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From Compliance to Prevention:

Understanding and Strengthening Responses to Reports of Sexual Misconduct in California State Men's Prisons

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AMEND AT UCSF

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AMEND

Amend at the University of California San Francisco School of Medicine ("Amend") draws on public health, medical ethics, occupational health, and international correctional practices to inspire transformative change in carceral environments to reduce harm and promote the health and humanity of prison staff and people who are incarcerated.

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EXECUTIVE SUMMARY

More than two decades after the passage of the Prison Rape Elimination Act (PREA), sexual misconduct in carceral settings remains a threat to the health and safety of both incarcerated people and correctional staff. While PREA established important national standards for prevention, reporting, and accountability, compliance alone has not eliminated sexual victimization in correctional settings.

As one of the largest state prison systems in the United States, the California Department of Corrections and Rehabilitation (CDCR) provides an important opportunity to better understand the institutional conditions that contribute to sexual misconduct and identify strategies that move beyond compliance toward prevention.

This report is focused on examining sexual misconduct in California's men's prisons. We recognize that men's and women's prisons differ in their populations, institutional environments, and operational contexts. These differences may shape the nature, prevalence, and response to sexual misconduct, making separate assessment important. For these reasons, although some findings herein may have broader relevance across CDCR, women's prisons warrant a dedicated analysis using methods and measures tailored to their specific context.

Drawing on publicly available data, policy and oversight reports, and interviews with subject matter experts, this report evaluates what is currently known about sexual misconduct within CDCR, with a focus on men's prisons, and identifies key factors that influence prevention, reporting, investigations, accountability, and sexual safety.

We find that important gaps in data and transparency limit the ability to understand the true scope of sexual misconduct or evaluate the effectiveness of current policies. We also identify barriers to reporting, evidence of constraints within investigative systems, limitations in existing oversight and PREA auditing processes, and broader institutional conditions, including staffing, housing practices, supervision, and access to basic needs, that may influence the risk of sexual misconduct.

Based on these findings, we recommend a series of reforms aimed at strengthening prevention, improving reporting and investigations, increasing transparency and accountability, and supporting ongoing evaluation and learning. These recommendations are intended to inform future research, policy development, and advocacy efforts. They should also serve as a starting point for continued engagement with CDCR leadership, policymakers, people with lived experience, advocates, and other stakeholders to refine priorities and identify practical pathways for implementation.

INTRODUCTION

Background

Sexual misconduct in correctional settings inflicts immediate and long-term harm on victims and poses a significant threat to the health and safety of both incarcerated people and prison staff. Public awareness of the scope of this problem increased substantially following Human Rights Watch's 2001 report, *No Escape: Male Rape in US Prisons*, which documented widespread sexual abuse in correctional facilities across the United States based on accounts from more than 200 incarcerated men in 37 states.[1] Alongside sustained advocacy from formerly incarcerated people and their loved ones, the report helped catalyze passage of the Prison Rape Elimination Act (PREA) in 2003. Recognizing that an estimated 13% of incarcerated people in the United States experienced sexual victimization while in custody, Congress established PREA to address the incidence and consequences of sexual abuse in correctional settings and to develop a national framework for prevention, detection, and response.[2]

Since its enactment, PREA has led to important reforms in correctional policy, auditing, reporting, data collection, and investigative practices. The law established a zero-tolerance approach to sexual misconduct, required national standards for correctional facilities, and affirmed that deliberate indifference to a substantial risk of sexual victimization may violate constitutional protections under the Eighth and Fourteenth Amendments.

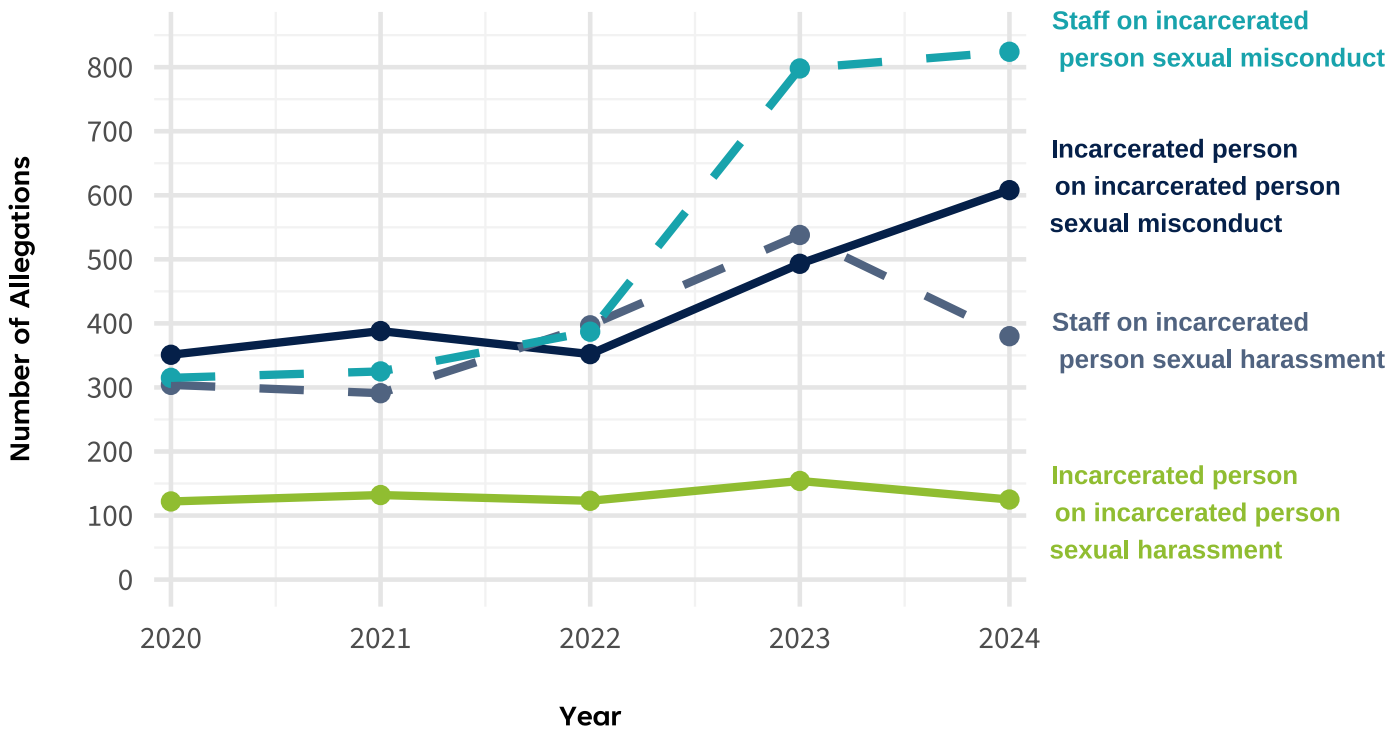
However, sexual misconduct in US correctional facilities persists, and estimates show that rates of experiencing sexual victimization while in custody haven't changed much (and in some cases have increased) in over two decades.[3]

This persistence reflects both ongoing gaps in compliance with PREA standards, and the limits of an approach that primarily focuses on reporting and response, rather than prevention. The risk of sexual misconduct in prisons is shaped by a broad set of factors, including institutional and staff culture, leadership practices, physical environments, interpersonal dynamics, and daily operational routines; many of which fall outside the scope of audits to ensure PREA compliance.

[S]exual misconduct in US correctional facilities persists... [which] reflects both ongoing gaps in compliance with PREA standards, and the limits of an approach that primarily focuses on reporting and response, rather than prevention.

Within the California Department of Corrections and Rehabilitation (CDCR), California's state prison system, reports of sexual abuse and harassment have increased steadily in recent years (**Figure 1**). From just 2022 to 2023, there was a 57% increase in all PREA allegations, and the number of staff-on-incarcerated person sexual misconduct allegations more than doubled.[4] While CDCR leadership points to lawsuits, changed reporting systems, and increased education as contributing factors,[4] limited data are available to explain these trends or to identify the true underlying drivers and contexts of sexual misconduct and increased PREA allegations within CDCR facilities. This lack of visibility constrains the ability of policy makers and the public to assess risk and to design or advocate for effective, evidence-based prevention strategies.

Figure 1. Allegations of most types of sexual misconduct within CDCR have increased substantially from 2020 to 2024.



***Note**: Incarcerated person-on-incarcerated person sexual misconduct combines the reported categories of incarcerated person-on-incarcerated person nonconsensual sex act and incarcerated person-on-incarcerated person abusive sexual contact. This is done to make the data more comparable to staff-on-incarcerated person data.*

Scope and Goals of this Report

This report was commissioned by the Criminal Law & Justice Center at University of California, Berkeley, to examine the extent and prevention of sexual misconduct in California's men's prisons. Given that men's and women's prisons differ in their populations, institutional environments, and operational contexts, and these differences may shape the nature, prevalence, and response to sexual misconduct, a dedicated analysis of women's facilities is therefore warranted but falls outside the scope of this report.

Limitations in publicly available and system-level data, particularly the lack of consistent PREA data disaggregated by gender and facility, constrain the ability to effectively isolate patterns specific to men's institutions. As a result, this report draws on publicly available data and reports that are often system-wide, to show what data exist in the public sphere that can be used to drive policy responses. To contextualize these findings and to identify potential policy-relevant solutions to rising PREA allegations, we also conducted interviews with a range of experts including prison leaders, formerly incarcerated people, community-based organizations, and PREA legal experts, as well as experts from systems outside CDCR. While not all of our findings are exclusive to California's men's prisons, this report highlights policies, practices, and cultural dynamics that are critical to understanding and preventing sexual misconduct across CDCR, including within men's facilities.

There have been limited systematic analyses of the structural and cultural factors that influence the prevention, reporting, investigation, and resolution of sexual misconduct allegations within CDCR's men's prisons. This report helps address that gap by examining how allegations are reported, investigated, and resolved in California state prisons, drawing on publicly available administrative data, system reports, and interviews conducted with practitioners and subject matter experts.



A critical next step is to share these findings and recommendations with CDCR leadership and California policy makers to collaboratively identify targeted policy and practice reforms. Ultimately, the findings and recommendations presented here are intended to guide conversation, inform policy decisions and operational improvements, and support future research aimed at strengthening sexual misconduct prevention and response in CDCR's men's prisons. While the findings and recommendations may often be relevant to all CDCR institutions including women's prisons, we recommend additional investigation and adaptation of the recommendations in this report, to address the specific dynamics of sexual misconduct in women's prisons.

Terminology

This report uses *sexual misconduct* as an umbrella term encompassing sexual abuse, sexual violence, sexual harassment, and other conduct prohibited under PREA and CDCR policy, including acts perpetrated by both staff and incarcerated people. It encompasses unwanted sexual acts, coercion, and verbal or nonverbal behaviors of a sexual nature that violate institutional rules or compromise the safety and dignity of incarcerated people.* This report then uses the term *sexual victimization* to refer to the experience of being a victim of sexual misconduct.

*These categories as mandated by PREA and recorded by CDCR are categorized as: 1) Incarcerated person–on–incarcerated person: Abusive sexual contact - non-consensual or coerced touching of intimate body parts; Nonconsensual sex acts - non-consensual penetration or oral contact; Sexual harassment - Repeated verbal comments, gestures, or unwanted advances of a sexual nature and 2) Staff-on-incarcerated person: Sexual misconduct - threatened, coerced, attempted, or completed sexual contact, assault or battery; Sexual harassment: Repeated verbal comments or gestures of a sexual nature.

METHODS

Publicly Available Data Sources

This report assesses and describes the publicly available data sources that can be used to better understand sexual misconduct in CDCR. It also examines the scope and limitations of these sources. The types of data reviewed include administrative data, self-reported survey data, oversight and audit data, and legal and legislative materials. Additional details on the data sources described in this report can be found in the **Data Landscape** section.

Expert Interviews

We conducted semi-structured interviews with national and international subject matter experts to provide context and additional insight into findings derived from publicly available data and the literature. Participants were identified through professional networks and targeted outreach based on publicly available information about their expertise. The interview protocol was reviewed by the UCSF Institutional Review Board and approved as exempt research (#25-45312). Interviews were conducted via Zoom, and all interviewee information was de-identified to reduce the risk of identifying individual participants.

The 12 interviewees included service providers and advocates (n = 4), researchers (n = 2), legal support providers (n = 2), and corrections professionals (n = 4). Their expertise covered the following areas:

- PREA standards, implementation, and compliance in California and nationally (n = 7)
- Best practices for preventing sexual misconduct in prisons, nationally, and internationally (n = 6)
- Housing, safety, and support for transgender incarcerated people in California (n = 3)
- Direct service provision to currently or formerly incarcerated people in California (n = 3)
- Training and work with prison staff nationally, and internationally (n = 5)

Analysis and Limitations

We generated findings by triangulation and iterative analysis of publicly available data, reports, and interviews to identify recurring patterns, with a focus on how reporting, investigation, and institutional response systems function in practice, as well as the institutional and cultural factors shaping outcomes. New insights emerging from the integration of publicly available data, interview data, and published literature are described in the **Findings** section.

Due to the scope of this project, timeline, and required approvals, we were unable to interview current CDCR employees or people currently incarcerated in CDCR. Their perspectives will be critical for future work building on the findings from this report.

DATA LANDSCAPE

Multiple publicly available data sources provide partial insight into sexual misconduct in correctional settings, but no single source captures the full scope of incidence, institutional response, or accountability. The sources below reflect distinct scopes and perspective, including self-reported experiences, administrative records, oversight reviews, and legal findings, each with specific strengths and limitations. Collectively, **they provide an incomplete and sometimes inconsistent picture of sexual misconduct** within the California Department of Corrections and Rehabilitation (CDCR) and the broader US correctional system.

Data Sources

ADMINISTRATIVE DATA*

SOURCE	CONTENTS	KEY LIMITATIONS
PREA Reports Time period: Annual *Published by California Department of Corrections and Rehabilitation (CDCR)*	Administrative reports summarizing aggregate PREA allegations by report type and case outcomes (system-wide only), and both institution level and system-wide compliance and prevention activities. Collection and reporting mandated by PREA.	• Only includes formally reported incidents. • Limited to aggregate counts. No facility-level, sub-population level, or case-level detail. • Publication delay of 1+ years after data reporting year.
Public Records Act (PRA) Requests Time period: Irregular *Data is shared by California Department of Corrections and Rehabilitation (CDCR) to members of the public who make a request but is not published in a publicly accessible location.*	Quantitative data about PREA allegations and investigations, with details and data aggregation level dependent on the request.	• PRA requests may be unfulfilled by CDCR or face significant delays in being fulfilled. • Data may not be available with the detail requested. • The additional information needed to understand how the data are counted and summarized may not be provided. • Data is not published in public location or made available proactively to multiple groups.

*CDCR has made multiple changes to what data is reported publicly, and how, during the period of writing this report. The table does not include data systems, that to our best knowledge, are no longer used as of May 1st, 2026.

SOURCE	CONTENTS	KEY LIMITATIONS
Survey of Sexual Victimization (SSV) Time period: Conducted annually, public reporting is less frequent and irregular. *Published by the Bureau of Justice Statistics (BJS)*	Administrative survey collecting standardized, agency-reported data on allegations of sexual misconduct and case outcomes across correctional systems nationwide. Collection and reporting mandated by PREA as a part of BJS's *National Prison Rape Statistics Program*.	• Only includes formally reported incidents. • Limited to aggregate counts. More detailed data on context and specifics is reported at national level and incident counts reported at state level. • Publication delay of 3+ years after data reporting year.

SELF-REPORTED DATA

SOURCE	CONTENTS	KEY LIMITATIONS
National Inmate Survey (NIS) Time period: Irregular and unpredictable (conducted 4 times since 2007). *Published by the Bureau of Justice Statistics (BJS).*	Self-reported experiences of sexual victimization among incarcerated people, collected through anonymous, nationally representative surveys. Collection and reporting mandated by PREA as a part of BJS's *National Prison Rape Statistics Program*.	• Irregular data collection and reporting. • Participating prisons are randomly selected based on past population data and statistical sampling methods, however 8 of the 10 CDCR men's prisons that were selected for inclusion in the sample in the most recent NIS were excluded due to CDCR "concerns around burden".[5] * • Publication delay of 2+ years after survey data collection.

OVERSIGHT AND AUDIT DATA

SOURCE	CONTENTS	KEY LIMITATIONS
Oversight Reports Time period: Irregular *Published by the California Office of the Inspector General (OIG).*	Oversight reports assessing compliance with policies and procedures related to complaint intake, investigation, and staff misconduct processes within CDCR. Not necessarily limited to PREA complaints.	• Based on sampled cases or defined review scopes; not representative of system-wide performance. • Analyses specific to sexual misconduct and PREA are limited in scope.

*See page 13 of the cited report, titled *Sexual Victimization in Prisons Reported by Inmates, 2023–24*.

SOURCE	CONTENTS	KEY LIMITATIONS
PREA Audit Reports Time period: Every 3 years for each facility. *Written by independent auditors and published by CDCR.*	Independent audit reports evaluating facility-level compliance with PREA standards through review of policies, procedures, and selected practices.	• Based on periodic, time-limited assessments. • Rely heavily on pre-existing documentation generated by the prison being audited and structured compliance processes. • Reflect conditions at the time of the audit and may not capture routine operations or lived experience over time.

LEGAL DATA

SOURCE	CONTENTS	KEY LIMITATIONS
Lawsuit Records Time period: Cases are submitted and generate documents as they progress through the court system, typically with some delay in document upload. *Documented as part of court proceedings and published in legal databases.*	Legal records addressing claims of sexual misconduct in custody and interpretations of institutional responsibility and constitutional violations.	• Represent a small, non-representative subset of cases that initiate and proceed through litigation. • Shaped by legal standards, evidentiary thresholds, and procedural constraints rather than underlying incidence.
Legislative Records Time period: As bills/legislation are proposed, and progress through voting and approval stages. *Documented as part of the state legislative process.*	Records of proposed and enacted legislative changes.	• Generally, is informative about current politics and important policy change areas, but not actual data behind these issues.

We note important differences in measurement noted across these sources. Self-reported data (e.g., NIS) capture experiences that may never be formally reported, while administrative data (e.g., CDCR reports, SSV) reflect only allegations known to (and investigated by) institutions. Across all administrative sources, oversight and audit sources focus on compliance and procedural processes rather than incidence. As a result, differences across sources are expected and reflect distinct measurement approaches rather than direct inconsistencies. However, these differences can highlight a reporting gap between lived experience and formally recorded incidents.*

Overall trends in sexual victimization in correctional facilities can be seen through various data sources, despite their limitations. The SSV shows that in 2020 across the US, about 6% of PREA allegations were substantiated compared to 11% seven years prior.[6] The NIS from 2023-2024 shows that about 4% of incarcerated people in the US reported being sexually victimized in the past year, and that male and female incarcerated people report similar rates of sexual victimization by facility staff.[5] In California specifically, CDCR's annual PREA reports and special reports from the Office of the Inspector General (OIG) show that rates of sexual misconduct allegations have been on the rise in recent years and that there is still substantial mishandling of sexual misconduct reporting and investigations.[7–11]

Critical Gaps in Available Data

Critical gaps in publicly available data limit the ability to assess risk, evaluate institutional response, and identify effective strategies to prevent sexual misconduct in CDCR. While aggregate counts of allegations and basic compliance indicators are available, they provide limited insight into how risk, reporting, and outcomes vary across institutions, populations, and over time.

> **...It is not possible to assess how cases move through the system, where delays occur, or whether investigations are conducted consistently and with sufficient quality.**

One major limitation of the publicly available data is the lack of institution-level and population-specific data. Public reporting does not include allegation rates, investigative outcomes, or patterns at the individual institution level, making it difficult to identify high-risk facilities or assess variation across settings. Data are also not consistently disaggregated by gender, housing type, or demographic characteristics, including transgender and gender-diverse populations, limiting the ability to understand differential risk.

There are also significant gaps in visibility into investigative processes and case progression. Public data do not show how allegations are routed or classified, nor do they provide detail on investigative timelines or practices. Despite careful review of publicly available information and CDCR's operation's manual, we are still left without definitive answers or a clear process diagram (see **Appendix Figure A-1**). For example, available data do not indicate how long cases remain unassigned or under investigation, or what steps, such as interviews or forensic evidence collection, are conducted. As a result, it is not possible to assess how cases move through the system, where

*See Finding 2: Barriers to reporting may result in underreporting and limit the extent to which PREA data reflect the true incidence of sexual victimization for further discussion.

delays occur, or whether investigations are conducted consistently and with sufficient quality. Oversight data offer limited insight but are typically based on sampled cases rather than comprehensive system-wide analysis, and aggregate patterns suggest these gaps may affect investigative performance.*

These limitations also constrain the use of publicly available data to design prevention efforts. Although PREA standards require agencies to review incident data and take corrective action, publicly available information in California does not clearly indicate whether or how such analyses inform policy or operations. As a result, data collection may function more as a tool for compliance than for prevention.

Overall, these gaps limit the ability to interpret trends, evaluate system performance, design data-informed policy solutions, and assess the impact of policy decisions.

*See Finding 4: The investigative system shows evidence of capacity constraints in handling the volume of PREA complaints for examples of the data that support this pattern.



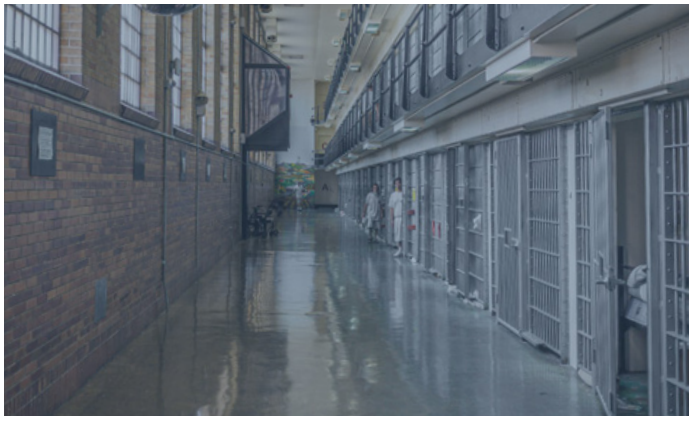
FINDINGS

The findings that follow provide context for the data limitations and oversight deficiencies identified in the preceding sections. Drawing on expert interviews, policy analysis, reports, research, and case-based evidence, they identify conditions and dynamics that may influence risk, reporting, investigations, and case outcomes within CDCR and affect sexual safety.

1. EFFECTIVE POLICY RESPONSES REQUIRE IMPROVED AND TIMELY DATA

Importance

Without timely, reliable, and disaggregated data, California policymakers cannot determine whether existing or proposed policies are reducing sexual victimization and/or inadvertently creating new risks. This leaves policymakers relying on anecdote, litigation, and political pressure rather than objective evidence when making decisions about housing, classification, oversight, and resource allocation that could impact sexual safety in prison.

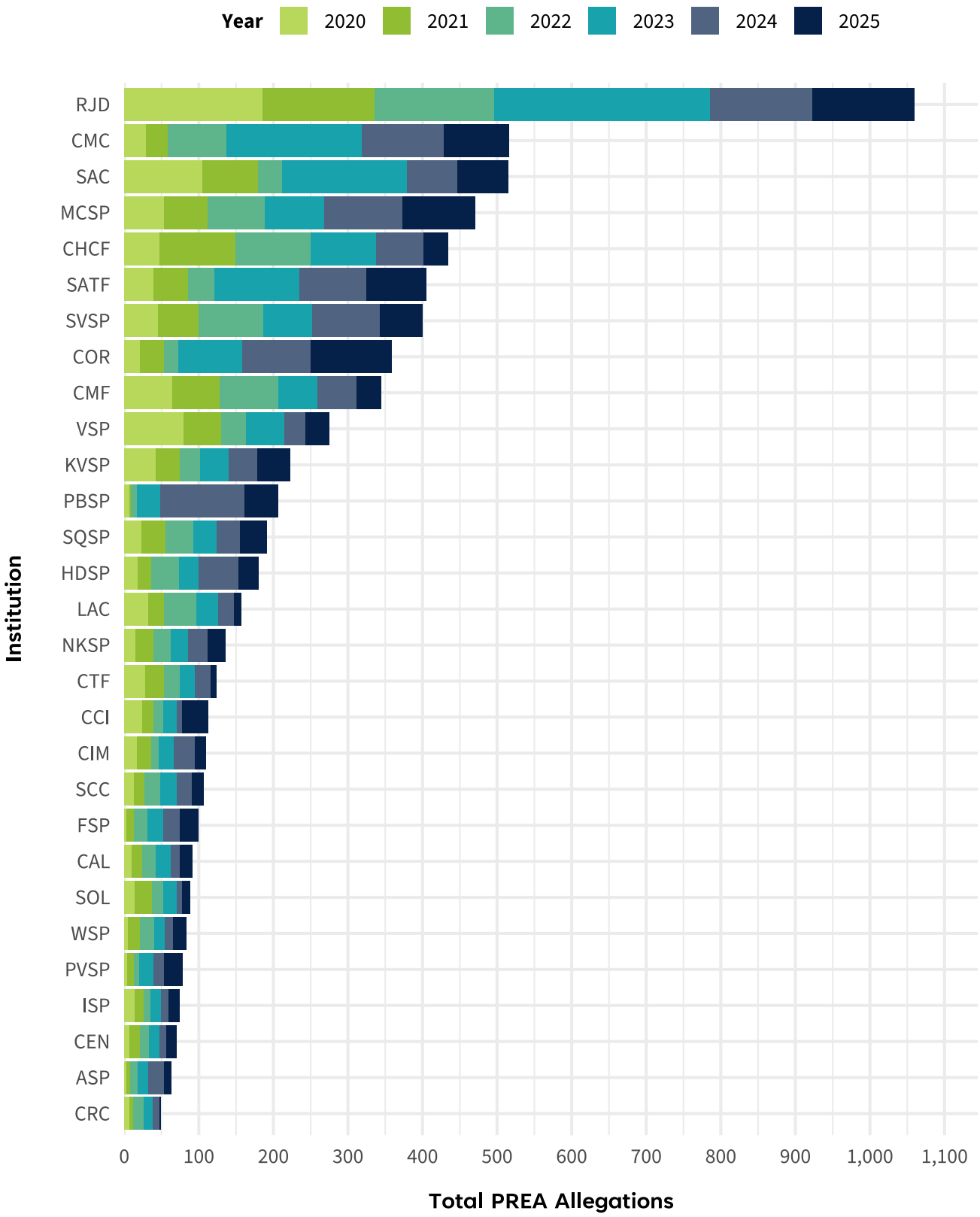


Policy debates over the housing and classification of transgender people in California prisons underscore the consequences of limited data availability. SB 132 (2020) [12] established a framework for individualized housing decisions based on gender identity and safety considerations, consistent with PREA standards. More recent proposals, such as proposed SB 311 (2025) [13], sought to mandate segregated housing for transgender women, partly in response to a backlash against SB 132 and anecdotal reports alleging that such placements create safety concerns for other incarcerated (cis-gender) women. Although SB 132 was enacted and SB 311 was ultimately rejected following significant legal and policy opposition, these debates highlight the importance of grounding correctional policy in rigorous evidence rather than isolated narratives.

Personal stories and anecdotal accounts can be highly influential and emotionally compelling. However, when used to shape public policy, they should be systematically collected and analyzed using rigorous qualitative research methods. Combining scientifically grounded qualitative inquiry with robust data analysis is essential to informing evidence-based policy discussions in California and nationally. Data that the Criminal Law & Justice Center at UC Berkeley recently obtained from CDCR through a Public Records Act request show just how important more robust and detailed quantitative data can be. These data show that from 2020 through 2025, the total number of allegations of sexual misconduct varied dramatically across different men's institutions (**Figure 2**). These differences indicate that site-specific data and analysis are needed to develop policies that address the different contexts, cultures, and needs across various CDCR institutions.

Policies developed in the absence of strong empirical evidence may also undermine the long-term stability and defensibility of legislation once enacted, particularly in the face of political and legal challenges. For example, the US Department of Justice recently announced an investigation into

Figure 2. Total PREA allegations (across all categories) in CDCR men's prisons, by institution, from 2020 through 2025.



Note: *Institutions that have closed within the time period shown (2025-2025) were removed. Data were provided from an initial Public Records Act request and may be subject to updates as more information becomes available through these requests.*

whether California's policies regarding housing of transgender women violate the constitutional rights of other people incarcerated in women's prisons.[14]

Several recent proposals addressing housing configurations, including AB 1140 (single-occupancy cell pilot), [15] SB 850 (Women's Prison Reform Act), [16] and broader budget decisions affecting facility capacity,[17] have also been framed in part as strategies to reduce sexual victimization. Publicly available data documenting where sexual victimization occurs would help policymakers.

At the same time, several pending and enacted measures in California, including AB 464 (retaliation monitoring),[18] SB 337 (PREA policy codification),[19] and SB 1069 (expanded oversight authority for the OIG), [20] aim to strengthen reporting mechanisms, oversight, and accountability. The effectiveness of these policies will depend on the availability of robust data systems capable of capturing, tracking, and analyzing incidents over time, and the effective ability to share results with policy makers and the public to inform rationale policy making. Without such infrastructure, it remains difficult to evaluate whether these proposed protections will reduce victimization, identify patterns across facilities or populations, or detect unintended consequences of policy changes.

Summary

In the absence of high-quality data, policy interventions intended to improve safety may produce unintended harms, resources may be allocated inefficiently, and policy debates may become increasingly driven by anecdote and political framing rather than evidence. Strengthening data collection, transparency, and independent analysis is therefore essential to ensure that California's efforts to prevent sexual violence in prisons are both effective and responsive to the needs of individuals at greatest risk.

Strengthening data collection, transparency, and independent analysis is therefore essential to ensure that California's efforts to prevent sexual violence in prison are both effective and responsive to the needs of individuals at greatest risk.

2. BARRIERS TO REPORTING MAY RESULT IN UNDERREPORTING AND LIMIT THE EXTENT TO WHICH PREA DATA REFLECT THE TRUE INCIDENCE OF SEXUAL VICTIMIZATION

Importance

If people do not report sexual misconduct because they fear retaliation, distrust staff, or doubt the confidentiality and effectiveness of reporting channels, PREA data will systematically understate the true scope of harm. As a result, decision-makers may interpret low reporting rates as low incidence, when they may instead reflect low trust in the system. Underreporting also limits the state's ability to identify high-risk environments, institute and evaluate prevention efforts, and respond to victims in a timely and effective manner.

Findings

Barriers to reporting sexual misconduct in prisons are systemic and multifaceted, shaped by both institutional practices and broader cultural dynamics.

Distrust of staff and reporting mechanisms is a central barrier. Incarcerated people are less likely to report sexual misconduct when they do not trust that staff will handle reports safely, confidentially, and without retaliation.[21–23] Interviewees emphasized the difficulty of relying on correctional staff for protection: "If you're assaulted… then you have to go to the people who are incarcerating you for help…and that dynamic is a difficult one for most people." Concerns are particularly acute when staff are the alleged perpetrators: "Maybe it was a staff member that assaulted me…I'm not going to use any of those reporting mechanisms." A documented history of inconsistent protection and accountability may further erode trust, making reporting less likely.

Fear of retaliation and adverse consequences further discourages reporting. People incarcerated in US prisons who report sexual victimization may face placement in restrictive housing, transfers, or loss of access to programs, employment, or personal property, as well as retaliation from staff or other incarcerated people.[21,24–26] In California, protective responses to reports of sexual misconduct may involve separation or movement that disrupts housing, programming, and daily life. Interviewees described these outcomes as destabilizing: "Anytime someone has made a report, they get thrown in protective custody… lose their housing placement, programming, job, property… why would I come forward and risk that?" Another interviewee noted, "There's no incentive to report… you're put in segregation, you're moved, and being moved can be even more awful." Oversight findings indicate that delays and incomplete investigations may prolong these disruptions, further intensifying the perceived risks of reporting.[27,28]

Stigma, shame, and gender norms also limit reporting. Men in the US, including in correctional facilities, may fear not being believed, being labeled, or being perceived as weak if they report sexual victimization.[29] Our interview data reflect these dynamics: "If a man was raped in the prison, they're not going to come say, I was raped yesterday…you will be banned…by your own culture." Interviewees also described how sexual violence against LGBTQ people is shaped by stigma, hostility, and gender norms, as well as the broader dehumanizing effects of incarceration. One interviewee noted that incarcerated people may internalize shame in ways that discourage reporting: "The impact of incarceration is dehumanization… that makes it less likely for them to report harm."

> **…[R]eporting may be experienced not as a pathway to protection and prevention, but as a process that introduces additional risk and instability.**

Lack of confidentiality further undermines reporting. Where reporting mechanisms are not private, people may fear exposure or retaliation. Interviewees described limitations such as shared phone access and monitored calls: "The phones are all together… that's not very confidential" and "Phone calls to victim advocates [are] monitored or recorded… and they shouldn't have that for reports." Concerns about whether staff will protect sensitive information compound these barriers. Some interviewees described how important new confidentiality measures were, such as the ability to submit a PREA report from prison through a tablet.

Finally, limited confidence in investigations and accountability reduces the likelihood of reporting.

Incarcerated people may choose not to report when they believe it will not lead to meaningful action.[23,24] Oversight findings from the OIG document delays, incomplete evidence collection, and weak investigative practices that limit substantiation and discipline.[27,30] Even when misconduct is substantiated, consequences may be reduced, delayed, or resolved through settlement.[31,32] Interviewees who were formerly incarcerated in California prisons described a lack of communication and follow-through with people who have submitted PREA complaints: "It becomes radio silence… so then people think they're not actually doing anything."

Summary

Barriers to reporting sexual misconduct are systemic and reinforcing. Distrust, fear of retaliation, stigma, lack of confidentiality, and limited confidence in investigation and accountability all contribute to underreporting. As a result, reporting may be experienced not as a pathway to protection and prevention, but as a process that introduces additional risk and instability. These dynamics undermine the effectiveness of reporting systems and limit the ability of CDCR to accurately identify, respond to, and prevent sexual victimization.

3. PREA REPORTING MECHANISMS MAY BE USED TO ADDRESS IMPORTANT UNMET NEEDS BEYOND SEXUAL SAFETY

Importance

Despite barriers to reporting, people sometimes use PREA mechanisms to obtain separation, protection, or relief from unsafe conditions that are not related to sexual misconduct. This blurs the line between reporting sexual violence and addressing broader safety needs, contributing to staff skepticism of the PREA reporting process and undermining the credibility of true sexual misconduct allegations. In turn, this dynamic may discourage reporting and weaken PREA's effectiveness as an accountability tool.

Findings

Interviewees reported that incarcerated people sometimes use PREA reporting mechanisms for reasons beyond sexual misconduct, most often to address immediate safety concerns, particularly the need to be separated from another person where no other mechanism to ensure one's safety exists. As one interviewee explained, PREA reporting may be used "when you have no other solution to absolutely separate yourself from somebody else, or to get reprieve." In this context, PREA is often perceived as the most effective, or only, available option: "I'm unsafe on this yard… the only way to get off of this yard is to file a PREA."

While staff may interpret this as misuse or "weaponization" of PREA, interview data suggest it reflects structural limitations in how safety concerns are addressed in CDCR. When alternative mechanisms for protection or housing changes are limited, PREA reporting becomes a default pathway to address broader safety needs. As one respondent noted, "PREA is used for housing… PREA is used for classification."

These dynamics can create a reinforcing cycle. Perceived misuse increases staff skepticism toward PREA allegations, which in turn undermines trust in the system and discourages reporting. This skepticism may be reinforced by PREA response processes that trigger rapid protective actions, such as housing changes, regardless of whether allegations are substantiated. As a result, what is

often labeled as “misuse” may instead reflect reliance on limited mechanisms to address serious unmet safety or basic needs.

Summary

PREA reporting mechanisms are sometimes used to address broader safety and protection needs in the absence of effective alternatives. While often perceived as misuse, these patterns reflect structural gaps in how safety concerns are managed within CDCR. At the same time, perceptions of misuse can shape staff responses, contribute to skepticism, and discourage reporting, including for incidents that are truly sexual misconduct.

4. THE INVESTIGATIVE SYSTEM SHOWS EVIDENCE OF CAPACITY CONSTRAINTS IN HANDLING THE VOLUME OF PREA COMPLAINTS

Importance

If allegations are not investigated promptly and thoroughly, victims may face prolonged uncertainty while evidence is lost and witnesses become harder to reach. Capacity constraints can reduce the quality of investigations, lower substantiation rates, and weaken confidence that reporting will lead to meaningful action. Over time, these delays can also distort the data used to assess the scope and nature of sexual misconduct in CDCR facilities.

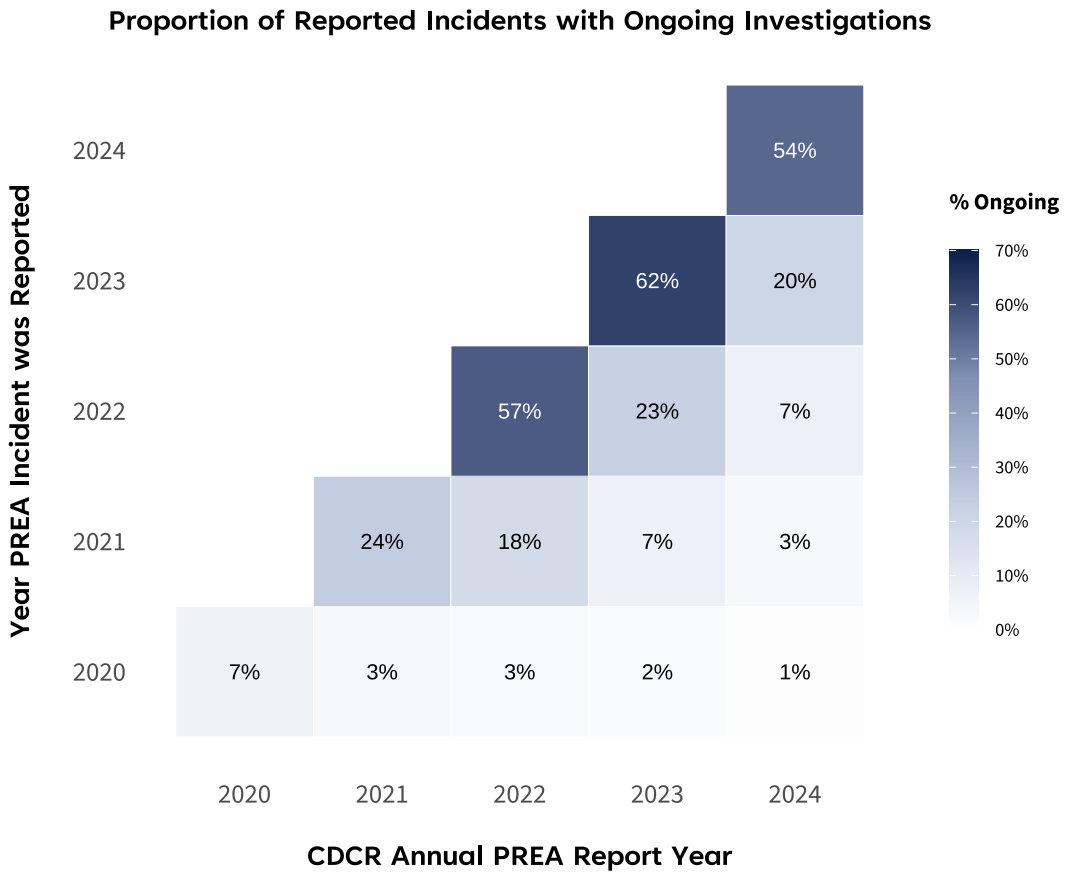
Findings

Reported PREA allegations in CDCR have increased in recent years, while indicators of the system’s ability to process and investigate cases suggest it is not keeping pace with this growth. As the number of allegations has increased, the proportion of cases remaining ongoing has also grown, and time to case resolution has lengthened (see **Figure 3**). These patterns suggest that investigative resources are not keeping pace with the volume of allegations and that more personnel resources are required.

Similarly, the OIG has documented substantial delays in conducting, or failure to conduct, important investigative steps including interviews with victims, suspects, and witnesses.[10] An OIG special review of 288 incarcerated person-on-incarcerated person PREA allegations made between March 1 and August 31, 2024 found that investigators failed to perform one or more required investigative procedures in 91% (67/74) of cases. These included failures to conduct interviews, to collect physical or documentary evidence, to consider all available evidence in making case determinations, and to prepare accurate reports. These failures and delays indicate that cases are not being processed in a timely manner and suggest constraints in investigative capacity or knowledge of the process.

Our interview data corroborated these concerns, with reports that people who submit PREA allegations in CDCR prisons may “never be interviewed… or [people who are] accused of a PREA never get interviewed about their accusation” indicating failures to carry out basic investigative steps. Interviewees also described gaps in forensic evidence collection, including limited access to medical examinations following reported assaults. One interviewee noted that “[In California] I don’t think people are going out for forensic exams… I’ve only spoken with one survivor… that got to go out for a forensic medical exam… I just don’t think it’s happening.” Another interviewee reported known cases of rape in which victims were not taken out for medical exams until days after the incident. These accounts indicate that critical evidence may not be collected consistently and, when it is collected, may be significantly delayed.

Figure 3. Time to resolution for PREA incident investigations are increasing steadily over time.



Note: *The PREA Annual Report Year indicates the year the report is focused on, but they are typically published mid-year the following year.*

Summary

These findings suggest that the investigative system is not consistently able to process the volume of PREA allegations in a timely or complete manner. Increasing numbers of allegations, longer case resolution times, delayed investigative actions, and gaps in evidence collection point to capacity constraints (and possibly knowledge deficits among staff about the reporting process) that may affect both the quality and outcomes of investigations. These limitations may contribute to lower substantiation rates and weaken confidence in the system's ability to respond effectively to reports of sexual misconduct.

5. THE INVESTIGATIVE RESPONSE TO STAFF SEXUAL MISCONDUCT LACKS ADEQUATE INDEPENDENCE

Importance

When the same institution responsible for staff conduct also controls aspects of screening, routing, and investigation decisions, there is a greater risk that allegations will be minimized, misclassified, or diverted away from independent review. Even the perception of internal bias can undermine trust in the complaint process and discourage reporting. Independence is therefore essential not only for accountability, but also for ensuring that serious allegations are evaluated consistently and credibly.

Findings

Screening and classification processes serve as the primary entry points through which complaints are identified as potential staff misconduct and referred for investigation. These early decisions shape whether cases are investigated, what evidence is collected, and whether misconduct can ultimately be substantiated.

Oversight findings from the California OIG indicate that PREA complaint screening does not function as a neutral intake process in CDCR. Instead, it operates as a gatekeeping stage in which complaints may be misidentified, incompletely captured, or excluded before an investigation begins.[33] These early determinations affect whether allegations are subject to independent review.

CDCR has implemented multiple reforms to address bias, lack of independence, and inconsistency in the handling of staff misconduct cases. In 2020, the Allegation Inquiry Management Section (AIMS) was established in response to findings that institution-based investigations contributed to biased and inadequate inquiries. However, subsequent OIG oversight found that AIMS did not achieve its intended goals. Screening and routing continued to involve multiple layers of review, with discretionary judgments determining whether complaints were classified as misconduct and advanced for investigation. As a result, some cases were filtered out before reaching independent review, including allegations involving sexual misconduct, retaliation, and excessive force.[7]

In 2022, CDCR further centralized screening by establishing the Centralized Screening Team (CST) within the Office of Internal Affairs (see **Appendix Figure A-1**). CST is responsible for receiving and classifying complaints, determining whether they constitute staff misconduct, including PREA-related allegations, and deciding how cases are routed (e.g., formal investigation, local inquiry, or routine handling).[8,11]

Despite these reforms, OIG oversight findings indicate that misclassification and downgrading of cases persist. In 2024, the OIG identified instances in which allegations of sexual misconduct and other serious misconduct were not properly identified or were routed to local inquiry or routine handling rather than formal investigation.[34,35] The OIG also rated 11 percent of CDCRs screening decisions as poor.[29]

> **...[D]iscretionary decision-making and misclassification persist despite multiple reforms, allowing some complaints to be downgraded, misrouted, or excluded before formal investigation.**

In 2024, Senate Bill 1069 (SB 1069) expanded the OIG's authority to investigate staff sexual misconduct, including initiating investigations where none have been opened and intervening when investigations are inadequate.[36] It is too early yet to assess the impact of these changes.

Summary

Screening and classification processes function as critical mechanisms within the investigative system. Oversight findings by the OIG show that discretionary decision-making and misclassification persist despite multiple reforms, allowing some complaints to be downgraded, misrouted, or

excluded before formal investigation. These dynamics limit the independence of the investigative process and weaken accountability for staff sexual misconduct, even as recent reforms attempt to strengthen oversight.

6. EVIDENCE DEMONSTRATES INACCURACIES AND LIMITATIONS IN FEDERALLY MANDATED PREA AUDITS

Importance

When PREA audits do not consistently capture conditions in practice, compliance findings may overstate institutional safety and obscure persistent gaps. This can weaken accountability and reduce incentives for corrective action. Audits are also limited to identifying practices that meet (or do not meet) formal requirements but fall short of the intent of PREA standards, limiting their effectiveness in reducing harm.

Findings

Findings from interviews, review of PREA audit reports, and examination of oversight materials suggest that federally mandated PREA audits have important structural and practical limitations that may reduce their effectiveness as tools for identifying risk and improving institutional safety.

Interviewees described concerns that audits often rely heavily on documentation, formal policies, and institution-prepared materials rather than routine operational practices or lived experiences within facilities. Several interviewees noted that institutions may temporarily alter practices or conditions during audit periods in ways that do not reflect typical operations. One interviewee described facilities as being able to "put up a front for a couple of days" during the audit process, limiting auditors' ability to assess everyday institutional conditions.

Interviewees also described broader challenges related to the complexity of PREA standards and the audit process itself. The large number of detailed standards and extensive documentation requirements may make audits highly procedural and difficult to implement consistently across institutions. Interviewees suggested that this level of complexity, combined with the limited time available for on-site audits, may contribute to incomplete or inaccurate assessments. Additionally, there are limitations to what auditors can address when institutional practices appear inconsistent with the intent of PREA standards but do not technically violate formal requirements (see **Case Study One**).

Concerns were also raised regarding the degree of independence within the auditing system, particularly where auditors rely extensively on information, documentation, coordination, and access provided by the institutions being audited.

Summary

Federally mandated PREA audits appear to have important limitations as mechanisms for evaluating institutional safety and accountability. Heavy reliance on documentation, limited visibility into routine operations, potential constraints on auditor independence, and emphasis on technical compliance may reduce the ability of audits to identify meaningful gaps in prevention and reporting systems. As a result, audit findings may not fully reflect the lived realities of incarcerated people or the effectiveness of institutional efforts to prevent sexual misconduct.

CASE STUDY ONE

PREA audits typically review the *Inmate Orientation Manual* in CDCR facilities to make sure it contains appropriate information. Many of the PREA audits we reviewed included examples of information that conflicts with the goals of PREA but doesn't result in a failed audit. One such example is the encouragement of incarcerated people to resolve complaints with staff before filing a grievance. At California State Prison – Los Angeles County, the audit report from 2023[37] states that:

The facility's Inmate Orientation Manual encourages inmates to attempt to resolve issues with appropriate staff before filing an appeal…Staff confirmed during interviews that no time limits are imposed for allegations of sexual abuse, and further; that there are no requirements imposed using an informal grievance process prior to making an allegation of sexual abuse.

However, because auditors are told that this informal resolution is not a requirement, facilities that state this are found compliant and no corrective action is required or even recommended in the audit reports. We found the same to be true in our sample of other audit reports reviewed, including the California State Prison – Sacramento 2025 PREA audit report, North Kern State Prison 2025 PREA audit report, and California State Prison – Solano 2023 PREA audit report.[38–40]

7. INDEPENDENT OFFICE OF THE INSPECTOR GENERAL (OIG) OVERSIGHT IN CALIFORNIA HAS BEEN LIMITED IN RELATION TO PREA

Importance

Without robust independent oversight, there is less visibility into how allegations are screened, investigated, and resolved across the system. Limited oversight also makes it harder to identify recurring patterns, evaluate what reforms are needed and whether existing reforms are working, and hold institutions accountable for delayed or incomplete investigations and responses. Expanding oversight is important because it can improve transparency, but its impact depends on the OIG having sufficient access, authority, and information to monitor the full process.

Findings

Evidence indicates that independent oversight of PREA-related processes in California has historically been limited in both scope and authority. While the Office of the Inspector General (OIG) conducts monitoring and review of staff misconduct investigations, its oversight has not consistently extended to all PREA-related allegations or all stages of the process.

Reporting from the OIG between 2020 and 2024 was limited to all complaints of staff misconduct (including sexual misconduct), and not the handling of other PREA allegations.[41–45] This limited scope constrains the ability to assess system-wide patterns of sexual misconduct or evaluate consistency in investigative practices. The OIG's scope was recently expanded, and in August of 2025 the OIG published a Special Review[10] providing detailed evidence of deficiencies in reporting, investigation, and response of incarcerated person-on-incarcerated person sexual misconduct cases. Staff-on-incarcerated person allegations, which constitute the largest category of reported sexual misconduct in CDCR, were not included. As a result, it does not fully capture the broader conditions shaping sexual safety within the system.

Recent legislation has expanded the OIG's role in oversight of sexual misconduct. Senate Bill 1069 (2024)[20] grants the OIG authority to conduct supplemental investigations into allegations of staff sexual misconduct involving incarcerated individuals, including the authority to initiate investigations where none have been opened and to intervene in cases where investigations are inadequate.[36] This expansion reflects a recognition that failures in screening, routing, and investigation may prevent allegations from being fully examined.

While this legislation represents a shift toward more active and independent oversight, the extent to which these expanded authorities address previously identified limitations in oversight, investigation, and accountability remains unclear. Historically limited oversight has constrained transparency into how allegations are handled and limited visibility into system-wide patterns and investigative practices, reducing the system's ability to identify patterns, assess investigative quality, and address factors contributing to sexual victimization and accountability across the system.

Summary



Independent oversight of PREA-related processes in California has historically been limited in both scope and authority, reducing visibility into how allegations are screened, investigated, and resolved across the system. Although the OIG has identified important deficiencies in misconduct screening, investigations, and accountability processes, oversight has not consistently covered all categories of PREA allegations or all stages of institutional response. Recent legislative changes, including expanded authority under SB 1069, represent a significant step toward stronger and more independent oversight. However, it remains too early to determine whether these reforms will meaningfully address longstanding limitations in transparency, investigative quality, and accountability related to sexual misconduct in CDCR facilities.

8. STAFFING LEVEL, SELECTION, TRAINING, AND OVERSIGHT CAN ADVERSELY IMPACT SEXUAL SAFETY IN PRISONS

Importance

Sexual safety depends not only on formal policy, but also on whether staff have the training, supervision, and institutional support needed to identify risks and intervene effectively. Understaffing, inadequate supervision, poor training, and weak accountability can create opportunities for sexual misconduct by both staff and incarcerated people and limit the system's ability to prevent harm.

Findings

Interview data indicate that staffing levels, population size, and supervision practices may

constrain the system's capacity for meaningful oversight and proactive prevention. Low staff-to-incarcerated person ratios, combined with high population levels and overcrowded conditions, reduce staff capacity to monitor interactions, respond to emerging risks, and intervene before situations escalate. As one interviewee explained, "You have too many people there… too few staff… and you've not allocated your resources in the places that are most likely to lead to diminution of sexual assault…".

Facility design and physical infrastructure may further limit oversight. Features such as inadequate camera coverage, poorly maintained or underutilized spaces, double-celling in spaces designed for one person, and areas with limited visibility can create environments where misconduct occurs undetected. One interviewee described incidents occurring "in places that don't have cameras … an abandoned set of buildings… nobody there, no cameras."

Institutional practices may also reduce accountability. Interviewees reported that staffing patterns, such as fixed posts or long-term assignment to the same role, can create conditions in which staff become less subject to oversight. As one respondent noted, "… people bid on their position. They become very comfortable in those positions …and everybody covers for everybody." These practices may limit rotation, reduce supervision, and create opportunities for misconduct to occur without detection.

> **"...you should never let a staff member work alone... [preventing this] would probably kill 90% of [staff-on-resident sexual assault]."**

Staff isolation may also increase risk in settings where staff work alone or in positions with limited supervision. Interviewees highlighted situations where staff end up working along with incarcerated people, and that this increases risk. According to one interviewee, "there are posts… where you do work alone… you should never let a staff member work alone… [preventing this] would probably kill 90% of [staff on resident sexual assault]".

Federal PREA standards require facilities to maintain staffing plans that ensure adequate supervision and monitoring, considering factors such as facility design, population characteristics, and areas where individuals may be isolated. However, interview data suggest that current staffing levels, infrastructure constraints, and supervision practices may limit the system's ability to meet these expectations in practice.

Summary

Overall, our findings indicate that staffing levels, overcrowded and isolated facility conditions, and supervision practices may constrain the system's ability to provide consistent oversight and implement effective prevention strategies. These limitations reflect broader resource allocation and operational decisions that may not prioritize sexual safety, reducing the system's capacity to meet PREA supervision standards and prevent misconduct.

9. HOUSING AND CLASSIFICATION DECISIONS PLAY A CENTRAL ROLE IN SEXUAL SAFETY, BUT LIMITED DATA CONSTRAIN UNDERSTANDING OF HOW TO USE THEM EFFECTIVELY

Importance

Housing and classification can be powerful tools for reducing exposure to sexual misconduct, but they can only be effective when implemented consistently and informed by reliable data. Without clear evidence on who benefits, how risks shift, and how outcomes vary across facilities and populations, California cannot determine whether these decisions about housing and classification are improving safety.

Findings

Housing contexts and classification processes play a central role in shaping exposure to sexual victimization, with risks varying across institutional settings and populations. Interview data indicate that patterns of sexual misconduct differ by institution type. In men's institutions, transgender women are described as facing elevated risk of sexual victimization from other incarcerated people, including assault and ongoing harassment. In contrast, women's facilities are more frequently described as settings in which staff are the primary perpetrators of sexual misconduct.

Effective classification depends on trust, which shapes the accuracy of risk assessment. When people do not trust intake or classification staff, they may withhold critical information about prior victimization or safety concerns. One interviewee observed that, "the intake staff said very few women tell us that they've ever been sexually assaulted" while "mental health… shared with me, like 90% of the women have been previously sexually assaulted," emphasizing that "it came down to trust… if they're not gonna trust the people who are collecting that information, we can never actually keep them safe."

Even when risks are identified, implementation of housing policies and placement decisions is not always consistent or well documented. Oversight findings indicate that, under SB 132, placement and bed change requests were not always formally recorded and could be made or denied verbally, limiting transparency and oversight.[46] Additional findings suggest that implementation varies across institutions due to capacity constraints, classification processes, and institutional readiness.[46] Interviewees described incarcerated people in California experiencing delays, lack of communication, and uncertainty in transfer processes, with individuals sometimes remaining in "holding patterns" without clarity on outcomes.

CASE STUDY TWO

Case-based evidence further demonstrates that housing decisions are directly linked to sexual victimization risk. Across multiple lawsuits documents reviewed, plaintiffs reported safety concerns, requested housing changes, and were denied or not meaningfully accommodated, with sexual assault occurring subsequently.*

These cases indicate that safety concerns do not consistently result in housing changes, despite requirements for individualized, safety-informed placement decisions. Because there is no constitutional right to a specific housing placement, failures to meet these standards may occur without legal consequence, limiting accountability for housing decisions that contribute to risk.

*Cases included Israel v. Salinas; Fuller v. Kamara; Johnston v. Diaz; Smith v. Diaz. While these cases did not, or have not yet, led to lawsuit success for the plaintiff, the main facts related to housing and sexual assault are often undisputed.

Housing decisions may also introduce unintended risks when underlying cultural and institutional dynamics are not addressed. Interview data describe instances in which transgender women transferred to new facilities faced hostility, bias, and targeted violence, suggesting that placement decisions alone may not ensure safety without adequate preparation and support.

More broadly, classification and housing processes do not always function as reliable mechanisms for addressing safety concerns. Interview data suggest that people may rely on alternative pathways, including PREA reporting, to obtain housing changes when classification systems are perceived as ineffective or inaccessible.

A key limitation in the use of housing as a prevention strategy is the absence of systematic data needed to evaluate outcomes. Available data do not capture how risk varies across housing types or placement decisions, nor do they track whether expressed safety concerns lead to protective placements or reduce subsequent victimization. Data on housing decisions and outcomes are fragmented and inconsistently documented, limiting the ability to assess effectiveness or identify patterns across the system.

Summary

Housing and classification systems are central to managing risk of sexual victimization, but their effectiveness is limited by inconsistent implementation, lack of trust, and variation across institutions. Without reliable data on how placement decisions affect safety, it is difficult to evaluate whether these strategies reduce or inadvertently increase risk. These limitations constrain the system's ability to use housing and classification as effective, evidence-based tools for prevention.

10. LIMITED ACCESS TO BASIC RESOURCES MAY CREATE CONDITIONS OF DEPENDENCE THAT INCREASE RISK OF SEXUAL COERCION AND EXPLOITATION

Importance

Access to basic resources, such as communication, healthcare, and daily necessities, is essential to safety and well-being in correctional settings. When access to these resources is limited, inconsistent, or controlled by others, it can create conditions of dependence in which incarcerated people are more vulnerable to coercion, exploitation, and abuse.

Findings

Interview data indicate that scarcity of basic resources can create conditions in which those resources function as leverage for coercion. Limited access to essentials, such as phone calls, medical care, or administrative support, may enable staff or other incarcerated people to exert control or extract compliance. As one interviewee described, "Scarcity… creates… levers. And so, people are… having sex for phone calls… for access to medical visits…".

> **"…there's a black-market economy around some of the sexual activity…anytime you have that…harm is more likely."**

Scarcity may also shape interactions between incarcerated people. Limited access to goods, protection, or stability can contribute to informal economies in which sexual exploitation

becomes more likely. One interviewee described how these dynamics can increase vulnerability, particularly for marginalized groups: “You have trans women in [men’s] prisons who are very vulnerable to attack… there’s a black-market economy around some of the sexual activity… anytime you have that… harm is more likely.”

These findings suggest that sexual coercion and exploitation may sometimes emerge not only through direct violence or force, but also through systems of dependency created by institutional scarcity and unequal access to resources. Such dynamics may be especially difficult to identify through formal PREA reporting systems, particularly where exploitative interactions are normalized, economically motivated, or perceived as necessary for access to basic resources or protection.

Summary

Limited or unequal access to basic resources may create conditions that increase vulnerability to sexual coercion and exploitation within correctional settings. Scarcity can produce systems of dependence in which access to necessities, protection, or stability becomes linked to coercive or exploitative relationships. These dynamics may disproportionately affect already vulnerable populations and may not always be fully captured through formal reporting systems. Addressing institutional scarcity and improving equitable access to basic resources may therefore be an important component of broader sexual misconduct prevention efforts.



RECOMMENDATIONS

Based on our findings, we offer recommendations aimed at reducing sexual misconduct and improving sexual safety within CDCR's men's prisons. These recommendations begin with foundational reforms needed to address institutional conditions that limit the effectiveness of prevention, reporting, and investigative systems. Without addressing these underlying structural and operational barriers, other reforms are less likely to produce meaningful or sustained improvements.

The recommendations then focus on strengthening sexual misconduct reporting and investigative processes, improving education and support for both staff and incarcerated people, and enhancing systems for oversight, accountability, data analysis, public reporting, and organizational learning. Together, these reforms are intended to improve CDCR's capacity to prevent, identify, investigate, and respond to sexual misconduct across institutions.

These recommendations were developed for UC Berkeley's Criminal Law & Justice Center to support future research, policy development, and advocacy efforts. Identifying the specific government entities responsible for facilitating or implementing each recommendation, including CDCR, the OIG, the state legislature, or other oversight bodies, is beyond the scope of this report. However, determining implementation responsibilities, resource needs, and oversight structures will be an important next step that should involve a broad range of stakeholders.

1. SET THE SYSTEM UP FOR SUCCESS IN IMPROVING SEXUAL MISCONDUCT PREVENTION AND RESPONSE

1.1 Establish a better baseline understanding of current conditions and available data

Recommendation

A comprehensive assessment of current sexual misconduct reporting, investigation, and prevention systems should be conducted to establish a clearer baseline understanding of institutional conditions, investigative practices, case outcomes, and available data. This assessment should incorporate internal data sources that are not currently publicly available and evaluate variation across facilities, housing types, and populations.

Some analysis may require the development of more robust data systems (see Recommendation 1.2) or the implementation of quasi-experimental studies and pilot programs. For example, while there are many documented benefits to single-cell housing in prisons, such as improved mental health and emotional well-being,[47, 48] a pilot program could help to better understand the specific impact on sexual misconduct as well as how to negate potential risks with broader single-cell implementation.

This baseline assessment should also include creating better process descriptions of how PREA allegations are formally reported, how they progress, and where different decision points along this process exist (see Critical Gaps in Available Data section).

Rationale

This recommendation is in response to Findings **1**, **2**, **3**, **4**, **6**, and **9**.

Limited publicly available data constrain understanding of the scope, characteristics, and handling of sexual misconduct incidents within CDCR facilities. Establishing a stronger baseline is necessary to identify gaps in prevention and response systems, determine priority areas for intervention, guide future data collection efforts, and measure progress over time.

1.2 Improve data systems and transparency

Recommendation

CDCR should be supported to modernize and standardize PREA data collection, tracking, and public reporting practices to improve transparency, accountability, and systemwide prevention efforts. Public reporting should include timely, disaggregated information on allegations, investigations, investigative timelines, outcomes, and case progression across facilities, housing types, and demographic groups.

There should also be regular public reporting and ongoing analysis of PREA-related data to identify systemwide trends, emerging risks, investigative bottlenecks, and areas requiring operational or policy intervention.

Rationale

This recommendation is in response to Findings **1**, **2**, **3**, **4**, **6**, and **9**.

Current publicly available PREA data provide limited visibility into how allegations are processed, investigated, and resolved across CDCR facilities. These limitations reduce the ability of policymakers, oversight entities, CDCR leadership, and the public to evaluate system performance, identify unmet needs, assess the effectiveness of reforms, and allocate staffing and resources appropriately. Improved transparency and data infrastructure would also strengthen trust and legitimacy in PREA processes among incarcerated people, staff, and the public. Existing data reporting and dashboards from CDCR, with many other data points, indicate this would be feasible within current data reporting systems.

1.3 Address the backlog of incidents needing further investigation

Recommendation

CDCR should take immediate steps to reduce the backlog of PREA allegations requiring further investigation and establish mechanisms to ensure investigations are completed in a timely manner going forward. As of August 28, 2025, 1,054 of the 1,937 PREA allegations from 2024 (54%) remained under ongoing investigation.[49] Available annual PREA reports also suggest that investigative backlogs have increased in recent years.

Efforts to reduce the backlog should include prioritizing unresolved cases, improving investigative capacity and workflow management, and implementing oversight mechanisms to monitor investigative timelines and case progression across facilities.

Rationale

This recommendation is in response to Finding **4**.

Large investigative backlogs undermine the effectiveness, timeliness, and credibility of CDCR's response to sexual misconduct allegations. Delayed investigations may reduce accountability, limit

opportunities for timely intervention, and discourage reporting among incarcerated people and staff. Addressing the backlog is necessary to improve investigative capacity and ensure that broader reforms to PREA reporting, prevention, and response systems can be implemented effectively. Past challenges within CDCR's staff misconduct investigative systems also suggest that unresolved backlogs can contribute to persistent operational and accountability failures over time.[11]

1.4 Reduce prison populations and improve custody staff-to-incarcerated person ratios

Recommendation

California policy makers should reduce prison populations to improve institutional safety, strengthen supervision capacity, and support more effective prevention and response to sexual misconduct. At a minimum, California policy makers should reduce institutional populations to 100% of designed capacity, rather than relying on the 135% threshold established under *Brown v. Plata* (2011),[50] which was based primarily on deficiencies in medical and mental health care systems rather than broader safety considerations inherent in an overcrowded environment.

There should also be an evaluation of opportunities to reallocate staffing resources in CDCR from administrative functions and headquarters toward housing-unit and frontline supervision roles to strengthen direct oversight without relying solely on substantial increases in total staffing levels.

Rationale

This recommendation is in response to Findings **1**, **2**, **3**, **4**, **5**, **6**, **7**, **8**, **9**, **10**.



Higher prison population levels place substantial strain on institutional systems intended to maintain safety for both incarcerated people and staff. Overcrowding can reduce supervision effectiveness, limit housing flexibility, increase tensions within facilities, and constrain the ability of staff to respond promptly and effectively to sexual misconduct allegations and other safety concerns.

Reducing institutional populations would improve staff-to-incarcerated person ratios within housing units and create greater flexibility for safer housing arrangements, including increased use of single-cell placements where appropriate, which may reduce opportunities for sexual victimization and other interpersonal safety risks. Lower population levels may also reduce housing-related conflicts and safety concerns that can contribute to PREA allegations made to facilitate housing changes. Overall, population reduction would improve operational capacity and create conditions more conducive to effective sexual misconduct prevention and response.

2. ADDRESS KNOWN ISSUES WITH SEXUAL MISCONDUCT INCIDENT REPORTING

2.1 Assess and improve access to confidential reporting options

Recommendation

Conduct a review of confidential PREA reporting options to clarify levels of access, limitations to confidentiality, and opportunities for improvement. Although residents in CDCR prisons can now submit PREA reports to the OIG through tablets and choose to remain anonymous when reports are forwarded to CDCR, questions remain about whether tablet monitoring and data access practices could still allow individuals to be identified.

This review should include:

- Examining if there are any populations that lose access to their tablets for any reason, and what (if any) other confidential reporting options are then available to them.
- Examining what populations may experience challenges filling out a tablet-based form.
- Analysis of the true anonymity level of PREA reports submitted via tablets and via any other means of reporting.
- Analysis of any changes to this process that may occur, or cause delays in accessing confidential tablet-based reporting, due to the ongoing change in tablet vendor for CDCR and challenges with this process.[51]

After a review, anonymous reporting options should be improved and expanded where possible. Limits to anonymity should be clearly communicated to all incarcerated people.

Rationale

This recommendation is in response to Finding **2**.

Anonymous tablet-based reporting has significant potential to improve reporting access and safety, but additional evaluation is needed to assess its accessibility, effectiveness, and confidentiality protections. There are likely ways to improve anonymous reporting options, and all limits to anonymity in reporting should be clearly communicated back to incarcerated people. Incarcerated people should also be informed of any downsides of submitting a report anonymously, such as the possibility that the prison may be able to do less to support them and follow up.

2.2 Assess potential retaliation at both the individual level and group level

Recommendation

Existing data systems should be used to systematically identify and monitor potential retaliation related to PREA reporting at both the individual and group levels. Findings from this report indicate that incarcerated people may experience retaliation from staff following complaints or reporting activity, including both targeted actions against individuals and broader actions affecting groups or housing units. However, little is currently known about the prevalence of retaliation, how it is monitored, or what steps are taken to prevent or address it within CDCR.

CDCR should conduct a structured assessment, informed by stakeholder input, to determine what data elements and indicators should be incorporated into retaliation monitoring efforts. The objective would be to identify patterns or signals that may indicate retaliatory practices, including but not limited to disciplinary actions, housing changes, transfers, program restrictions, lockdowns, loss of privileges, or other adverse outcomes following PREA-related reporting.

This effort should include:

- Development of a clearly documented process for tracking follow-up actions affecting individuals who submit PREA reports, including potential retaliation indicators over time.
- Assessment of retaliation patterns at both the individual level and group level, including actions that may disproportionately affect units, peer groups, or populations associated with reporting activity.
- Integration of relevant administrative data sources to support ongoing monitoring and trend analysis.
- Clear documentation of investigative, supervisory, or corrective actions taken in response to identified retaliation concerns.
- Public or stakeholder-facing communication, where appropriate, regarding CDCR's retaliation prevention and monitoring practices.

Although this report did not include interviews with CDCR employees and therefore could not assess existing internal retaliation-monitoring practices, any current approaches should be documented and evaluated, and additional systems should be developed where gaps exist.

Rationale

This recommendation is in response to Findings **2** and **3**.

Preventing retaliation is a critical component of effective sexual misconduct prevention and reporting systems. Findings from this report suggest that concerns about retaliation may undermine willingness to report misconduct and may contribute to distrust in institutional processes. Evidence also suggests that retaliation can occur in both direct and indirect forms, affecting not only individual complainants but also broader groups of incarcerated people.

Existing CDCR data systems may already contain information that could support more proactive monitoring of retaliation-related indicators, similar to approaches used in other correctional systems. Developing structured retaliation-tracking processes could improve accountability, strengthen protections for incarcerated people who report misconduct, and support more effective oversight of PREA-related practices.

2.3 Use clear and timely communication to improve trust in reporting systems and investigations

Recommendation

Improve communication and transparency throughout the reporting and investigative process by clearly informing incarcerated people about the expectations, procedures, timelines, and status of submitted reports. Individuals who submit complaints should receive timely updates regarding case progress and resolution, as well as information about how to obtain additional assistance or clarification when needed.

Rationale

This recommendation is in response to Finding **2**.

Although communication alone cannot fully resolve distrust in reporting systems, findings suggest that lack of follow-through and limited transparency contribute significantly to distrust in PREA processes. Interviewees described instances in which complaints were submitted without any subsequent communication regarding investigative progress or case outcomes. Improving communication and follow-up practices could strengthen accountability, increase confidence in reporting systems, and support greater trust in institutional responses to complaints.

2.4 Develop alternative pathways for addressing non-sexual safety concerns

Recommendation

Develop and document a clear process for addressing safety concerns that are unrelated to sexual misconduct that has already occurred, but may still involve risks of violence, retaliation, coercion, or unsafe housing conditions. This process should apply both to complaints specifically related to concerns about future sexual violence risk and to broader non-sexual safety concerns, including complaints initially submitted through PREA reporting mechanisms that are later determined not to involve sexual misconduct.

Because evidence indicates that incarcerated people sometimes use PREA reporting pathways to raise a wider range of safety concerns because no alternative urgent reporting method exists, establishing alternative and clearly communicated response pathways is necessary both to improve institutional safety and to reduce reliance on PREA processes for issues outside PREA's intended scope.

This process should include:

- An analysis of how safety-related complaints move through grievance systems and PREA reporting pathways, including how cases are handled when a PREA allegation is determined to be unfounded or outside PREA jurisdiction but still reflects a legitimate safety concern.
- Clear, publicly available documentation describing how PREA complaints and other safety-related complaints proceed through reporting, review, investigation, resolution, and follow-up stages.
- Defined referral and response procedures to ensure that non-PREA safety concerns are not dismissed solely because they do not meet PREA criteria.
- Guidance for staff and incarcerated people on the appropriate mechanisms for reporting different types of safety concerns and the protections available through each pathway.

Rationale

This recommendation is in response to Finding **2**.

Findings indicate that PREA reporting mechanisms are frequently used to address broader safety

concerns, particularly those related to housing placement, threats, interpersonal conflict, and fears of violence. While these concerns may fall outside the formal scope of PREA, they often reflect legitimate risks to safety and well-being and therefore require meaningful review and response.

Developing alternative urgent pathways for non-sexual safety concerns could improve institutional responsiveness, ensure that safety risks are addressed more consistently, and reduce strain on PREA investigative processes. At the same time, maintaining clear referral procedures between PREA and other safety-response systems would help ensure that concerns are directed to the appropriate process without leaving individuals unsupported or unprotected.

3. IMPROVE INVESTIGATIVE SYSTEMS AND ACCOUNTABILITY

3.1 Centralize and standardize complaint intake, screening, classification, and tracking

Recommendation

Complaint intake and classification processes for staff misconduct allegations, including PREA-related complaints, should be centralized outside of CDCR operational chains where possible. This could include expanding the authority and resources of the OIG or establishing an independent screening and intake body. Intake criteria, routing decisions, documentation practices, and case-tracking procedures should be standardized across the system to improve consistency, transparency, and accountability.

This should include publicly available documentation describing:

- The full complaint intake and processing flow, including each decision point within the system.
- Which entities or personnel are responsible for decision-making at each stage of the process.
- The circumstances under which complaints may be downgraded, rerouted, or screened out, and how those complaints are subsequently handled.
- Standardized classification and tracking procedures to ensure complaints can be consistently monitored from submission through resolution.

Rationale

This recommendation is in response to Findings **2**, **4** and **5**.

Despite multiple reforms and efforts to centralize complaint screening processes for staff misconduct allegations, including PREA-related complaints, the system appears to continue to struggle with consistency, accuracy, and transparency. Complaints may be filtered out, downgraded, or rerouted before reaching formal investigation, limiting accountability and reducing confidence in the integrity of the process.

OIG findings suggest that multiple layers of discretionary review contribute to inconsistent handling of complaints and create opportunities for serious allegations to be misclassified or inadequately investigated. Strengthening independence, standardization, and transparency within intake and screening systems could improve accountability, reduce inappropriate case filtering, and increase trust in investigative processes.

3.2 Improve investigative timelines for evidence collection and case resolution.

Recommendation

Multiple steps should be taken to improve the timeliness, consistency, and completeness of PREA investigations. Clear and enforceable investigative timelines and performance expectations should be established for key stages of the investigative process. Improving compliance with these timelines will likely require additional staffing and resource allocation to expand investigative capacity.

Interviews with victims, witnesses, and people who are accused, as well as forensic evidence collection where applicable, should be prioritized and completed within a short and clearly defined timeframe following a PREA allegation. Delays in investigative steps and cases that remain unresolved beyond established timelines should be closely monitored and subject to additional oversight, including review by an entity outside of CDCR, such as the OIG.

Rationale

This recommendation is in response to Findings **2** and **4**.

Delays in investigations can reduce the quality and availability of evidence, limit the ability to reach reliable conclusions, and weaken the effectiveness of institutional responses to sexual misconduct allegations. Timely and thorough investigations are necessary to address immediate safety concerns, support accountability, and reduce the risk of additional incidents. Improving investigative timeliness, follow-through, and case completion may also strengthen trust in reporting systems and increase confidence that complaints will be taken seriously and resolved appropriately.

4. STRENGTHEN INSTITUTIONAL PREVENTION CAPACITY THROUGH SUPERVISION AND ENVIRONMENTAL SAFETY

4.1 Reduce isolated staff assignments and improve staff oversight

Recommendation

Single-staff posts should be reduced where possible, and staff assigned to high-risk or isolated areas should receive increased supervision, support, and oversight. CDCR should evaluate staffing models and deployment practices across institutions with the goal of increasing frontline custody staffing in ways that reduce staff isolation and improve safety for both staff and incarcerated people (see Recommendation 1.4).

Monitoring and supervisory review of staff assignments should also be strengthened, with particular attention to positions that involve working alone, limited visibility, or reduced routine oversight. CDCR should also assess whether staffing patterns, post assignments, or operational practices create environments in which misconduct is more difficult to detect or prevent.

Rationale

This recommendation is in response to Findings **8**, **9** and **10**.

Isolation and limited oversight can create conditions that increase opportunities for sexual misconduct involving both staff and incarcerated people. Staff working alone or in poorly supervised environments may have greater opportunity to engage in misconduct without detection. At the same time, isolated staffing patterns may reduce the ability of staff to effectively supervise housing units

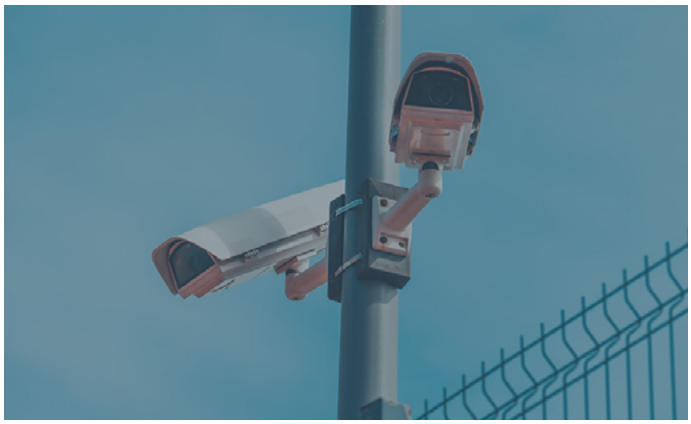
and monitor interpersonal dynamics, limiting opportunities to identify and prevent incarcerated person-on-incarcerated person sexual misconduct. Strengthening staffing models, supervision, and oversight in high-risk areas may therefore improve both institutional safety and accountability.

4.2 Expand camera coverage and reduce physical blind spots

Recommendation

In addition to other efforts to strengthen supervision and oversight, CDCR should expand and modernize camera coverage throughout its institutions. This should include identifying and addressing known blind spots, using incident data and institutional knowledge to prioritize high-risk locations for enhanced surveillance, and regularly assessing whether camera placement aligns with evolving safety concerns.

CDCR should also evaluate camera quality, monitoring practices, and data retention policies to ensure that video evidence can effectively support investigations. Given that PREA allegations may be reported long after an incident occurs and are not subject to reporting time limits, consideration should be given to extending video retention periods in high-risk areas where feasible.



Rationale

This recommendation is in response to Findings **4**, **8**, and **9**.

Interviews, OIG oversight findings, PREA audit reports, and CDCR's own assessments indicate that facilities often contain known blind spots and areas with limited visibility that may increase opportunities for sexual misconduct and other safety incidents. These vulnerabilities are frequently only formally identified after incidents occur rather than being addressed proactively. Expanding camera coverage, improving surveillance infrastructure, and reducing blind spots could strengthen prevention efforts, improve accountability, and increase the availability of evidence when incidents are reported and investigated.

4.3 Improve housing and classification practices to better support sexual safety

Recommendation

Housing and classification practices should be comprehensively reviewed to ensure they effectively support sexual safety and respond to identified risks. Policies, procedures, and decision-making processes should be clearly documented and communicated to incarcerated people, including how safety concerns are evaluated, what factors influence housing decisions, and how individuals can request review of housing placements.

This review and update of practices should include:

- Ensuring that housing-related safety concerns are consistently documented, tracked, and incorporated into classification and placement decisions.

- Evaluating opportunities to increase the use of single-cell housing as a strategy to reduce opportunities for victimization and other interpersonal safety risks.
- Improving data collection and analysis related to housing assignments, classification decisions, safety concerns, transfers, and victimization outcomes.
- Conducting ongoing evaluation of whether reported safety concerns result in meaningful protective actions, housing modifications, or other interventions.
- Assessing the implementation and safety impacts of transfers between men's and women's prisons under SB 132, including outcomes for transgender individuals and broader institutional safety considerations.
- Providing transparent and publicly available information regarding housing practices and outcomes to support evidence-based policymaking and reduce reliance on anecdotal accounts or misinformation.

Rationale

This recommendation is in response to Findings **8**, **9**, and **10**.

Findings from this report indicate that housing and classification decisions play a central role in shaping exposure to sexual victimization and perceptions of safety. At the same time, available data provide limited insight into how housing decisions are made, whether safety concerns are consistently addressed, and what outcomes result from placement and transfer decisions. Inconsistent documentation, limited transparency, and gaps in outcome data constrain the ability to evaluate the effectiveness of housing-related safety interventions. Strengthening housing and classification processes, improving data collection, and regularly evaluating outcomes would support more effective and evidence-based approaches to sexual misconduct prevention and response.

4.4 Invest in scanners and practices that reduce the use of body searches.

Recommendation

CDCR should reduce reliance on body searches, including both pat-down and unclothed searches, wherever possible. While institutional safety and contraband prevention remain important objectives, available technologies such as body scanners can help achieve these goals while reducing the need for more invasive search practices. CDCR should continue to evaluate and expand the use of technologies and operational practices that minimize unnecessary physical searches while maintaining institutional security.

Rationale

This recommendation is in response to Findings **3** and **4**.

Findings from this report show that grievances and PREA reports related to body searches in CDCR likely contribute significantly to the burden of report processing and investigation. Body searches are often considered sexual misconduct by residents, and rationale for use often remains unclear.

In order to create an environment that supports increased bodily autonomy, within the constraints of a correctional setting, scanners and practices that would reduce the reliance on body searches are necessary.

Findings from this report suggest that grievances and PREA reports related to body searches may contribute substantially to the volume of allegations requiring review and investigation. Body searches are often very invasive and can create real harm, particularly when the purpose, necessity, or conduct of the search is unclear. Reducing reliance on body searches through the use of scanners and other alternatives can help decrease opportunities for harm, improve perceptions of safety and legitimacy, and support greater bodily autonomy within the constraints of a correctional environment.

4.5 Address scarcity and unmet basic needs that may increase vulnerability to coercion and exploitation

Recommendation

CDCR should improve equitable access to basic necessities, programming, communication, health-care, and other resources that support safety and well-being. Efforts should focus on identifying and addressing institutional conditions that create scarcity, dependence, or unequal access to resources that may increase vulnerability to coercion, exploitation, and sexual victimization.

This should include:

- Assessing areas where limited access to resources or opportunities may create situations where incarcerated people or staff have leverage over incarcerated people.
- Identifying institutional practices or resource shortages that contribute to informal economies, dependency relationships, or increased vulnerability to exploitation.
- Improving access to essential resources, including communication with family and support networks, healthcare services, programming, and basic necessities.
- Evaluating whether particular populations face disproportionate barriers to accessing resources and support.
- Incorporating considerations of scarcity, coercion, and exploitation into broader sexual misconduct prevention efforts.

Rationale

This recommendation is in response to Finding **10**.

Findings from this report suggest that the environment in CDCR is characterized by scarcity and unequal access to resources, and that this may increase vulnerability to sexual coercion and exploitation. Interviewees described instances in which sexual acts were exchanged for access to resources, reflecting broader systems of dependence and informal economies that can emerge in correctional settings. Until this scarcity is better addressed, incarcerated people will remain at a much higher risk for transactional sex and exploitation. As this is driven largely by institutional conditions, it cannot be addressed through response to individual incidents alone.

5. STRENGTHEN EDUCATION AND RESOURCES FOR BOTH STAFF AND INCARCERATED PEOPLE

5.1 Increase resident education and provide multiple avenues of support

Recommendation

Incarcerated people should receive clear, consistent, and accessible education regarding how to report sexual misconduct and other safety concerns, what reporting options are available, and what to expect after a complaint is submitted. Education should include guidance on how to submit different types of complaints, including PREA allegations, safety concerns unrelated to PREA, grievances, and requests for protection or housing review.

Training and informational materials should clearly explain:

- Which forms, reporting pathways, or processes should be used for different types of concerns.
- Available confidential or anonymous reporting options and any limitations to confidentiality or anonymity.
- Expected timelines, follow-up procedures, and possible outcomes after a complaint is submitted.
- Available protections against retaliation and mechanisms for requesting additional support or information.

All information should be documented in written materials in addition to being communicated through regular education and orientation processes. Educational materials and handbooks should be reviewed to remove language or informal guidance that may discourage reporting or conflict with PREA standards, including suggestions that incarcerated people should attempt to resolve complaints involving staff misconduct directly with staff before filing a complaint (see Case Study One).

Additional approaches to education and support should also be evaluated. Educational programming related to PREA and sexual safety may be more effective when delivered or supported by outside organizations, victim advocates, or community-based groups that are perceived as more independent and trustworthy. CDCR should also explore opportunities to expand peer-support models and other support mechanisms for individuals affected by sexual misconduct or safety concerns.

Because the sensitive nature of sexual misconduct allegations may create barriers to traditional peer-support approaches, alternative and technology-assisted models should also be considered and evaluated. This could include carefully designed anonymous or confidential peer-support systems accessible through tablets or other technology platforms, with appropriate screening, oversight, and safeguards to address confidentiality, misuse, and safety concerns.

Rationale

This recommendation is in response to Findings **2** and **3**.

Findings suggest that confusion about reporting processes, limited communication, distrust in institutional systems, and uncertainty about available protections may reduce willingness to report sexual misconduct and other safety concerns. This may also result in reporting processes being

used in ways they are not intended. Improved education and communication regarding reporting pathways, confidentiality, investigative processes, and available support may improve understanding of the system and increase access to appropriate resources.

Findings also suggest that incarcerated people may be more likely to trust and engage with support systems that include independent organizations, external advocates, or peer-based approaches. Expanding education and support options could improve access to information, strengthen trust in reporting systems, and provide additional avenues for assistance beyond formal institutional processes.

5.2 Evaluate existing staff training curriculum and identify areas for improvement.

Recommendation

CDCR should evaluate and strengthen staff training and professional culture to better support sexual misconduct prevention, appropriate staff-resident interactions, and early intervention when concerns arise. This should include both improvements to formal training curricula and broader efforts to reinforce prevention-oriented institutional culture and accountability practices over time.

Training should move beyond basic PREA compliance requirements and include ongoing, scenario-based instruction focused on professional boundaries, communication, de-escalation, supervision practices, and identification of behaviors that may increase risk of misconduct or exploitation. Refresher and applied trainings should occur after staff begin working in housing units and other operational settings, rather than relying solely on academy-based instruction for staff who may have limited or no experience with the settings they will be working in.

This effort should include:

- Evaluation and revision of existing PREA and professional conduct training curricula to identify gaps and opportunities for improvement.
- Training focused on maintaining clear professional boundaries while supporting respectful and effective communication with incarcerated people.
- Scenario-based training addressing common situations involving grooming behaviors, boundary violations, retaliation concerns, reporting obligations, and staff responses to allegations.
- Training on how staff should respond when they observe potentially inappropriate behavior or possible boundary violations by coworkers or supervisors.
- Education regarding investigative and reporting processes to address confusion, fear, or misunderstanding among staff related to PREA allegations and complaint systems.
- Review of supervision, accountability, and workplace culture practices that may discourage reporting or normalize inappropriate conduct.

Rationale

This recommendation is in response to Finding **8**.

Findings from this report suggest that staff training, institutional culture, and informal workplace norms may play a substantial role in shaping sexual safety within correctional settings. Prevention depends not only on formal PREA compliance, but also on whether staff have the training, supervision, and institutional support necessary to maintain professional boundaries, identify risks, intervene appropriately, and report concerns when misconduct occurs.

Interview data and oversight findings suggest that entrenched workplace cultures, inconsistent supervision, fear surrounding PREA allegations, and limited accountability mechanisms may undermine prevention efforts and contribute to distrust in institutional systems. Strengthening staff professionalism, communication practices, training in responding to various scenarios, and prevention-oriented culture may improve institutional safety, increase accountability, and reduce opportunities for sexual misconduct and exploitation.

6. ENSURE ONGOING EVALUATION AND IMPROVEMENT

6.1 There should be regular evaluation of sexual misconduct and victimization risks with findings made publicly available.

Recommendation

Existing and improved data systems should be used to conduct regular evaluations of sexual misconduct and victimization risks across CDCR. These evaluations should assess trends over time, identify emerging risks, and examine the impact of policy, operational, and practice changes that may influence sexual safety. Findings should be made publicly available to ensure that policymakers, advocates, researchers, and the public have timely information about institutional conditions and the effectiveness of reform efforts.

Rationale

This recommendation is in response to Findings **1**, **2**, **3**, **4**, **5**, **6**, **7**, **8**, **9**, **10**.

Throughout this report, we identified significant gaps in available data, transparency, and ongoing analysis. Existing systems are often oriented toward compliance reporting rather than prevention and continuous improvement. Regular evaluation of sexual misconduct risks and prevention efforts is essential for identifying what is working, where gaps remain, and how policies can be refined over time. Public transparency is also critical for accountability and for supporting evidence-based policymaking.

6.2 Review and strengthen PREA audit processes to improve accuracy, independence, and prevention impact

Recommendation

There should be a comprehensive review of federally mandated PREA audit processes to identify limitations, sources of bias, and opportunities to strengthen their value as tools for prevention, accountability, and continuous improvement. This review should assess whether PREA audits accurately capture routine institutional practices, lived experiences of incarcerated people, and

conditions that contribute to sexual misconduct risk. Attention should be given to the extent to which audit findings reflect actual operational conditions rather than temporary compliance efforts, documentation practices, or narrowly defined interpretations of PREA standards.

This review and reform should be conducted with the involvement of various stakeholders, including the PREA Resource Center (PRC) run by Impact Justice,* due to their extensive experience with auditor training and support. While the auditing process is mandated at a federal level, California policymakers should work to support important changes in this process that could have a substantial impact on California prisons.

The review of the current auditing process should include:

- Assessment of auditor independence, including potential conflicts created by reliance on information, documentation, coordination, and access provided by the facilities being audited.
- Evaluation of whether current audit methodologies adequately incorporate confidential input from incarcerated people, custody staff, victim advocates, community organizations, and other stakeholders.
- Assessment of whether audits effectively identify practices that undermine the intent of PREA standards, even when those practices technically comply with audit requirements.
- Exploration of mechanisms to incorporate unannounced reviews, supplemental oversight visits, independent validation of audit findings, or other approaches that better assess routine operations.
- Review of opportunities to strengthen transparency by making audit evidence, corrective action plans, and progress toward corrective actions more accessible to policymakers and the public.
- Evaluation of whether audit findings correlate with other indicators of sexual safety, including allegations, victimization surveys, litigation, oversight findings, investigative outcomes, and institutional climate measures.

Rationale

This recommendation is in response to Findings **6** and **7**.

Findings from this report suggest that federally mandated PREA audits have important limitations as mechanisms for evaluating institutional safety and accountability. Interviews and review of audit materials indicate that audits often rely heavily on documentation, policy review, and institution-prepared materials, while providing limited visibility into routine operations, institutional culture, and the lived experiences of incarcerated people. Interviewees also described concerns that facilities may temporarily modify practices during audit periods in ways that do not reflect normal conditions.

*More information can be found on the website for the PREA Resource Center.

This report further identified examples in which practices that may undermine the goals of PREA were nevertheless found compliant because they did not technically violate audit requirements. These findings suggest that audits may be more effective at measuring procedural compliance than identifying conditions that contribute to sexual victimization or barriers to reporting.

Because PREA audits remain one of the primary accountability mechanisms used to assess institutional performance, it is important to evaluate whether they are producing accurate, meaningful, and actionable information. Strengthening audit independence, improving auditing methods, and incorporating broader measures of institutional safety could improve transparency, support prevention-focused reforms, and enhance public confidence in correctional oversight systems.

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APPENDIX

Figure A-1. The Complex Process of PREA reporting, screening, investigation, and resolution process as defined by publicly available information (with multiple questions remaining).

