PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: July 16, 2015

Auditor Information			
Auditor name: Barbara Jo Denison			
Address: 3113 Clubhouse Drive, Edinburg, TX 78542			
Email: denisobj@sbcglobal.net			
Telephone number: 956-566-2578			
Date of facility visit: July 14 – 15, 2015			
Facility Information			
Facility name: Mid Valley House			
Facility physical address: 2520 South Expressway 281, Edinburg, TX 78539			
Facility mailing address: *(if different from above)*			
Facility telephone number: 956-383-0663			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☒ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Ivan Iglesias, Facility Director			
Number of staff assigned to the facility in the last 12 months: 32			
Designed facility capacity: 132			
Current population of facility: 104 in house and 37 on home detention			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 19 - 70			
Name of PREA Compliance Manager: Claudia Herrera		**Title:** Assistant Director/PREA Compliance Manager	
Email address: cherrera@geogroup.com		**Telephone number:** 956-383-0663	
Agency Information			
Name of agency: The GEO Group, Inc.			
Governing authority or parent agency: *(if applicable)*			
Physical address: One Park Place, Sute 700, 621 Northwest 53rd St., Boca Raton, Florida 33487			
Mailing address: *(if different from above)*			
Telephone number: 561-999-5827			
Agency Chief Executive Officer			
Name: George C. Zoley		**Title:** Chairman of the Board, CEO and Founder	
Email address: gzoley@geogroup.com		**Telephone number:** 561-893-0101	
Agency-Wide PREA Coordinator			
Name: Phebia L. Moreland		**Title:** Director, Contract Compliance, PREA Coordinator	
Email address: pmoreland@geogroup.com		**Telephone number:** 561-999-5827	

AUDIT FINDINGS

NARRATIVE

The PREA audit of Mid Valley House was conducted on July 14-15, 2015 by this Certified PREA Auditor, Barbara Jo Denison. Prior to the audit, the facility provided the auditor with policies and supporting documentation related to each standard for review. Agency policy 5.1.2, facility policies and all training PowerPoint materials were reviewed and found to be very comprehensive. The auditor was provided prior to the on-site visit with a list of staff sorted by title and shift, a list of residents sorted by housing unit, a list of residents identified through the PREA screening process to be at high risk for victimization and abusiveness and a list of Spanish speaking residents. From these lists, residents and staff were randomly selected to be interviewed. At the time of the audit there were no residents with visual, hearing or cognitive impairments and there were no self-disclosed lesbian, gay, bisexual, transgender or intersex residents.

On the first day of the audit an entrance meeting was held at 8:00 a.m.- 8:15 a.m. with the following people in attendance: Ivan Iglesia, Facility Director; Claudia Herrera, Assistant Director/PREA Compliance Manager; Terry Garcia, Texas Regional Director Community Based Services; Jonathon Dressler, Program Fidelity Manager, Reentry Services PREA Divisional Coordinator; and, Robert Walling, Manager Contract Compliance PREA, followed by a tour of the facility. All housing units and all areas that residents are allowed access to were toured. While touring, four staff members and twelve residents were informally interviewed and questioned about their knowledge of PREA. While touring the male dorms the auditor noted that the placement of the bunks located in the further back left and right corners of the dorms made visibility of these areas difficult for staff when doing rounds. It was recommended that the installation of corner dome mirrors in those areas would increase visibility and safety of residents occupying those bunks. The Texas Regional Director Community Based Services stated that she would contact the customer for approval for installation of the mirrors. Through e-mail following the audit, she responded that the customer approved this recommendation. The population of the facility on the first day of the audit was 104 residents in house and 37 on home detention. Three residents from each housing unit were formally interviewed for a total of 12 residents. Of that number, two were Spanish speaking, one was identified through risk screening to be a potential predator and three were identified as potential victims. All residents interviewed were knowledgeable of the agency's zero-tolerance policy and the methods available to them to report sexual abuse and sexual harassment. Numerous posters in both English and Spanish were displayed throughout the facility.

A total of 16 staff members were interviewed throughout the course of the audit. Of that number, were seven specialized staff and one volunteer. Specialized staff interviewed included: the Facility Director; Assistant Director/PREA Compliance Manager; Chief of Security; Case Manager Supervisor; Kitchen Worker; Office Support Specialist and the Program Fidelity Manager, Reentry Services PREA Divisional Coordinator. Random staff selected to interview were: two Security Monitors from each shift and two Security Monitor Supervisors. Staff interviewed was well versed in their responsibilities in reporting sexual abuse and suspected sexual abuse. When questioned about evidence preservation, staff responses reflected agency policies and standard requirements. The PREA Coordinator and the Agency Head were not in attendance at the audit, but were interviewed on an earlier date. There are no SANE at the facility. They are available by a Memorandum of Understanding (MOU) with the McAllen Regional Medical Center or the Mission Regional Medical Center.

In the past 12 months, there were two staff-on-resident allegations of sexual abuse. One allegations was found to be unsubstantiated and one unfounded. Investigative files were reviewed with the Assistant Director/PREA Compliance Manager. In both cases, proper procedures were followed in the handling of the investigations.

At the conclusion of the on-site vist, an exit meeting was held. There were no standards found to require corrective action. The auditor explained the process that follows the on-site audit. The final report will be made available to the public on the GEO website. The auditor acknowledged the willingness of all staff involved to accomplish PREA compliance as a team.

DESCRIPTION OF FACILITY CHARACTERISTICS

Mid Valley House provides temporary housing, monitoring and transitional services for 132 minimum security adult males and females. The facility is located at 2520 N. Expressway 281, Edinburg, Texas. The GEO Group, Inc. assumed operations of the facility in 2010. Prior to 7/1/14, the facility was located at 402 W. Chapin St., Edinburg, TX. The relocation to the newly renovated building increased the bed capacity from 100 to 132. Assignments to the facility are made through contracts with the Federal Bureau of Prisons and the U.S. Probation and Pre-Trial Offices for adult males and females who are serving the last six months of their sentences. Residents may also be direct court commitments that have been designated to serve their entire confinement at the facility or referred for placement due to conditional requirements of supervision. Programs offered include life skills training in anger management, stress management, parenting, suicide prevention, sexual abuse intervention, personal hygiene, budgeting, banking and housing assistance. All residents are required to secure full-time gainful employment within 21 days of arrival to the facility. Employment assistance and training is provided which includes resume writing, job search strategies, application assistance and interview techniques. Programs and services offered help prepare residents to return to their local communities. Home detention is offered to eligible residents for the last 10% of their sentence. Home detention requires weekly visits to the facility and weekly home/job site visits from a Job Developer or Case Manager.

The facility consists of four residential dorms; three male and one female. The dorms are open with 20 bunk beds in Dorm 1, 38 bunks beds in Dorm 2, 36 bunk beds in Dorm 3 and 38 bunk beds in Dorm 4. The male and female residents are not allowed to socialize together and are prohibited from engaging in any emotional or physical relationships. The facility has a total of 32 carmers with 8 located at the exterior of the facility and 24 cameras in the interior. The facility is contained in one building and includes male and female exercise rooms, day rooms, a dining room, a classroom, a computer lab, separate laundry rooms for male and female residents and administrative offices. A recreation area in front of the building has a canopy for females and one for males, both havng picnic tables and a basketball hoop. The area is well lit at night and residents are allowed to access the area until 9 p.m. curfew.

The Mission Statement of Mid Valley House is as follows: "Mid Valley House is committed to assist all residents transition back into the community. We will provide quality residential treatment and educational services to those entrusted to our care while working in partnership with contracting agencies, community leaders and residents' families. We believe each resident must be given the greatest opportunity to change his or her life".

GEO's Mission Statement is as follows: "GEO's mission is to develop innovative public-private partnerships with government agencies around the globe that deliver high quality, cost-efficient correctional, detention, community reentry, and electronic monitoring services while providing industry leading rehabilitation and community reintegration programs to the men and women entrusted to GEO's care".

SUMMARY OF AUDIT FINDINGS

The following is a summary of the audit findings:

Number of standards exceeded: 5

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2 is a written plan mandating zero tolerance towards all forms of sexual abuse and sexual harassment and outlines the agency's approach to preventing, detecting and responding to such conduct. The policy includes definitions of prohibited behaviors and sanctions for those found to partictipate in these prohibited behaviors.

GEO policy 5.1.2-A, pages 6 & 7, section III, B, 1-3 and facility policy 2014-1, pages 2 & 3, section VI, A, outline the responsibilities of the PREA Coordinator and the PREA Compliance Manager. The agency also employs a Program Fidelity Manager, Reentry Services PREA Divisional Coordinator. Upon interview, the PREA Coordinator (interviewed at an earlier date), the PREA Compliance Manager and the Program Fidelity Manager, Reentry Services PREA Divisional Coordinator, all stated that they have sufficient time and authority to manage their PREA-related responsibilities.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO is a private provider and does not contract with other agencies for the confinement of residents; therefore this standard is not applicable.

Standard 115.213 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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corrective actions taken by the facility.

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 2014-1, pages 3 & 4, section B-1, the agency has developed, documented and made its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents against sexual abuse. A PREA Annual Facility Assessment is completed by the PREA Compliance Manager and the Facility Director and forwarded to the agency's PREA Coordinator and the Corporate Divisional Vice President for review and approval. The last annual assessment was completed on 9/30/14. That assessment noted that there were no deviations from the staffing plan during the past year and there were no recommendations for any changes to the established staffing plan. The assessment noted recommendations for the installation of three security corner dome mirrors for increased visibility and security. In the past 12 months, there have been no deviations to the established staffing plan as confirmed by interview with the Facility Director.

For increased efforts for supervision and monitoring, the facility has in place a count verification procedure to monitor surveillance tapes on a weekly basis to ensure staff are conducting formal resident counts. These verifications are documented on a "Resident Count Verification Checklist". In addition, facility management staff and mid-level supervisors conduct and document unannounced PREA rounds within their respective areas to identify and deter employee sexual abuse and sexual harassment. This practice was confirmed by interview of residents and staff who all reported numerous rounds being conducted on a daily basis.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 15 & 16, section I, 1-10 and facility policy 2014-4, pages 2 & 3, section VI, address resident pat searches, strip searches, body cavity searches and the limits to cross-gender viewing and searches. All staff receive training in pre-service and in annual in-service training on how to conduct searches, including searches of transgender and intersex residents. This information is also reviewed at monthly staff meetings. The facility staff do not conduct cross gender pat down searches, strip searches or visual body cavity searches. A staff member of the same gender conduct pat searches and these searches are documented on a pat search log.

The agency has policies and procedures in place that enable residents to shower, perform bodily functions and change clothing without staff viewing their breasts, buttocks or genitalia. Staff of the opposite gender announce themselves when they enter the housing units and signs on each housing unit door reminds them of this practice. Residents interviewed confirmed that this practice is being adhered to and indicated that they feel they have privacy to toilet, shower and change clothing when staff of the opposite sex are in their housing unit.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency takes appropriate steps to ensure that residents with disabilities and residents that are limited English proficient have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and harassment. GEO policy 5.1.2-A, page 10, section E and facility policy 2014-2, pages 1 & 2, section V, were used to verify compliance to this standard. The" PREA Education Manual for Residents" is available in both English and Spanish and is also available in large print in both languages for residents with visual impairments. PREA posters, a GEO PREA brochure and all PREA educational materials are provided in both English and Spanish. A Language Line Service is available for the translation of any other languages. A TTY is available for hearing impaired residents. At the time of the audit there were no residents with hearing or visual impairments. Two Spanish speaking residents interviewed reported that they received all PREA information in Spanish and they were knowledgeable about methods of reporting sexual abuse and sexual harassment. The agency does not use residents as interpreters, readers or other types of resident assistants.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In review of policy 5.1.2-A, pages 7 & 8, section C-2, and page 15, section H-4, the facility is prohibited from hiring or promoting anyone who may have contact with residents who has engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in a confinement setting or the community. Criminal background checks are conducted for all potential employees through a contract with Accurate Background, Inc. as well as BOP clearance for all staff both through NCIC and the Civilian Application System. The agency also performs criminal background checks on any contractors and volunteers who have contact with residents. Mid Valley House does not have contractors. For consideration for promotions, employees complete a "PREA Disclosure and Authorization Form Promotions – PREA Related Positions" and another background check by Accurate Background Inc. is completed. At the time of application, annual performance evaluations and promotions, employees complete a "PREA Disclosure and Authorization Form Annual Performance Evaluation" form. Background checks for all employees and volunteers are completed every five years when the BOP contract is renewed. All current employees had a background check in July 2014.

In interview with the Office Support Specialist who is responsible for HR duties, criminal background checks are completed on all applicants and volunteers. If an applicant/volunteer answers that he/she has worked in a confinement facility previously, the prior institution is contacted to obtain information on substantiated allegations of sexual abuse. Records of four employees and one volunteer hired in the past 12 months a of five employees employed for five years or longer were reviewed with the Office Support Specialist. All records were complete and verified background checks completed as required, as well as drivers license checks every two years.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, page 8, section C, 3 and facility policy 2014-1, page 4, section B, 3, state that the facility takes into consideration the effect that any new design, acquisition, expansion or modificatioins of the physical plant or monitoring technology might have on the facility's ability to protect residents from sexual abuse. Mid Valley House's previous location was closed and the current location was occupied on 7/1/14. A total of 33 cameras were installed and renovations were made to the existing building with consideration given to the security and protection of residents from sexual abuse. The camera monitors were reviewed by the auditor with the Chief of Security. There are three cameras on the front exterior of the building. One camera was able to view the male canopy, but there was no camera view of the female canopy. A recommendation was made to consider camera coverage to that area. By the conclusion of the audit, the angle of one of the exterior cameras was changed to capture a view of the female canopy.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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According to GEO policy 5.1.2-E, pages 6–10, section D-J, and facility policy 2014-6, page 7, section C-3 and section 5–f & h, the facility follows a uniform evidence protocol for the collection and preservation of evidence for administrative and criminal investigations of sexual abuse. It is the responsibility of the Edinburg Police Department to conduct all criminal investigations and to ensure that all evidence is collected and preserved according to evidence protocols established by the Department of Justice.

Forensic examinations are not performed at this facility. The McAllen Regional Medical Center and the Mission Regional Medical Center provides for SANE examinations at no cost to the resident. In the past 12 months, there have been no residents that required SANE exams.

The facility has MOU's with Mujeres Unidas located in McAllen, TX and the Rape Crisis Center, Odessa, TX to provide emotional support for victims of sexual abuse. Recently contact was made with the Rio Grande Empowerment Zone of McAllen, TX in an effort to secure an MOU with that agency. A meeting is scheduled for early next week with the Facility Director and the Assistant Director/PREA Compliance Manager and staff from that agency to discuss services they may be able to provide to the facility.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-E, page 4, section III, A and facility policy 2014-6, page 7, section C, 2 & 3, outline the agency's policy and procedure for investigating and documenting incidents of sexual abuse. The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment including resident-on-resident sexual abuse or staff sexual misconduct. All allegations of sexual abuse are referred to the agency's Office of Professional Responsibility (OPR) and the BOP. The Edinburg Police

Department is responsible for conducting criminal investigations per an MOU with the facility. The agency's policy regarding referral of allegations for sexual abuse and sexual harassment for criminal investigations is available on the GEO website. In the past 12 months, there were two allegations of sexual abuse that were investigated administratively. There were no allegations referred to the Edinburg Police Department for criminal investigation.

Standard 115.231 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO employees receive training on the agency's zero tolerance policy for sexual abuse and sexual harassment at pre-service and annually at in-service training. Employees sign a "PREA Basic Training Acknowledgement" form stating that they have received and understood the training they received. Ten employee training records reviewed showed this documentation is being maintained by the facility. GEO policy 5.1.2-A, pages 11 & 12, section F-1, addresses the agency's training requirements. The PREA training program was reviewed and found to be very comprehensive and meets all the elements of 115.231(a) of this standard. The Facility Director, the Assistant Director/PREA Compliance Manager and occasionally the Facility Director of Reality House, another GEO reentry facility located in Brownsville, TX, provide the staff PREA training. Additionally, PREA discussions are held and ongoing training occurs during monthly staff meetings. In interview with staff, they were able to confirm receiving this training and knew their responsibilities for preventing, detecting and responding to allegations of sexual abuse. In review of the training records for ten staff and one volunteer, it was confirmed that staff acknowledge receiving and understanding this training and that this documentation is maintained in their training files.

Standard 115.232 Volunteer and contractor training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2.A, page 13, section G and page 14, section H, outline the training requirements for volunteers and contractors. The objective of the training ensures that volunteers and contractors are notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and are informed of how to report such incidents. The facility does not have contractors. There is one active volunteer who received PREA training on 1/15/15 and a signed a "PREA Basic Training Acknowledgement" form stating she received and understood the training. This acknowledgement was found in her file. When interviewed, the volunteer confirmed she received this training and understood her responsibilities under the agency's sexual abuse and sexual harassment policy.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, page 11, section E-2 and facility policy 2014-2, page 4, were used to verify compliance to this standard. Incoming residents, during the intake process, are provided with educational information explaining the zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents of sexual abuse and sexual harassment. They receive a "PREA Education Manual for Residents"and a GEO PREA brochure. All residents view a PREA video which is shown once a week in the dining room for new residents. Residents sign an acknowledgement of receiving the manual and other required training. All information is provided in both English and Spanish. Weekly Town Hall Meetings are held and where PREA topics are discussed. Random review of ten residents' files showed this documentation is maintained in their file. When interviewed, residents acknowledged receiving the PREA training information and were knowledgeable of the agency's zero-tolerance policy and how to report incidents of sexual abuse and sexual harassment.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Based on GEO policy 5.1.2-A, page 13, section F-3, the facility's investigators receive specialized training in addition to the general education provided to all staff. The agency's PREA Coordinator provides a four-hour webinar specialized training for investigators. There are 30 investigators throughout the division. At Mid Valley House there are three trained investigators who received their training on 10/21/14. They are the Assistant Director/PREA Compliance Manager, the Chief of Security and the Case Manager Supervisor. The facility mantains documentation that the investigators have received this training. Upon interview of the investigators, they all confirmed receiving this training and were all knowledgeable of their responsibilities in conducting sexual abuse investigations.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Mid Valley House has no medical or mental staff on site. Off site providers are used for medical and mental services; therefore this standard is not applicable.

Standard 115.241 Screening for risk of victimization and abusiveness

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

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Based on GEO policy 5.1.2-A, pages 8 & 9, section D-1 and pages 2 & 3, section VI, B-1, the agency requires that residents be screened upon admission for risk of sexual abuse victimation or sexual abusiveness toward other residents. A "PREA Risk Assessment" form is used to screen residents upon admission and was found to contain all requirements of this standard. Residents may not be disciplined for refusing to answer any questions or for not disclosing complete information. In addition to the screening form, a thorough review of any available records which can assist in determining risk assessment is required. Within 30 days of arrival, a "PREA Vulnerablity Reassessment Questionnaire" is completed to reassess the risk of victimization or abusiveness of all residents and reassessments are warranted due to a referral, request, incident of sexual abuse or receipt of additional information. The Case Manager Supervisor is responsible for initial and 30-day reassessment screenings. Review of 10 residents' files confirmed that screening upon intake and reassessments within 30 days of arrival are being completed timely and per policy. In interview with the Case Manager Supervisor, she was able to explain her responsibilities and how she tracks the timeframes for the 30-day reassessments to ensure compliance. The facility's efforts for compliance to this standard is outstanding with documentation, including referral information, maintained in a binder by month of residents' arrival to the facility. This information is securely maintained in a locked room with access to the room allowed by only the Facility Director and the Assistant Director/PREA Compliance Manager to ensure confidentiality.

Standard 115.242 Use of screening information

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

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The agency uses the information from the risk screening form to make housing, bed, work and program assignments wih the goal of separating residents at high risk of being sexually victimized from residents at high risk of being sexually abusive. Upon interview with the Facility Director, he explained how the facility utilizes the information from the "PREA Risk Assessment". Male residents identified to be at risk for vicitimization or abusiveness are housed in Dorm 2 in the bunks in the front of the dorm closests to the door and females are housed in Dorm 1 closest to the door to ensure their visability during housing rounds.

Guidelines on housing and program assignments and for the management of transgender and intersex residents are outlined in GEO policy 5.1.2-A, page 10, section D, 3 and in facility policy 2014-3, page 3, section 2. The agency does not place LGBTI residents in housing units soley based on their sexual orientation. In the past 12 months, there have no self disclosed transgender or intersex residents housed at the facility. If there were, they would be given the opportunity to shower separately from other residents.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 17, section K-1 and facility policy 2014-2, page 4, las t paragraph and page 5, section VI, outline the procedure for resident reporting methods. The agency provides multiple ways for residents to privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse and sexual harassment. Residents are made aware that they can inform a staff member immediately, contact the facility PREA Compliance Manager, put their allegation in writing, or call one of three crisis hotline numbers. Those numbers access the RAINN National Hotline Network (1-800-656-4673), the Crisis Center in Odessa, TX (432-333-2527), or Mujeres Unidas, McAllen, TX (1-800-580-4879). Calling any of those toll-free numbers allows the residents to remain anonymous upon request. All three crisis hotline numbers were called in one of the housing units and found to be accessible to residents. Residents can also call the BOP Residential Reentry Management Branch to report an allegation of abuse. Information on resident reporting options are posted throughout the facility at various locations in both English and Spanish. The "PREA Educational Manual for Residents", that each resident receives upon arrival, provides the residents with methods of reporting available to them. Staff have access to private reporting by calling the Employee Hotline at (866-568-5425) or the Corporate PREA Director at (561-999-5827). Information for resident and staff reporting is available on the GEO website. The agency's policy mandates that staff accept all reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Resident and staff interviewed were well versed in the methods of reporting available to them.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In review of GEO policy 5.1.2-A, pages 17 & 18, section K, 2 and facility policy 2014-5, pages 3-5, there is a procedure in place for residents to submit grievances regarding sexual abuse and the agency has procedures for dealing with these grievances. Instructions on how to file grievances are provided in the "PREA Education Manual for Residents". There is no time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. Grievances may also be submitted by third parties on behalf of a resident. Emergency grievances may be filed if the resident feels he is at substantial risk of imminent sexual abuse. The Assistant Director/PREA Compliance Manager receives all copies of grievances related to sexual abuse and sexual harassment for monitoring purposes. In the past 12 months, there have been no grievances filed related to sexual abuse or sexual harassment.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As stated in GEO policy 5.1.2-A, page 23, section N-8 and facility policy 2014-6, page 11, section H-6, residents are provided with access to outside victim advocates for emotional support. MOU's with The Crisis Center, Odessa, TX and Mujeres Unidas and McAllen, TX provides residents with access to confidential support services. Residents are given mailing addresses and telephone numbers and the facility informs residents prior to giving them access of the extent to which such communications will be monitored. Instructions on how to access these agencies are provided to residents in the "PREA Education Manual for Residents" and on posters displayed throughout the facility. When interviewed, residents were knowledgeable about the outside confidential support services available to them.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 18, section K-3 and facility policy 2014-2, page 4, last paragraph under section entitiled "Documentation", the agency has a method to receive third party reports of sexual abuse and sexual harassment. Family members or other individuals may report verbally or in writing any time they have knowledge or suspect a resident has been sexually abused, sexually harassed or requires protection. Outside parties can reports verbally or in writing to the unit administration. Information for third party reporting can be found on the GEO website at www.geogroup.com. Residents interviewed were aware of this method of reporting.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As outlined in GEO policy 5.1.2-A, pages 13 & 14, section G- 2, page 14, section H-2 and pages 18 & 19, section K-4, and facilty policy

2014-6, pages 5 & 6, section VII, B, all staff, contractors and volunteers are to report immediately any knowledge or information regarding an incident of sexual abuse or sexual harassment. The facility does not have contractors. Any retaliation or suspected retaliation against residents or staff is also to be reported immediately. Interviews with staff and a volunteer revealed that they are very aware of their reporting responsibilies and know not to reveal any information about sexual abuse incidents to anyone other than to the extent necessary. In the past 12 months, there have been no incidents that required reporting according to the Vulnerable Persons State Statue.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

When the agency learns that a resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Policy 5.1.2-A, page 19, section L-1 and facility policy 2014-6, page 5, section VI, 2nd paragraph, outlines the agency's procedures related to its efforts to protect residents at risk for sexual abuse. In interview with the Facility Director, there were no times during the past 12 months that it was necessary for the agency to take immediate action in regards to a resident being in substantial risk of sexual abuse. Staff interviewed was aware of their responsibilities if they felt a resident was at risk for sexual abuse.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 22, section L,5 and facility policy 2014-6, pages 9 & 10, section F, there are procedures in place if an allegation is received that a resident was sexually abused while confined at another facility. The facility is required to document the allegation and the Facility Director is required to notify the Director of the facility of where the abuse is alleged to have occurred as soon as possible, but no later than 72 hours. This information is required to be shared with the PREA Compliance Manager and the PREA Coordinator who ensure that the allegation is investigated in accordance with the PREA standards. The Facility Director reported during interview that in the past 12 months there were no allegations received that a resident was abused while confined at another facility and no notifications were received from other confinement facilities of abuse occurring while a resident was confined at Mid Valley House.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In accordance with GEO policy 5.1.2-A, page 22, section L-5 and facility policy 2014-6, pages 9 & 10, section F, upon learning that a resident was sexually abused, the first security staff member to respond to the report is required to separate the alleged victim and abuser, preserve the crime scene and preserve the evidence. If the first staff responder is not a security staff member, the responder is required to request the alleged victim not take any actions that could destroy the evidence and notify security staff immediately. Security and non-security staff interviewed were knowledgeable of the policy and the practice to follow. They reported that they knew that the alleged victim and abuser must be separated and how to preserve the crime scene and the evidence. In the past 12 months, there have been no allegations that required action by first responders.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 5 & 6, section A-4 and review of the "Mid Valley House PREA Coordinated Response Plan" dated 3/13/15 were used to verify that there is a plan in place to coordinate actions to be taken in response to an incident of sexual abuse. The plan provides written guidance to staff and administration regarding actions to take and notifications to be made. Staff interviewed confirmed that they are knowledgeable of the plan and the necessary actions to be taken in reponse to an allegation of sexual abuse.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 5, section A-3 and facility policy 2014-6, page 6, section C-1-a, were used to verify compliance to this standard. In all cases of abuse by staff, contractors or volunteers the abuser will be subject to disciplinary sanctions for violating GEO policies on sexual abuse and sexual harassment. Mid Valley House does not have a collective bargaining unit. GEO would not enter into any collective bargaining agreement at any of its facilities that would limit a facility's ability to remove an alleged sexual abuser from contact with residents pending the outcome of an investigation.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section M-2 and facility policy 2014-6, page 11, section 9, state that residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations will be protected from retaliation from other residents and staff. Housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents who fear retaliation will be protection measures used as per policy. The Assistant Director/PREA Compliance Manager is responsible for weekly monitoring for retaliation. These meetings will be recorded on the "Protection from Retaliation Log". Monitoring will continue for at least 90 days and longer if needed. When interviewed, the Assistant Director/PREA Compliance Manager knew her responsibilities of this process per policy. In the past 12 months, there has been no retaliation monitoring required.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has policies governing administrative and criminal investigations of sexual abuse as outlined in agency policy 5.1.2-A, pages 4 – 6, section III, B, 1 & 2. The Assistant Director/PREA Compliance Manager, the Case Manager Supervisor and the Chief of Security are responsible for administrative investigations at the facility. When interviewed they were knowledgeable in their responsibilities in conducting administrative investigations of allegations of sexual abuse. An OPR referral form is completed and submitted to OPR and e-mail notification is made to the BOP. The Edinburg Police Department is the agency responsible for conducting criminal investigations of sexual abuse. In the past 12 months, there have been no allegations of sexual that required a criminal investigation.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

According to GEO policy 5.1.2-E, page 6, section B, 2-d, the facility shall impose no standard higher than the preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated. When the investigators interviewed were asked what standard of evidence was used in determining if an allegation is substantiated, they confirmed the agency policy.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As stated in GEO policy 5.1.2-E, pages 10 & 11, section III, K and facility policy 2014-6, pages 11 & 12, section J, indicate that proper notification be given to residents as to the outcome of an investigation of sexual abuse and sexual harassment if the outcome of the investigation proved to be substantiated, unsubstantiated or unfounded. Attachment D of policy 5.1.2-E, available in English and Spanish, would be presented to the alleged victim at the conclusion of the investigation. This form is signed by the resident nand maintained in the investigative file. For both allegations received in the past 12 months, the resident left the facility so no notification was required. Based on interview with the Facility Director and the Assisant Director/PREA Compliance Manager, this process in is place and notifications would be made as required by policy.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Staff shall be subject to disciplinary sanctions up to and including termination for violating the agency's sexual abuse policy as outlined in GEO policy 5.1.2-E, page 11, section L, and facility policy 2014-6, page 13, section M-1. All terminations and resignations for sexual misconduct shall be reported to the Edinburg Police Department. An Employee Handbook, given to all staff, explains the zero-tolerance policy. In the past 12 months, there one violation of the agency's policy related to sexual abuse or sexual harassment and the staff member resigned before the conclusion of the investigation.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 12, section 3, states that any contractor or volunteer who engages in sexual abuse or sexual harassment shall be prohibited from contact with residents and shall be reported to law enforcement agencies. In interview with the Facility Director, there have been no incidents of sexual abuse by volunteers and the facility does not have contractors. If a violation were to occur, appropriate remedial actions would be taken.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As per GEO policy 5.1.2-E, page 12, section 2 and facility policy 2014-6, page 13, section M-2, residents found guilty of engaging in sexual abuse involving other residents shall be subject to formal disciplinary sanctions. Disciplining residents for engaging in sexual activity with an employee is prohibited unless the employee did not consent to the contact. The "Resident Handbook" provided to all residents upon admission pages 12, sections 205 & 206 and page 20 section 409, clearly state offenses of sexual misconduct that residents will be disciplined for. In the past 12 months, there were no administrative or criminal findings of resident-on-resident sexual abuse that have occurred at the facility.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 23, section 7, and facility policy 2014-6, page 7, section 5-f and page 8, section 5-h. Mid Valley House does not have medical or mental health staff on site; therefore referrals are made to off site providers for all medical and mental health services. Residents are referred to the McAllen Regional Medical Center or the Mission Regional Medical Center for emergency medical services and

to Tropical Texas, Edinburg, TX or Mujeres Unidas, McAllen, TX for mental health services. These services are provided to every victim without financial cost to them. In the past 12 months, there have been no off site referrals for emergency medical or mental health services due to sexual abuse.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 23 & 24, section M-1 and facility policy 2014-6, page 8, section 4-h and page 10, section H, 1 & 2, were used to verify compliance to this standard. The facility offers medical and mental health evaluation and treatment to all residents victimized by sexual abuse. Female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. If pregnancy results from sexual abuse, victims receive timely and comprehensive information about to all lawful pregnancy-related medical services. All victims are offered tests for sexually transmitted infections. These services are provided off site by local providers. In the past 12 months, there have been no residents requiring ongoing medical and mental health care due to sexual abuse.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Per GEO policy 5.1.2-A, pages 25, section 3 and facility policy 2014-6, page 12, section K, facilities are required to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation in which the allegation has been determined to be substantiated or unsubstantiated. The incident review team at Mid Valley House includes the Facility Director, the Assistant Director/PREA Compliance Manager, the Case Manager Supervisor and the Chief of Security. A "PREA After Action Review Report" is completed and forwarded to the PREA Coordinator. The Assistant Director/PREA Compliance Manager maintains copies of all completed review forms in the corresponding investigative file. There was one staff-on-resident allegation of sexual abuse and a "PREA After Action Review Report" was completed.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility shall collect data related to sexual abuse and this data is aggregated at least annually according to GEO policy 5.1.2-A, page 25, section III, N-1 and facility policy 2014-6, page 14, section M-1. It is the responsibility of the Assistant Director/PREA Compliance Manager to compile data collected on sexual activity, sexual harassment and sexual abuse incidents and forward this information to the PREA Coordinator on a monthly basis using the "Monthly PREA Incident Tracking Log' (attachment D of policy 5.1.2-A). The agency provides data collected to the Department of Justice from the previous calendar year upon request.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 26, section III, N-2 and facility policy 2014-6, page 14, section M-2, GEO shall review all data collected in order to assess and improve the effectiveness of its sexual abuse prevention and intervention program. The PREA Coordinator prepares an annual report which includes findings and corrective actions taken for each GEO Reentry facility. The annual report includes a comparison of the current year's data and corrective action with those from prior years. The most current report is available on GEO's website (www.geogroup.com).

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Per policy 5.1.2-A, pages 25 & 26, section N-2 and facility policy 2014-6, page 14, section M-3, all data collected is securtely retained for 10 years or longer if required by state statute. Before making aggregated sexual abuse data publicly available on the GEO website, all personal identifies are removed.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Barbara Jo Denison July 16, 2015

Auditor Signature Date