C.F.R. section 115.63(b); DOM Section 54040.7.4.

76. *Specialized PREA Training*, pp. 29 and 48–49.

77. *Specialized PREA Training*, pp. 48 and 49.

Although most of the interviews in the PREA investigations we reviewed were not recorded, the benefits of recording interviews were apparent when we listened to the few which were. For example, in one incident we reviewed, an investigator's report did not document that an alleged PREA victim made an unrelated PREA allegation during her interview. We found no evidence the unrelated allegation was reported or investigated.

Similarly, in another incident we reviewed, an alleged PREA victim stated in a video-recorded interview that he had previously reported his PREA allegation to a staff psychologist, but the investigator did not include this information in the investigative report. Consequently, there was no evidence the investigator attempted to determine if the allegation had been previously reported, and if it had been, why it was not investigated. We also identified from the alleged victim's recorded interview that he reported a second unrelated PREA allegation to the investigator. However, we did not find any documentation that the investigator either reported the second allegation or conducted a separate investigation of the second PREA allegation.

We were also concerned about an investigator's conduct during a third video-recorded interview we reviewed. As the alleged victim began to explain the details of the abusive sexual contact allegation, the investigator interrupted the alleged victim several times. We heard one investigator interrupt the alleged victim, asking, "So you do want to file a PREA, correct?" As the alleged victim continued to speak, the investigator interrupted again, "It's a yes or no" and "We will be out of here real quick." Eventually, the investigator appeared to realize he was being unnecessarily argumentative and changed his tack.

According to departmental policy and training, victims of sexual misconduct may be seriously traumatized physically and/or mentally; therefore, staff are expected to be sensitive to alleged victims.[78] Many of the statements made during the interview demonstrated a lack of consideration and respect toward the alleged PREA victim and escalated, rather than deescalated, the already tense interview. Investigators may have also potentially compromised the investigation, admitting to the alleged PREA suspects that the investigation would not take long because they did not have enough evidence.

An investigator told one suspect, "[There is] not a lot of evidence for me to review . . . it's Tuesday, we'll be done by the end of the week." Also, when speaking with another suspect, the investigator said, "Like I was telling the other individual out there who was hootin [*sic*] and hollerin [*sic*]. . . . these things tend to go fast, there's not a lot of evidence to our investigations."

Source: California Department of Corrections and Rehabilitation.

78. DOM Section 54040.8 and *Specialized PREA Training*, pp. 10–11, 39.

If they are available and are reviewed, recorded interviews provide both departmental management and review committees a better tool to assess and oversee the quality of PREA investigations by identifying and addressing clear deficiencies in either the investigators' conclusions or reporting. Given the clear benefits, the department should require investigators to record all interviews unless they document a legitimate reason for not doing so.

Investigators Did Not Always Collect and Secure Potential Physical or Documentary Evidence

As we stated earlier in this report, investigators determine PREA allegations to be unsubstantiated if there is insufficient evidence to establish whether the incident occurred.[79] Therefore, it is critical for investigators to collect and review available evidence in order to conduct thorough investigations and reach supportable determinations, as required by law and departmental policy.[80] However, we found that in several incidents we reviewed, investigators determined PREA allegations to be unsubstantiated without collecting or reviewing available evidence.

When sexual misconduct occurs, physical or biological evidence may be present at the crime scene. Custody supervisors are required to secure crime scene locations to allow investigators to collect potential evidence.[81] As we discussed earlier in this report, of the 19 nonconsensual sex act allegations that victims reported less than 72 hours after occurrence, investigators determined most to be unsubstantiated. However, we found no evidence that anyone secured crime scenes in eight of the 19 incidents (42 percent), six of which investigators specifically determined to be unsubstantiated without attempting to collect evidence from the scenes. Failure to secure the crime scene could have led to the loss of potential evidence due to contamination or tampering, and prevented investigators from collecting evidence which may have substantiated the PREA allegations.

Even when evidence was collected, investigators did not always consider it before reaching their conclusions. For example, investigators closed five nonconsensual act investigations before the results of the alleged victims' and suspects' forensic medical examinations were considered. One investigator closed a case the same day the incident was reported, before the alleged victim and suspect were even transported to forensic medical examinations. Another investigator concluded an allegation was unfounded without reviewing the forensic examination results. In all five cases, the alleged victims reported the PREA violations either

79. 28 C.F.R. section 115.5 and DOM Sections 54040.12.5.

80. 28 C.F.R. section 115.71; and DOM Sections 54040.12–12.1.

81. 28 C.F.R. section 115.64(a)(2); DOM Sections 54040.8.1, 54040.12.1 and 54040.12.2; and *Specialized PREA Training*, pp. 30–35.

on the same day or within a day of the alleged misconduct. PREA investigators are required by law and departmental policy to gather and preserve all relevant evidence, which should clearly include the results of forensic medical examinations.[82] If investigators do not consider all evidence, their investigations are not thorough, and neither departmental management, nor PREA victims and suspects can be assured that the investigators' conclusions were supported by an unbiased review of all available evidence.

In four additional cases we reviewed alleging nonconsensual sex acts, investigators collected physical evidence including clothing worn by alleged PREA victims. This is important because, as stated earlier in this report, biological evidence is more likely to be present in allegations of nonconsensual sex acts. However, like the forensic medical examination results we discussed above, we found no documentation that the collected evidence was tested or considered during the investigations. In addition, despite failing to test available evidence, investigators determined there was insufficient evidence to reach a conclusion on the merits of the PREA allegations.

Investigators may also have access to potentially relevant evidence such as audio-video surveillance system recordings of the alleged crime scene, phone records, or mail sent and received by those involved in the PREA allegation. However, in 28 of the 74 cases (38 percent) we reviewed, investigators determined the PREA allegations to be unsubstantiated without making any attempt to identify evidence beyond conducting interviews. By not pursuing other potential avenues of investigation, investigators may have missed evidence that could have supported or refuted the PREA allegations.

Some Investigative Reports Lacked Basic Facts and Contained Errors and Inconsistencies

Some investigative reports we reviewed lacked documentation of basic facts or contained errors and inconsistencies. For example, in one case, an investigator reported he canvassed the facility where the PREA incident allegedly occurred but was unable to find witnesses with information relevant to the investigation. However, the investigator did not describe how he canvassed the facility or document the incarcerated people or staff he spoke with. In addition, the investigative report contained errors and inconsistencies in the alleged victim's and suspect's housing history. The investigator correctly reported that the alleged victim and suspect were housed together from May 2024 through July 2024. However, in another section of the report, the investigator mistakenly stated that the alleged victim and suspect were housed together from September 2023 through November 2023. We confirmed

82. 28 C.F.R. section 115.71(c); Penal Code section 2639; and DOM Sections 54040.8.1 and 54040.9–12.2.

through prison records that the alleged victim did not arrive at the prison until May 2024, six months later.

In another case, an alleged victim reported a PREA violation in March 2024, on the same day the incident allegedly occurred, but the investigator incorrectly documented in his report the alleged violation occurred in January 2024. The error likely led to the investigator's decision to not transport the alleged victim to a forensic medical examination because he believed the incident occurred two months earlier. Consequently, the opportunity to obtain medical evidence supporting or refuting the PREA allegation was lost.

In four cases we reviewed, the investigative reports included information not documented elsewhere. In one case, the investigator concluded an allegation was substantiated citing, "Two independent sources [who] provided similar information." However, the investigative report only documented one source witness. Furthermore, the investigator relied only on the witness's statement to substantiate the allegation even though the witness had been previously found to have committed a PREA violation against the suspect.

In another separate case, an investigator reported that an alleged PREA victim did not know what object the suspect used to sodomize him. However, on a sexual assault interview guideline form used to gather information about the allegation, the same investigator documented that the suspect used his penis to anally rape the alleged victim. In the third case, it was unclear from the investigative report who received the initial PREA allegation. The investigative report stated that a "yard supervisor" received the allegation, but there was no documentation that the investigator identified the "yard supervisor" or contacted the individual to gather additional information. In the fourth case, the investigator incorrectly named a different incarcerated person as the alleged victim when documenting his review of the alleged victim's PREA case history. The incorrectly named person was not involved in the PREA allegation being investigated.

Chapter 3. The Prisons' Institutional PREA Review Committees Did Not Provide Proper Oversight to Ensure That Applicable Laws, Regulations, and Policy Were Followed

PREA review committees are responsible for thoroughly reviewing allegations to ensure staff followed federal and state laws, as well as departmental policy and guidelines when responding to PREA allegations.[83] In nearly all incidents we analyzed, review committees did not provide proper oversight to determine if investigators used standard investigative techniques to gather evidence and corroborate allegations. In many cases, review committees failed to identify significant short comings that should have required investigators to complete additional work, or to receive training on conducting thorough and adequate investigations.

In the cases we reviewed, we also found no evidence that review committees meaningfully discussed the investigations they reviewed. Lastly, review committees did not review several PREA incidents within the time frame required by departmental policy. In one case, the review committee finalized its incident review before the PREA investigation had been completed.

Quality Control Among the Prisons' PREA Review Committees Is Poor and Needs Improvement

Review committees are responsible for providing quality control for prisons' PREA reporting and response processes.[84] However, as explained earlier in this report, we identified many deficiencies in investigative reports we reviewed. If review committees had properly reviewed those investigations, they would have identified the same deficiencies and either required investigators to conduct additional work, or made recommendations for improvement, as departmental policy requires.

In one case, an alleged victim identified the suspect and an officer who may have witnessed his sexual assault, but the investigator did not interview either individual. Furthermore, in his report, the investigator stated a forensic medical examination was not warranted due to the lapse of time from when the incident allegedly occurred. However, a PREA response supervisor reported that both the alleged victim and suspect had been transported for forensic medical examinations. Had the prison's review committee reviewed the investigative report as we had, the committee would have identified the blatant discrepancy and requested clarification on this very important issue. The committee would have

83. 28 C.F.R. section 115.86; DOM Section 54040.17.

84. 28 C.F.R. section 115.86; DOM Section 54040.17.

also identified the investigator's failure to interview both the suspect and witnesses and likely required follow up.

In another case, an alleged victim reported in January 2024 that he was allegedly forced to engage in nonconsensual sex acts. However, the investigator did not attempt to interview the alleged victim until 41 days after he reported the allegation. Timely interviews are critical in all investigations, especially rape investigations. Consequently, departmental PREA training guidelines state investigators should complete victim interviews promptly to help ensure alleged victims provide specific details of the incidents before their memories fade.[85] Clearly, not attempting to interview the alleged victim until 41 days after the reported incident is a significant delay, and the prison's review committee should have questioned the investigator about the delay.

The deficiencies cited in this report are compounding evidence that the review committees did not conduct meaningful PREA incident reviews. While we bring attention to the deficiencies and errors found in the cases we reviewed, we have not analyzed the significance of these deficiencies and errors to determine whether they would have altered investigation outcomes. However, if review committees had thoroughly reviewed PREA investigations as PREA standards and departmental policy requires, both the department and the public would have been assured that investigators took the allegations seriously and collected the necessary information and evidence to substantiate investigation outcomes.[86]

Most PREA Review Committee Documentation Was Poor, Lacking Evidence of Meaningful Discussion or Recommendations for Improvement

In general, we found that documentation of review committee meetings lacked meaningful evidence that committees discussed PREA allegations and the corresponding investigative report(s) as required by PREA standards and departmental policy.[87] Most prison review committee members use a template checklist to document their participation during meetings. The checklist includes "yes" and "no" checkboxes for specific requirements review committee members must verify, as illustrated on Figure 2 on page 6.[88] The template also includes a space for review committee members to add additional information and comments regarding each checklist item.[89]

85. *Specialized PREA Training*, pp. 47–48.

86. 28 C.F.R. section 115.86; DOM Section 54040.17.

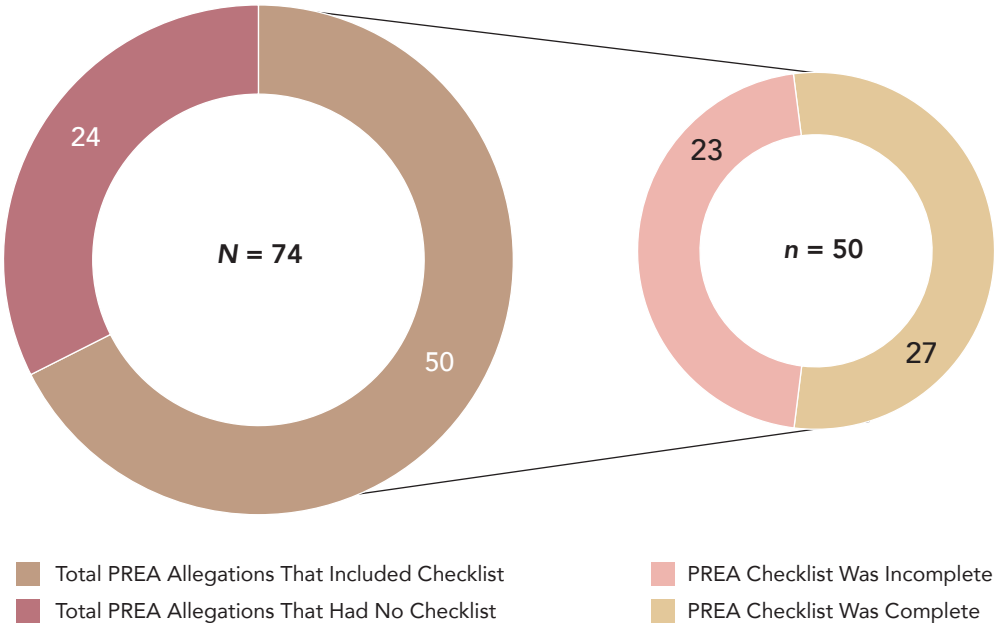
87. 28 C.F.R. sections 115.71(f)(2) and 115.86; DOM Section 54040.17.

88. Appendix D.

89. Appendix D.

We found that review committee members rarely did more than check the boxes on the checklist. In many cases, committee members only partially completed the checklist, and some committee members failed to complete the checklist at all. As illustrated in Figure 6 below, 24 of 74 case files (32 percent) of PREA incidents we reviewed did not contain review committee meeting checklists or any supplemental documentation to show the committees reviewed the incidents. Furthermore, of the 50 case files (68 percent) that contained review committee meeting checklists, 27 (54 percent) of the checklists were unsigned or incomplete with unanswered questions or missing pages. The review committee checklist includes one item bulleted and underlined for emphasis, "Ensure all discussions are documented."

Figure 6. Summary of PREA Cases With the PREA Review Committee Checklist



Source: The OIG's analysis of incarcerated-person-on-incarcerated-person-PREA allegations reviewed by the PREA Review Committee from March 1, 2024, through August 31, 2024.

The checklists we reviewed rarely included evidence that review committees discussed investigations, let alone documented those discussions. Our inspectors attended at least 48 review committee meetings at 18 prisons and found the meetings were brief and lacked robust discussion. At four prisons, the review committee meetings we reviewed lasted no more than five minutes, at three they lasted no more than 10 minutes, and at another three they lasted no more than 15 minutes. Finally, review committee meetings we attended at two prisons lasted between 15 and 35 minutes. At two prisons, the length of meetings ranged from between 15 and approximately 35 minutes.

We found discussion among the review committee members at some meetings we attended was limited to reading the questions from the templated checklist and then asking investigators if the allegations were substantiated, unsubstantiated, or unfounded. The review committee would then quickly move to the next investigation scheduled on the agenda until all incidents were "reviewed." Based on our observations during the meetings we attended, it is clear that most committee members did little to prepare for the meetings and did not fulfill their responsibilities under departmental policy. The poor documentation of what actions committee members took during review, and the insufficient reviews as evidenced by short, superficial meetings, causes us to question the department's commitment to ensuring a thorough and accurate PREA review process.

Finally, PREA standards and departmental policy require review committees to prepare reports of all findings and recommendations for improvement after each meeting:[90]

> [A review committee shall] prepare a report of its findings and any recommendations for improvement.[91]

As detailed at length above, we found deficiencies in virtually all PREA investigations we reviewed, but review committees did not identify any of these deficiencies. We did not find documentation that review committees made any recommendations to ensure prisons implemented, revised, or enforced procedures necessary to properly and efficiently respond to allegations in the cases we reviewed. If review committees do not conduct thorough incident reviews, investigators will likely continue to inadequately investigate PREA allegations.

Review Committees Did Not Always Timely Review PREA Allegations

Departmental policy requires review committees to review PREA allegations within 60 days of when the victim or a third party reported the incident, or within 30 days of completion of the investigation, whichever is sooner.[92] Review committees did not conduct incident reviews within 60 days of the date the PREA allegation was first reported in 27 percent (20 of 74) of the cases we reviewed. Prisons also did not hold review committee meetings within 30 days of the closure of investigation in 27 percent (20 of 74) of cases we reviewed.

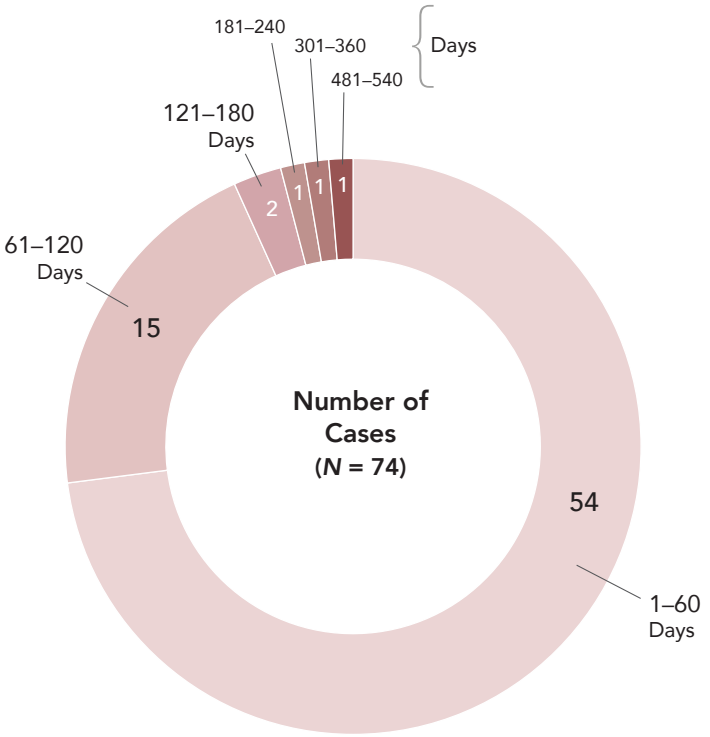
Figures 7 and 8 below provide breakdowns of the time review committees took to conduct incident reviews from when the allegations were first received by the prison, and from the dates the investigations were concluded.

90. 28 C.F.R. section 115.86(d)(6); DOM Section 54040.17.

91. DOM Section 54040.17.

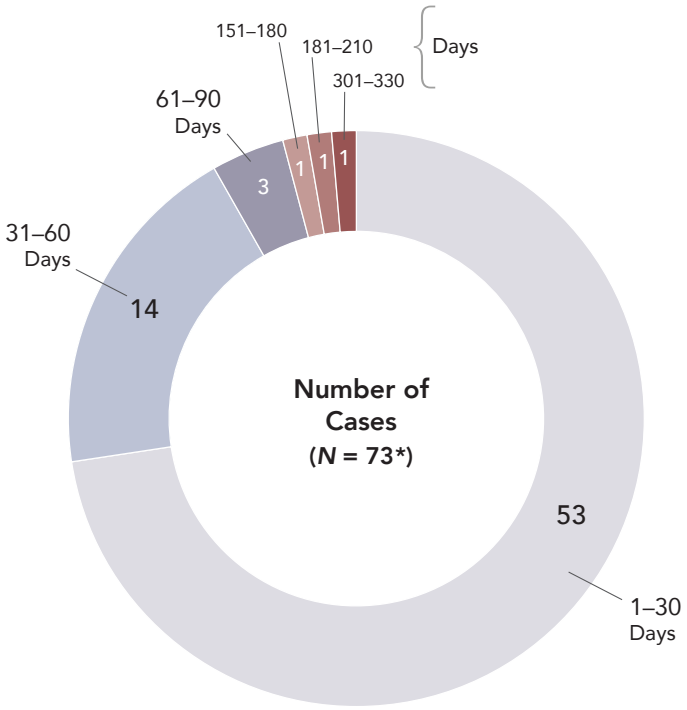
92. DOM Section 54040.17.

Figure 7. Distribution of Days From Discovery of PREA Allegation Until the First Review Committee Meeting



Source: The OIG's analysis of PREA allegations made against incarcerated people reviewed by the PREA Review Committee review from March 1, 2024, through August 31, 2024.

Figure 8. Distribution of Days From Completion of Investigative Report Until the Final Review Committee Meeting



* One case was excluded because the committee finalized its incident review before the investigation was completed.

Source: The OIG's analysis of PREA allegations made against incarcerated people reviewed by the PREA Review Committee from March 1, 2024, through August 31, 2024.

Notably, review committee members did not document any explanation as to why the reviews were delayed on the meeting checklists in any of the cases we reviewed. Timely review of PREA allegations is essential to ensure investigations—which carry significance to both victims and suspects—are both thorough and supported. For victims, a timely review can bring justice and resolution to a potential crime. For suspects, a timely review is essential for either exoneration, or to explain the next steps in the investigation process.

In one case we reviewed, we also found that a review committee finalized its review nine days before the investigator submitted a final report. There is no evidence the review committee looked at the investigative report after it was completed.

Review committee members have a critical role in the PREA review process. They provide quality control to ensure the department's policies, practices, and protocols comply with federal and state laws. Unfortunately, we did not find this to be the case in the 74 PREA investigations we reviewed. If neither the department nor the review committee is committed to improving the PREA review process and holding staff accountable for failing to follow departmental regulations and policy, then staff will continue to perform poorly, as identified in this report.

Furthermore, if the incarcerated population has the impression the department does not thoroughly review PREA allegations or investigations, the population may be less likely to report sexual misconduct. Consequently, the number of sexual assault victims may be underreported in California's prisons. This ultimately undermines the department's policy of zero tolerance for sexual misconduct and its mission to provide a safe, humane, secure environment, free from sexual misconduct.[93]

93. DOM Section 54040.1.

Chapter 4. Recommendations

1. The department should require all PREA allegation interviews to be audio or video recorded.
    a. The department should require a manager, or other designated staff to confirm on a sample basis that information from recorded PREA interviews is accurately and thoroughly documented in investigators' reports.
2. The department should ensure all investigators conducting PREA investigations receive specialized PREA investigator training as required by law and departmental policy.
    a. The department should consider requiring that all Investigative Services Unit investigator staff receive specialized PREA training.
3. Prison wardens or delegates should require corrective action if staff fail to comply with law or departmental policy when receiving, responding to, or investigating PREA allegations.
4. The department should implement monitoring processes to ensure:
    a. All staff follow departmental policy and training procedures when receiving and responding to PREA allegations.
    b. Staff who conduct PREA investigations properly apply the standard investigative techniques included in the departmental specialized PREA training program for investigators.
    c. Investigative reports are complete and accurate according to case documentation.
    d. PREA review committees fulfill all their responsibilities under departmental policy.
5. The department should identify and document areas for corrective action when PREA review committee members do not fulfill all their responsibilities under departmental policy.

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Appendices

Appendix A. Departmental Investigations of PREA Allegations We Reviewed and Determined to Be Inadequate for One or More Reasons

In this appendix, we present our determinations for 67 of the 74 PREA investigations we reviewed to be inadequate for one or more reasons. We used our professional judgment, criteria set forth in PREA standards and departmental policies and procedures, and recommended practices outlined in the department's PREA training manuals. We assessed the appropriateness of the investigative techniques applied to each investigation; interviews conducted with alleged victims, suspects, and witnesses; evidence collected; and the accuracy and thoroughness of the investigative report compared to supporting documentation. Our qualitative assessments, however, were not intended to reflect the validation or invalidation of the investigator's investigation outcome determinations. Below, we present the primary assessment questions and the general methodology we applied to assess each.

1. **Did the investigator interview the victim?**

   We evaluated whether the investigator interviewed the victim to gather information pertaining to the allegation, including pertinent details of the events requiring investigation, possible witnesses and available evidence.

2. **Did the investigator interview the suspect?**

   We evaluated whether the investigator interviewed the alleged suspect to gather information pertaining to the allegation, including pertinent details of the events requiring investigation, possible witnesses and available evidence.

3. **Did the investigator attempt to identify witnesses?**

   We evaluated whether the investigator attempted to identify potential staff or incarcerated person witnesses, if applicable, to gather information pertaining to the allegation, including pertinent details of the events requiring investigation, possible witnesses and available evidence.

4. **Did the investigator interview witnesses?**

   We evaluated whether the investigator interviewed potential staff or incarcerated witnesses, if identified.

5. **Did the investigator consider forensic medical examination results or other medical reports, as applicable?**

   We evaluated whether the investigator considered the results from forensic medical examinations, the Medical Report of Injury or Unusual Occurrence, or other medical reports, as applicable, to determine the investigation outcome.

6. Did the investigator obtain and review other evidence, other than audio video surveillance system (AVSS) footage?

We evaluated whether the investigator attempted to gather evidence, such as but not limited to, reviewing phone records, mail, clothing, bedding, housing history, and other relevant matter to support or refute allegations of sexual misconduct.

7. Did the investigator review prior complaints and reports sexual abuse that may be relevant to the allegation?

We evaluated whether the investigator reviewed prior complaints, disciplinary history, and reports of sexual abuse of individuals who were subjects of the PREA investigation to establish any relevant history as a basis to decide on the investigation outcome.

8. Did we find other discrepancies and shortcomings in the investigation, or investigative reporting?

We evaluated the investigation report, and relevant documentation for overall thoroughness of the report, including whether the reports were complete and accurate. We considered attributes including, but not limited to, the timeliness of interviews; follow-up to alleged victim, suspect, and witness statements; follow-up with evidence collected; and recorded interviews and documentation to support analysis and conclusions.

Table A–1. Investigations of PREA Allegations the OIG Reviewed and Determined to Be *Inadequate* for One or More Reasons

		Questions							
Case	Allegation Type	Q1 Victim Interview	Q2 Suspect Interview	Q3 Attempt to Identify Witness	Q4 Witness Interview	Q5 Medical Examination Reports	Q6 Additional Evidence, Other Than AVSS	Q7 Prior Misconduct	Q8 Other*
1	Nonconsensual	Yes	Yes	Yes	Yes	Yes	Yes	No	X
2	Abusive Sexual Contact	Yes	Refused	Yes	N/A	No	No	No	N/A
3	Nonconsensual	Yes	No	Yes	N/A	No	Yes	Yes	X
4	Abusive Sexual Contact	Yes	Yes	Yes	No	Yes	Yes	No	X
5	Abusive Sexual Contact	Yes	No	No	N/A	N/A	Yes	Yes	N/A
6	Abusive Sexual Contact	Yes	Yes	Yes	Yes	Yes	No	Yes	X
7	Nonconsensual	Yes	Yes	No	N/A	No	No	Yes	X
8	Nonconsensual	Yes	Yes	Yes	N/A	No	Yes	No	X
9	Harassment	Yes	Yes	Yes	Yes	No	No	No	X
10	Nonconsensual	Yes	No	Yes	No	No	Yes	No	X
11	Nonconsensual	Yes	No	No	No	No	Yes	No	X
12	Harassment	Yes	Yes	Yes	Yes	N/A	No	No	N/A
13	Nonconsensual	Yes	Yes	No	No	Yes	Yes	No	X
14	Abusive Sexual Contact	Yes	Yes	Yes	N/A	Yes	No	No	N/A
15	Nonconsensual	No	No	Yes	Yes	No	No	Yes	X
16	Nonconsensual	No	No	No	No	No	No	No	X
17	Abusive Sexual Contact	Yes	Yes	No	No	No	Yes	No	X
18	Nonconsensual	Yes	No	No	N/A	No	No	Yes	X
19	Nonconsensual	Yes	Yes	Yes	Yes	No	Yes	Yes	X
20	Nonconsensual	Yes	Yes	Yes	Yes	N/A	Yes	Yes	X
21	Abusive Sexual Contact	Yes	Yes	Yes	Yes	No	No	Yes	X
22	Nonconsensual	Yes	Yes	Yes	No	Yes	No	No	X
23	Nonconsensual	Yes	N/A	N/A	N/A	No	No	Yes	X
24	Abusive Sexual Contact	Yes	No	No	N/A	N/A	Yes	No	X
25	Nonconsensual	Yes	Yes	No	N/A	Yes	Yes	Yes	X
26	Nonconsensual	Yes	Yes	No	No	No	No	Yes	X
27	Nonconsensual	Yes	Yes	No	N/A	No	Yes	No	N/A
28	Nonconsensual	Yes	Yes	No	No	N/A	Yes	Yes	N/A
29	Abusive Sexual Contact	Yes	No	No	No	No	Yes	Yes	N/A
30	Nonconsensual	Yes	N/A	N/A	N/A	No	N/A	Yes	X
31	Nonconsensual	Yes	Yes	No	No	No	No	No	X
32	Nonconsensual	Yes	Yes	No	No	Yes	Yes	Yes	N/A
33	Nonconsensual	Refused	No	Yes	Yes	Yes	No	No	X
34	Nonconsensual	Yes	N/A	No	N/A	No	No	Yes	X

Continued on next page.

Table A–1. Investigations of PREA Allegations the OIG Reviewed and Determined to Be *Inadequate* for One or More Reasons (continued)

		Questions							
Case	Allegation Type	Q1 Victim Interview	Q2 Suspect Interview	Q3 Attempt to Identify Witness	Q4 Witness Interview	Q5 Medical Examination Reports	Q6 Additional Evidence, Other Than AVSS	Q7 Prior Misconduct	Q8 Other*
35	Abusive Sexual Contact	Yes	Yes	No	N/A	No	No	Yes	X
36	Nonconsensual	Yes	Yes	No	No	Yes	No	Yes	X
37	Nonconsensual	Yes	Yes	No	No	N/A	Yes	Yes	N/A
38	Nonconsensual	Yes	Yes	Yes	No	Yes	Yes	No	N/A
39	Abusive Sexual Contact	Yes	Yes	Yes	No	Yes	No	No	N/A
40	Abusive Sexual Contact	Yes	Yes	Yes	Yes	Yes	Yes	Yes	X
41	Nonconsensual	Yes	Yes	Yes	Yes	Yes	No	No	N/A
42	Nonconsensual	Yes	Yes	Yes	N/A	Yes	No	No	N/A
43	Nonconsensual	Yes	Yes	No	No	Yes	Yes	Yes	N/A
44	Nonconsensual	Yes	Yes	No	No	Yes	No	Yes	N/A
45	Abusive Sexual Contact	Yes	Yes	Yes	Yes	Yes	No	No	N/A
46	Nonconsensual	Yes	Yes	Yes	Yes	Yes	No	No	N/A
47	Abusive Sexual Contact	Yes	Yes	Yes	Yes	Yes	No	No	N/A
48	Abusive Sexual Contact	Yes	Yes	No	N/A	Yes	No	Yes	N/A
49	Nonconsensual	No	Yes	Yes	Yes	No	No	No	X
50	Nonconsensual	Yes	Yes	Yes	Yes	Yes	No	Yes	X
51	Abusive Sexual Contact	Yes	Yes	No	N/A	Yes	Yes	No	X
52	Nonconsensual	Yes	Yes	No	No	Yes	Yes	Yes	N/A
53	Abusive Sexual Contact	Yes	Yes	No	N/A	Yes	No	No	N/A
54	Abusive Sexual Contact	Yes	Yes	Yes	Yes	Yes	No	No	N/A
55	Nonconsensual	Yes	Yes	Yes	Yes	Yes	Yes	No	X
56	Abusive Sexual Contact	Yes	Yes	Yes	N/A	N/A	Yes	Yes	X
57	Nonconsensual	Yes	Yes	Yes	Yes	Yes	No	Yes	N/A
58	Nonconsensual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	X
59	Nonconsensual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	X
60	Nonconsensual	Yes	No	Yes	Yes	Yes	No	No	X
61	Nonconsensual	Yes	No	Yes	Yes	Yes	No	No	X
62	Nonconsensual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	X
63	Nonconsensual	Yes	Yes	Yes	Yes	No	Yes	Yes	X
64	Nonconsensual	Yes	Yes	Yes	N/A	Yes	Yes	Yes	X
65	Abusive Sexual Contact	Yes	Yes	Yes	No	Yes	Yes	Yes	X
66	Abusive Sexual Contact	Yes	Yes	Yes	Yes	No	No	No	X
67	Abusive Sexual Contact	Yes	Yes	No	N/A	N/A	Yes	Yes	N/A

Note: In the column labeled "Q8 Other," X signifies that the OIG found other discrepancies and shortcomings in the investigation, or investigative reporting as detailed in assessment question 8 above.

Source: The OIG's analysis for the 67 PREA investigations our staff reviewed and determined to be *inadequate* for one or more reasons.

Appendix B. Departmental PREA Custody Supervisor Checklist

STATE OF CALIFORNIA
CUSTODY SUPERVISOR CHECKLIST (PREA)

CLEAR FORM

DEPARTMENT OF CORRECTIONS AND REHABILITATION

Page 1 of 2

PRISON RAPE ELIMINATION ACT: **CUSTODY SUPERVISOR CHECKLIST**

CDCR #: _____ Last Name: _____ Date of Report: _____

Instructions: Complete all applicable sections, checking each box and documenting the time as you finish the task. Include this completed document with the Crime Incident Report.

Ensure the victim and suspect, to the best of your ability, do not:

- **Shower**
- **Remove clothing without custody supervision**
- **Use restroom facilities**
- **Consume any liquids**

SECTION 1: Upon Initial Contact with Staff

☐	Obtain briefing from the initial contact person.	Time Obtained:
☐	Ensure a time line is initiated.	Time Initiated:
☐	Ensure victim is secured **(Ensure no visual or physical contact occurs between victim and suspect(s).**	Time Completed:
☐	Ensure crime scene has been secured.	Time Completed:
☐	Notify Watch Commander of situation.	Time Completed:
☐	Secure the suspect(s), if identity is known. ***Ensure no visual or physical contact occurs between victim and suspect(s).***	Time Completed:
☐	Review ERMS/C-File/DECS to determine if a Staff Assistant is needed.	Time Completed:
☐	Assign custody escort to the victim. ***Consider same gender preference of victim. Custody escort will act as Staff Assistant (if needed).***	Time Completed:
☐	Assign custody escort to the suspect.	Time Completed:
☐	Designate an evidence officer to collect and process evidence.	Time Completed:
☐	Complete the Victim of Sex Crimes form.	Time Completed:

SECTION 2: While in TTA/designated medical location:

☐	Ensure medical assessment/triage has been initiated.	Time Completed:
☐	Ensure Sexual Assault/Battery Transportation Kits are utilized per DOM 54040.8.4, Transportation Responsibilities, for medical transport and/or SART contact.	Time Completed:
☐	Notify the Watch Commander of transport to the hospital or SART location.	Time Completed:
☐	For crimes listed under PC 264.2 (Rape, Sodomy, Oral copulation, Forcible Penetration) Explain right to Victim Support Person and Victim Advocate. *Watch Commander to contact Victim Advocate.* Document on a Crime Incident Report the decision and/or reason to deny the Support Person (ie Institutional Security).	Time Completed:

Appendix B. Departmental PREA Custody Supervisor Checklist (continued)

STATE OF CALIFORNIA
CUSTODY SUPERVISOR CHECKLIST (PREA)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

Page 2 of 2

SECTION 3: Upon return to institution/completion of medical assessment:

☐	Place victim under direct and constant observation until a Suicide Risk Evaluation(SRE) is completed (SRE is to be completed within four (4) hours of return from the hospital or SART location)	Time Completed:
☐	Work with RN – Suicide Risk Evaluation	Time Completed:
☐	Consider appropriate housing for victim/suspect • ***Separate buildings, if possible.*** • ***CDC Form Administrative Segregation Placement Notice***	Time Completed:
☐	Ensure preparation of a Crime Incident Report, if appropriate.	Time Completed:

SIGNATURE SECTION:

The employee who completes this form will print full name, sign and date the document. This form will be submitted with the Crime Incident Report.

_____ _____ _____

Printed Name of Staff Signature Date

Appendix C. Departmental PREA Initial Contact Guide

STATE OF CALIFORNIA
INITIAL CONTACT GUIDE (PREA)

CLEAR FORM

DEPARTMENT OF CORRECTIONS AND REHABILITATION

Page 1 of 1

Instructions: To be utilized as a guide during a PREA incident. If you are a non-custody staff member, notify the custody supervisor of the area for assistance in responding to this situation.

CDCR #: _____ Last Name: _____ Date of Report: _____

SECTION 1: **Ensure the victim and suspect, to the best of your ability, DO NOT:**

- Shower
- Remove clothing without custody supervision
- Use restroom facilities
- Consume any liquids

SECTION 2: Initial Contact with Victim

- Activate alarm, if needed.
- Assess immediate medical and custody needs.
- Contact supervisor and inform of situation.
- Take the victim to a secure location.
- Seek assistance to secure the crime scene.
- Listen to the victim and take notes on his/her statements.

SECTION 3: Initial Contact with Suspect

- Activate alarm and apply restraints, if needed.
- Place in holding cell. ***Ensure no contact with the victim.***
- Assess immediate medical and custody needs.

SECTION 4: Custody Escort

- Escort to designated medical location.
- Document spontaneous comments.

Appendix D. Departmental Institutional PREA Review Committee Checklist

Revised 09/20/2022

Institutional PREA Review Committee (IPRC) -- DOM Section 54040.17

Institution [redacted] ***PREA Log #*** [redacted]

- *IPRC not required for unfounded or sexual harassment allegations.*
- *Ensure all discussions are documented.*
- *Initial IPRC review shall be completed within 30 days of the conclusion of the investigation or 60 days of the date of discovery, whichever is sooner.*
- *Whenever an initial IPRC was conducted prior to the completion of the investigation, a subsequent IPRC shall be completed within 30 days of the conclusion of the investigation.*

Initial IPRC Date:_____ Date Reported: [redacted]

Date Incident Occurred: [redacted] Date Investigation concluded:_____ N/A ☐

Victim Name: [redacted] CDCR #: [redacted] Location: [redacted]

IR#: [redacted] Reported by: [redacted]

I/M Suspect(s) Name: [redacted] CDCR #: [redacted]

Type of Incident: Abusive Sexual Contact ■ Non-consensual Sex Act ■ Staff Sexual Misconduct ■

Was the SSV-IA Form completed within 2 business days? Yes ☐ No ☐

Was the initial IPRC completed within 30 days from the conclusion of the investigation or 60 days from date of discovery? Yes ☐ No ☐

- *Subsequent IPRC to be scheduled upon completion of investigation?* Yes ☐ No ☐ N/A ☐

Subsequent IPRC Required due to IPRC being unable to provide a thorough review? Yes ☐ No ☐

Subsequent IPRC Requested by Hiring Authority? Yes ☐ No ☐

ALLEGATION(S):	Substantiated		Unsubstantiated	Ongoing	
	SART Exam	MH Referral	Housing Change	PAR Form	RVR Issued
Victim	N/A	[redacted]	[redacted]	[redacted]	
Suspect	N/A	N/A	N/A		
Witness/Reporter	N/A	N/A	N/A		

1

Appendix D. Departmental Institutional PREA Review Committee Checklist (continued)

Revised 09/20/2022

Was the incident motivated by race, ethnicity, gender identity, LGBTI identification? Yes ☐ No ☐
Comments:_____

Was the incident the result of STG affiliation, status or perceived status? Yes ☐ No ☐
If yes, explain:_____

Was an examination of the area where the abuse allegedly occurred assessed to determine whether physical barriers enabled the abuse? Yes ☐ No ☐ If yes, attach photos.
If no, why not:_____

Did physical barriers aid or enable the abuse? Yes ☐ No ☐
If yes, explain:_____

Was a work order submitted? Yes ☐ No ☐
If no, explain:_____

Was CDCR Facilities HQ input required? Yes ☐ No ☐

Were staffing levels sufficient at the time of incident? Yes ☐ No ☐
If not, what action is being taken:_____

Have similar incidents occurred in the same location? Yes ☐ No ☐
If yes, explain:_____

Was the incident discovered or recorded by monitoring technology? Yes ☐ No ☐

Would augmentation or deployment of monitoring technology have prevented this incident? Yes ☐ No ☐
Explain:_____

2

Appendix D. Departmental Institutional PREA Review Committee Checklist (continued)

Revised 09/20/2022

Was the response to this PREA incident in compliance with CDCR PREA Policy and Procedures? Yes ☐ No ☐
If not, explain:_____

Was a Corrective Action Plan generated as a result of this incident? Yes ☐ No ☐
Explain:_____

Is there a need for change or review of departmental or institutional policy or procedure? Yes ☐ No ☐
Explain:_____
_____

Is Follow-up required?_____

Inmate notified of outcome as required by policy?_____

Committee Members present:

Chairperson (Institution Head or Designee):_____

PREA Compliance Manager:_____

Designated Managerial Employee:_____

In-Service Training Manager:_____

Health Care Clinician:_____

Mental Health Clinician:_____

Incident Commander or ISU Supervisor:_____

PREA Compliance Manager Print/Signature:_____ Date:_____
Warden or Designee Print/Signature:_____ Date:_____ Comments: _____ _____

3

Appendix E. Scope and Methodology

California Penal Code section 6126, subdivisions (b) and (c) authorize the OIG to initiate reviews of the department's policies, practices, and procedures. The Inspector General initiated this review focused on PREA allegations against incarcerated people reported at California State prisons. Our inspectors attended review committee meetings, reviewed PREA investigative reports and related documentation, interviewed and met with staff as necessary, and analyzed the results of PREA investigations.

We judgmentally selected 74 PREA allegations that underwent incident reviews by the review committees at 23 California prisons from March 1, 2024, through August 31, 2024, for the purposes of this review. While OIG inspectors did not attend all IPRC meetings, we focused our selection of PREA allegations on the general criteria listed below:

- We prioritized PREA allegations of nonconsensual sexual contact and abusive sexual contact.
- We prioritized PREA allegations that involved transgender incarcerated people.
- We considered the level of injury sustained by the PREA victim.
- We considered the incarcerated person's housing assignment and classification.

Appendix F. Review Objectives

1. Determine if prisons complied with laws and departmental policy to identify and document incarcerated person PREA allegations.
2. Determine if prisons adequately investigated and responded to incarcerated people's PREA allegations.
3. Determine if the review committee at each prison properly reviewed each incarcerated person PREA allegation and made an appropriate determination for the investigation outcome.
4. Review and assess any other issues that were significant to this review.

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The Department's Response to Our Report

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STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

OFFICE OF THE SECRETARY
PO Box 942883
Sacramento, CA 94283-0001

August 15, 2025

Ms. Amarik Singh
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The California Department of Corrections and Rehabilitation (CDCR) thanks the Office of the Inspector General (OIG) for the opportunity to review the draft report titled *Special Review of the California Department of Corrections and Rehabilitation's Response to Incarcerated-Person-on-Incarcerated-Person Allegations Under the Prison Rape Elimination Act.*

CDCR would like to highlight the Department's consistent record of full compliance in federal audits. These audits, conducted by Department of Justice-certified PREA auditors, unaffiliated with CDCR, substantiate CDCR's commitment to meeting and exceeding federal standards. These favorable outcomes stand in contrast to the findings reported by the OIG, raising concerns about the methodology employed and warranting a thorough reconsideration of its conclusions.

Upon reviewing the OIG's draft report, it became apparent that the criteria utilized to determine the rating of "inadequate" were not clearly articulated. Particularly concerning, it appears there may have been a conflation of the roles and responsibilities of the Institutional PREA Review Committee (IPRC) and the Institution Executive Review Committee (IERC). While both committees hold similarities, they are distinctly established to review different criteria, thus warranting separate evaluations based on their respective mandates.

The DOM Section 54040.17 delineates the specific criteria that the IPRC shall review, focused primarily on ensuring preventive measures and addressing systemic issues related to sexual abuse. Conversely, the IERC, as outlined in DOM Section 51020.19.5, is tasked with conducting a thorough assessment in compliance with use of force policies and procedures. The possible conflation of these two processes may have led to an assessment of inadequacies that do not account for the specific criteria set forth by federal standards and departmental policies. For example, the OIG indicates that investigators did not consistently record video or audio record interviews, marking this as an inadequacy; however, such a mandate is not established in CDCR's policies. Furthermore, the assertion that review committees failed to identify inadequacies in 67 out of 74 investigations may not hold when considering the differing responsibilities of the IPRC and IERC. These findings paint an inaccurate picture of the CDCR's adherence to federal standards and internal policy, leading to an unjust classification of inadequacy.

The Department's Response to Our Report (continued)

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Amarik Singh, Office of the Inspector General
Page 2

The Department acknowledges that certain institutional practices related to Incarcerated Person-on-Incarcerated Person investigations under the Prison Rape Elimination Act (PREA) present opportunities for improvement. CDCR is exploring opportunities to augment our resources to enable the unit to offer increased support and training to institutional investigators and PREA Compliance Managers. Our goal is to strengthen the unit's capacity to deliver comprehensive oversight of investigative processes, ensuring sustainable practices in alignment with the Code of Federal Regulations (28 CFR Part 115), the Department Operations Manual (DOM), and applicable provisions of the California Penal Code.

In conclusion, while the OIG report identifies several opportunities for improvement, it is crucial that the evaluative framework accurately reflects the established standards and practices governing our investigations. The Department remains dedicated to refining its processes and ensuring the safety and well-being of all individuals within its facilities.

We remain dedicated to addressing the issues identified and look forward to ongoing collaboration in fostering transparency and accountability. Please advise us of the anticipated release date for the final report.

If you have any questions, contact me at (916) 323-6001.

Sincerely,

DocuSigned by:
Jeff Macomber
5957F5D0C55F473...

JEFF MACOMBER
Secretary

The Office of the Inspector General's Reply to the Department's Response

Thank you for your response to our draft report titled S*pecial Review of the California Department of Corrections and Rehabilitation's Response to Incarcerated-Person-on-Incarcerated-Person Allegations Under the Prison Rape Elimination Act*.

Regarding your concern that our determinations of adequacy and inadequacy were based on either a conflation of the role of the Institutional PREA Review Committee (IPRC) with the role of the Institution Executive Review Committee (IERC) or the department's failure to record interviews, neither IPRC performance nor the failure to record interviews factored into our assessment of the 74 investigations we reviewed. Appendix A to the report sets forth a detailed explanation of the eight criteria we used to assess the adequacy of each investigation we reviewed during the course of this special review.

Similarly, the portions of the report that discuss the performance of the department's IPRCs are based solely on departmental policies and training on the role and responsibilities of IPRCs. We did not reference or apply criteria specific to IERCs in the report.

Respectfully,

Amarik K. Singh
Inspector General

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Special Review of the California Department of Corrections and Rehabilitation's Response to Incarcerated-Person-on-Incarcerated-Person Allegations Under the Prison Rape Elimination Act

OFFICE *of the* INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2025

OIG