PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

ADULT PRISONS & JAILS

Date of report: May 15, 2017

Auditor Information			
Auditor name: Barbara Jo Denison			
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Telephone number: 956-566-2578			
Date of facility visit: February 6-7, 2017			
Facility Information			
Facility name: Brooks County Detention Center			
Facility physical address: 901 County Road 201, Falfurrias, TX 78355			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: Click here to enter text.			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☐ Prison	☒ Jail	
Name of facility's Chief Executive Officer: Javier Aleman, Warden			
Number of staff assigned to the facility in the last 12 months: 147			
Designed facility capacity: 652			
Current population of facility: 549			
Facility security levels/inmate custody levels: Minimum - Maximum			
Age range of the population: 19-71			
Name of PREA Compliance Manager: Yvonne Garcia		**Title:** PREA Compliance Manager	
Email address: yvgarcia@geogroup.com		**Telephone number:** 361-455-3699	
Agency Information			
Name of agency: The GEO Group Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: One Park Place, Suite 700, 621 Northwest 53rd Street, Boca Raton, Florida 33487			
Mailing address: *(if different from above)* N/A			
Telephone number: 561-999-5827			
Agency Chief Executive Officer			
Name: George 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	
Email address: pmoreland@geogroup.com		**Telephone number:** 561-999-5827	

AUDIT FINDINGS

NARRATIVE

The PREA on-site audit of the Brooks County Detention Center was conducted on February 6-7, 2017, by this Department of Justice Certified PREA Auditor, Barbara Jo Denison. Pre-audit preparation included a thorough review of all policies, procedures, training curriculums, the Pre-Audit Questionnaire and supporting PREA-related documentation provided by the facility to demonstrate compliance to the PREA standards. For each standard, interviews, observations, and review of documentation provided verified that practices are consistent with agency and facility policies and practices. Questions during this review period were answered by Yvonne Garcia, PREA Compliance Manager.

On the first day of the audit, an entrance meeting was held with the following people in attendance: Javier Aleman, Warden, Yvonne Garcia, PREA Compliance Manager, Melissa Davila, Classification Supervisor, Omar Mata, Acting Chief of Security, Manuel Ruano, HSA and Rob Walling, Manager, Contract Compliance PREA. Following the meeting, Javier Aleman, Warden, Yvonne Garcia, PREA Compliance Manager, Omar Mata, Acting Chief of Security and Rob Walling, Manager, Contract Compliance PREA accompanied me on a tour of the facility. During the tour, the location of cameras and mirrors, the physical layout of the facility including shower/toilet areas, adequacy of staff supervision and placement of PREA information was observed. PREA information in both English and Spanish are available in all housing units and in numerous common areas throughout the facility.

The facility entered into a Memorandum of Understanding (MOU) with the Women's Shelter of South Texas on 9/21/16. Prior to the on-site visit, the Sexual Abuse Manager/Counselor of the Women's Shelter of South Texas was contacted to confirm and review the MOU. She shared that the agency works closely with the Doctor's Regional Hospital and SANE providers from the Driscoll Children's Hospital. When Doctor's Regional Hospital is notified of the need for a forensic examination, SANE providers are requested from Driscoll Children's Hospital. The Women's Shelter of South Texas is then contacted and they provide a victim advocate to be present during the forensic exam. The MOU also provides peer counseling and support, information and referrals, legal advocacy services and individual counseling in both English and Spanish, either at the facility or at the Shelter.

During the facility tour, the posted information to contact the Women's Shelter of South Texas (voice prompt #2) was telephoned from a detainee pay phone. A message was received which said that "the party is not accepting calls". After the tour, the Warden contacted the Women's Shelter of South Texas and after their investigation of the problem, reported that there was a problem with their answering service. Other posted reporting numbers were telephoned and found to be accessible. They included the Office of Inspector General (voice prompt #7 for USMS detainees) and voice prompt #3, an internal reporting number that alerts the Warden, the Acting Chief of Security and the PREA Compliance Manager on their phones that a call was made to that number.

The Brooks County Sheriff's Office was contacted to confirm and discuss the Mutual Assistance Agreement between the Sheriff's Office and the facility. The Commander of the department shared that if there was a sexual abuse at the Brooks County Detention Center, a deputy would be dispatched to the facility to get information and make an initial report. Depending on the outcome of the initial report, an investigator would be assigned to the case. The facility could contact the investigator for status updates

of the investigation and upon request, receive a written report of the investigation.

During the tour, it was observed that in Phase 2, D dorm, the shower area towards the rear of the restroom did not have a curtain across the large doorway entering into the shower area. Detainees undress in the shower area and hang their clothes on the wall opposite of the showers. When entering the dorm for the tour, one detainee was observed hanging his clothes and entering the shower unclothed in full view from the entrance of the dorm. It was recommended that a shower curtain be added to ensure privacy. Also, noted in Phase 2, D dorm was the need for privacy in front of the toilets. There is a metal grate in front of the toilets, but the grates did not obstruct vision to this area. It was recommended that a barrier of some sort be installed to the inside of the grates for added privacy. Before the end of the audit visit, shower curtains were added to the entrance of the shower doorway and a vinyl barrier installed on the inside of the metal grates in front of the toilet area. Restrooms in all other living areas were found to afford detainees privacy when showering, toileting and changing clothing.

While touring the kitchen, a blind spot was noticed in the far-right hand corner of the room. A camera that is opposite and to the left of that corner was viewed from the monitor located in the office and found not to capture that area. It was recommended that an adjustment to that camera may be able to include this area and installing a mirror on the opposite wall could increase visibility to that area. Another blind spot in the oven/mixer area was noted. A recommendation was made for a corner mirror be installed in this area. On the second day of the audit, both mirrors were added in the kitchen area as recommended and the camera adjusted which enabled a clear view of the area.

The population on the first day of the audit totaled 549. This number included 470 ICE detainees, 386 United States Marshal Service (USMS) detainees, 148 county detainees and 7 Bureau of Prison (BOP) detainees. A random selection of 34 detainees, one from every housing unit, were formally interviewed. This number included four detainees identified from initial screening to be potential victims, three detainees identified from initial screening as potential predators, two detainees who self-disclosed at initial screening being lesbian and twelve detainees who were Spanish speaking only. At the time of the audit visit, there were no detainees who were blind, had low vision, deaf, hard of hearing and none that had cognitive or other disabilities. There were no detainees who self-disclosed being transgender or intersex housed at the facility at the time of the audit visit. A large portion of the detainee population is Spanish speaking only; all other detainees were proficient in the English language. The Classification Supervisor provided translation during interviews for Spanish-speaking detainees.

During detainee interviews, several detainees reported that they had not viewed the *PREA: What You Need to Know* video and several reported not receiving the *Detainee Handbook.* In review of detainee files, documentation showed that by detainee signatures on required forms, they had received the handbook and had viewed the video. In discussion with facility staff, it was discovered that these forms were being signed at intake before the detainee receives the handbook or views the video. Due to the detainee interviews and the information obtained from detainee files and discussion with facility staff, the facility did not meet all subsections of standard 115.33, *Inmate Education*, necessitating the requirement of a corrective action to bring this standard into compliance. (See the narrative on standard 115.33 for details)

There were 25 staff members formally interviewed that included 10 specialized staff and 15 security

staff. Security staff included supervisors and line staff from each of the two security shifts. Also interviewed were three medical contractors and one volunteer, who was interviewed by telephone. All interviewed were knowledgeable of their responsibilities of detecting, preventing, responding and reporting allegations of sexual abuse and sexual harassment. They confirmed receiving PREA refresher training annually and shared that PREA is discussed during shift briefings and staff meetings.

The personnel files of 20 employees and 4 contractors were reviewed with the Human Resource Manager to determine compliance with required background checks. Documentation was found to be complete with background checks performed prior to employment as well as annually. The same 20 employee files were reviewed to determine compliance to training mandates. Records reviewed showed annual PREA training completed and documentation of this training is being maintained by the facility.

In the 12 months preceding the audit, the facility received 11 PREA allegations which were investigated, in addition to one allegation that was received in December 2016. The following is a breakdown of those allegations:

Number Received	**Description of Compliant**	**Investigative Results**
3	Detainee-on-Detainee Sexual Abuse	2 - Unfounded 1 – Ongoing
4	Detainee-on-Detainee Sexual Harassment	2 – Unsubstantiated 2 - Ongoing
4	Staff-on-Detainee Sexual Harassment	4 – Ongoing
1	Staff Voyeurism	1 - Substantiated

Investigative files were reviewed with the PREA Compliance Manager, with Rob Walling, Manager, Contract Compliance PREA present. The majority of the allegations were opened and ongoing when we began review of the files. Several that were ongoing required only minimal attention to conclude the investigation. Mr. Walling reviewed the open investigations with the facility investigators and by the conclusion of the audit; five of the open investigations were closed. It was highly recommended to the facility that they make investigations a priority as the timeliness and completion of investigations is very important.

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with Javier Aleman, Warden, Gary Gomez, Central Region Director of Operations, Omar Mata, Acting Chief of Security, Melissa Davila, Classification Supervisor and Rob Walling, Manager, Contract Compliance PREA in attendance. During the exit meeting, the facility was informed of the process that would follow the on-site visit including corrective action for standard 115.33. The team was thanked for their cooperation prior to the audit and during the on-site visit. They were complimented on the PREA

program they have developed and on their willingness to achieve PREA compliance as a team. It was evident that all staff take the PREA program very seriously and understand the importance of the program for the safety of the detainees and for themselves.

Following the on-site audit, the facility entered into a 60-day corrective action period to work towards compliance of standard 115.33. During the corrective action period, the facility staff and the PREA Coordinator worked together on a plan of action. See the narrative for standard 115.33 for details of the corrective action plan and its implementation and completion.

DESCRIPTION OF FACILITY CHARACTERISTICS

Brooks County Detention Center was constructed in 2001 by LCS Corrections. In February 2015, the GEO Group, Inc. gained ownership of the facility. The GEO Group began operations and oversight of inmates on February 15, 2015.

The facility sits on 40 acres one mile north of Falfurrias, Texas in Brooks County and is connected via a sally port with the Brooks County Sheriff's Office and Jail. The facility is surrounding by a 14-foot double perimeter fence equipped with nine rolls of razor wire, microwave detection and shaker system. Motion sensors are in the attic spaces, pipe chase and building tops.

The facility has six buildings, four that house inmates and two support buildings. The food service department is within the secure perimeter of the facility in one of the support buildings and feeds both satellite trays and a cafeteria-dining hall. The other support building houses the maintenance department outside of the secure fencing.

Each housing building has a control center that operates the doors and all life safety functions of the building. All housing units have an intercom system that is answered by security staff in the control center. At the beginning of each shift an opposite gender announcement is made and notices on the doors of the housing units reminds staff to make the opposite gender announcements. PREA information is available in all housing units color coded by client. The facility has ten counts in a 24-hour period. Security staff make rounds at a minimum of once per hour in the larger dorms and every 30 minutes in the Restricted Housing Units. The Acting Chief of Security makes unannounced PREA rounds at a minimum of once each week. The facility has 111 cameras to enhance staff supervision.

Building one houses 224 inmates and contains the administrative offices, inmate visitation, transportation, intake, classification and commissary. Building two houses 192 inmates in four 48-man dorms. Building three houses 128 inmates in 12 eight-man dorms and 32 single cells. Building four houses 108 inmates in 2 48-man dorms, 10 single cells and 2 medical cells and the building contains the medical and laundry departments. Housing areas are referred to as Phase 1 thru Phase IV.

General housing recreates in any of the four recreation yards, two of which are covered recreation areas. Restricted housing inmates recreate in individual outdoor recreation cells. Medical services are contracted through Correct Care Solutions (CCS) and commissary services are contracted through Brothers Commissary.

The facility has 146 employees, with 22 staff vacancies. There are 15 CCS employees and one contracted commissary staff. Five volunteers provide religious services to detainees.

Brooks County Detention Center's Mission Statement:

> "It is the mission of the GEO Group, Inc. Brooks County Detention Center to strive to provide a controlled correctional environment in a professional manner so as to protect the safety of the general public, the surrounding community, the staff and the offender population. Safety is an integral part of every operation at BCDC and all employees and

offenders are responsible for adhering to proper safety procedures at all times. Each offender is provided basic services relating to adequate e food, clothing, healthcare and shelter.

BCDC strives to provide an environment that enables positive behavioral change through religious opportunities to allow offenders to become successful citizens upon release and to enhance the ability of the offenders to live lawfully in the community. All of this is accomplished through an assortment of assessment, diagnostic, work, self-help, discipline, medical health and social; programs."

GEO's Mission Statement:

"GEO's mission is to develop innovative public-private partnerships with government agencies around the globe that deliver 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 initial on-site audit of the Brooks County Detention Facility revealed that the facility was not compliant with standard 115.33 and the facility entered into a corrective action period for 60 days. An interim report was submitted to the PREA Coordinator on March 7, 2017. The facility completed their corrective action measures at the conclusion of the corrective action period and provided documentation for my review. Upon my review of the documentation provided, the facility was found compliant with standard 115.33. The following is a summary of the audit findings:

Number of standards exceeded: 6

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A 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 participate in these prohibited behaviors (pages 3-5, section II-B). Brooks County Detention Center's policy 1300.05 is the facility policy that outlines the facility's approach to the prevention of sexual abuse of detainees. The policy also includes definitions of prohibited behaviors on pages 3-5, section II-B. GEO's policy 5.1.2-A and the Brooks County Detention Center's policy 1300.05 both are comprehensive and provide a thorough description of the agency's approach to reduce and prevent sexual abuse and sexual harassment of detainees, exceeding in the requirement of this standard.

GEO policy 5.1.2-A, pages 6 & 7, section III-B, 1-3, and facility policy 1300.05, pages 6 & 7, section IV-B outline the responsibilities of the PREA Coordinator and the PREA Compliance Manager. The agency employs an upper-level agency-wide PREA Coordinator and a facility PREA Compliance Manager as required by this standard. In interview with the PREA Coordinator and the PREA Compliance Manager, they both stated they have sufficient time and authority to manage their PREA-related responsibilities.

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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 detainees; therefore, this standard is not applicable.

Standard 115.13 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 7, section C-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 detainees against sexual abuse. The agency took into consideration the physical layout of the facility, the composition of the population and the prevalence of substantiated incidents of sexual abuse and the resources the facility has available to ensure adequate staffing levels in the development of the facility's staffing plan. Per the Texas Commission on Jail Standards, a 48:1 staff/detainee ratio is required at all times. Officer vacancies are filled with use of overtime.

A *PREA Annual Facility Assessment* is completed by the PREA Compliance Manager, along with other administrative team members, and forwarded to the PREA Coordinator and the Corporate Divisional Vice President for review and signature. The *PREA Annual Facility Assessment* completed on 10/13/16 noted no deviations from the staffing plan and no recommendations for any changes to the current staffing levels. In interview with the Warden, he stated that in the past 12 months, there have been no deviations to the staffing plan. The Shift Lieutenant develops staffing rosters and the roster is finalized by the shift supervisor and forwarded to the Warden for review.

GEO policy 5.1.2-A, page 7, section C-1-f & g, and facility policy 1300.05, page 7, section C-1-e & f, state that high level supervisors will conduct and document unannounced rounds to deter employee sexual abuse and sexual harassment. These rounds are to be completed on all three shifts and documented on the *PREA Unannounced Round Questionnaire*. While making rounds, department heads and Shift Supervisors are required to observe for cross-gender viewing, gender announcements, staff-detainee communication and ensuring that PREA signs are posted in housing areas and holding rooms. The facility prohibits staff from alerting other staff of the conduct of such rounds.

Documentation provided for review prior to the on-site audit and during the facility tour and in interview with staff and detainees, the practice of rounds by facility management staff and Shift Supervisors confirmed numerous rounds being conducted on all three shifts.

Standard 115.14 Youthful inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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 Brooks County Detention Center does not house youthful detainees; therefore, this standard in not applicable.

Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on review of GEO policy 5.1.2-A, pages 15 & 16, section I and facility policy 1300.05, pages 18 & 19, section I, cross gender strip searches and cross-gender visual body cavity searches are prohibited except in exigent circumstances. Facility policy prohibits cross-gender pat-down searches of female detainees, except in exigent circumstances.

The facility does not restrict female detainees access to regularly available programming or other outside opportunities in order to comply with this provision. The facility will document and justify all cross-gender strip searches and cross-gender visual body cavity searches of detainees. All searches are documented on *Brooks County Detention Center Strip Search Log.*

Staff is not allowed to physically examine a transgender of intersex detainee solely to determine their genital status. These searches are to be performed by a medical practitioner. In the past 12 months, there were no exigent circumstances requiring cross-gender strip searches or cross-gender visual body cavity searches be performed. In addition to general training provided to all employees, security staff receives training on how to conduct cross-gender pat-down searches and searches of transgender and intersex detainees. GEO's training curriculum, *Guidance in Cross-Gender and Transgender Pat Searches* was provided for review.

Staff signs a *Training Attendance Record – Pat Searches* and a *Cross Gender Pat Searches & Searches of Transgender and Intersex* acknowledgement form upon completion of this training and completion of this training is recorded electronically on the individuals training record. Receipt of this training was verified through review of staff training records and confirmed by staff interviews of security staff who verified receiving this training.

The agency has policies and procedures in place that enable detainees to shower, perform bodily functions and change clothing without staff of the opposite gender viewing their breast, buttocks or genitalia. Staff of the opposite gender announce their presence when reporting to duty or when entering a housing unit or any areas where detainees are likely to be showering, preforming bodily functions or changing clothes. Opposite gender announcements made when opposite gender staff report to duty in a housing unit are documented on the *Housing Unit Daily Shift Activity Log.* Staff are reminded to make opposite gender announcements by signs on the entry of all housing areas.

The practice of opposite gender staff announcing their presence when they entered the housing units was observed while touring the facility and detainees interviewed confirmed this practice. Detainees shared that they feel they have privacy when they shower, toilet and change clothing when staff of the opposite gender are in their housing unit.

Standard 115.16 Inmates with disabilities and inmates who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency takes appropriate steps to ensure that detainees with disabilities and detainees that are limited English proficient, as well as those who are deaf, hard of hearing, blind, have low vision, limited reading skills or cognitive disabilities, have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. GEO's policy 5.1.2-A, pages 10 & 11, section E and facility policy 1300.05, pages 12 & 13, section E address the agency/facility responsibilities to provide PREA education to detainees ensuring their understanding of the education they receive.

Detainees receive an *Offender Handbook* and a *Sexual Assault Awareness Program* pamphlet available in both English and Spanish. All PREA posters are displayed in both languages. Staff members who are proficient in both the English and Spanish language are available to provide interpretation for Spanish-speaking detainees. A contract with Language Line Services, Inc. provides translation of any other languages. The *PREA: What You Need to Know* video is shown in both English and Spanish The facility has a TTY available for deaf detainees.

The agency prohibits the use of detainee interpreters, detainee readers, or other types of detainee assistants except in limited circumstances. According to documentation provided and interviews with security staff, in the past 12 months, there have been no instances where detainees were used for this purpose.

Standard 115.17 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, pages 7 & 8, section C-2, facility policy 1300.05, pages 8 & 9, section 2, interview with the Human Resources Generalist and random review of employee files were used to verify compliance to this standard.

GEO and the Brooks County Detention Center do not hire or promote anyone who may have contact with detainees and does not enlist the services of any contractor or volunteer who may have contact with detainees who has engaged in sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility or other institution who has been convicted of engaging or attempting to engage in sexual activity in confinement settings or in the

community. GEO also considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with detainees. All applicants receive a background check by Aurico and an NCIC background check through the Brooks County Sheriff's Department Criminal background checks are performed by Aurico effective 1/30/17. Prior to that date, a contract with Accurate Background, Inc. performed criminal background checks.

The agency requires that all applicants and employees who may have contact with detainees have a criminal background check and every five years thereafter. In the past 12 months, there were 59 employee criminal background checks performed and 15 criminal background checks of contractors. For consideration for promotions or transfers, employees complete a *PREA Disclosure and Authorization Form Promotions-PREA Related Positions* and a criminal background check by Aurico and NCIC is completed. At the time of annual evaluations, employees complete a *PREA Disclosure and Authorization Form-Annual Performance Evaluation*. All employees, contractors and volunteers receive annual NCIC criminal background checks including motor vehicle checks through the Brooks County Sheriff's Department.

Agency policy mandates that material omissions regarding sexual misconduct and the provision of materially giving false information are grounds for termination as required by this standard. Employees have a continuing affirmative duty to disclose any sexual misconduct.

GEO will provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied for work. In the past 12 months, the facility has not received any request from institutional employers requesting information on substantiated allegations of sexual abuse or sexual harassment involving a former employee.

Employee, volunteer and contractor personnel files were randomly reviewed and found to be well organized and complete with background checks completed on all new employees and those considered for promotions and annually. The facility does not only perform criminal background checks every five years, but annually exceeding in the requirements of this standard.

Standard 115.18 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 8, section C-3 and facility policy 1300.05, page 9, section C-3, state that the facility takes into consideration the effect that any new design, acquisition, expansion or modifications of the physical plant or monitoring technology might have on the facility's ability to protect individuals in a GEO facility or program from sexual abuse.

The Brooks County Detention Center has not acquired any new facility or had any substantial expansion or modification of the existing facility since August 20, 2012.

When installing or updating video monitoring systems, electronic surveillance systems or other monitoring

technology, the agency considers how such technology may enhance the agency's ability to protect inmates from sexual abuse. Brooks County Detention Center is slated to have 10 additional cameras installed and eight cameras replaced in 2017.

Standard 115.21 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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According to GEO policy 5.1.2-E, pages 6 -10, sections III-D-J and facility policy 1300.05, pages 28 & 29, section 10, the facility follows a uniform evidence protocol for the collection and preservation of evidence for administrative and criminal investigations of sexual abuse. Subsection 115.21 (b) is not applicable to this facility as the facility does not house youth.

Forensic exams are not performed at the facility. Through a written agreement with Doctor's Regional Hospital, Corpus Christi, TX victims of sexual abuse are referred for SANE exams at no cost to the inmate. In the past 12 months, there have been no inmates that required SANE exams.

The facility has an MOU with The Women's Shelter of South Texas. The terms of the MOU provides detainees with emotional support services and the agency will coordinate all services needed by the detainee victim, at no cost to them. Detainees are informed that they can contact The South Texas Women's Shelter by accessing voice prompt #2 on a detainee pay telephone or send a letter to at 813 Buford St., Corpus Christi, TX 78355.

Standard 115.22 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, page 4, section III, A-1 and facility policy 1300.05, page 5, section IV-A-2, outline the agency's policy and procedure for investigating and documenting incidents of sexual abuse. The Brooks County Detention Center ensures that all allegations of sexual abuse or sexual harassment are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. A *Monthly PREA Incident Tracking Log* is used to track all incidents that occur at the facility.

The facility has four trained facility investigators who are responsible for conducting administrative investigations. The Brooks County Sheriff's Department is responsible for criminal investigations of sexual abuse per a Mutual Assistance Agreement entered into on January 3, 2016 between the Brooks County Detention Center and the Brooks County Sheriff's Department.

During the past 12 months, there were eleven allegations of sexual abuse/sexual harassment reported that were administratively investigated. One allegation was referred to the Brooks County Sheriff's Department for criminal investigation and returned to the facility for administrative investigation.

The agency's policy regarding referral of allegations of sexual abuse and sexual harassment is available on the GEO website (www.geogroup.com).

Standard 115.31 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO employees receive training on the agency's zero-tolerance policy for sexual abuse and sexual harassment at pre-service and annually as part of in-service training. GEO policy 5.1.2-A, pages 11 & 12, section F-1 and facility policy 1300.05, pages 13 & 14, section F-1, address the agency's training requirements. All employees, contractors and volunteers receive annual PREA refresher training.

The training curriculum was reviewed and found to contain all of the requirements of 115.31 (a)-1 of this standard. In the past 12 months, 147 employees have received PREA training. Upon completion of this training, employees, contractors and volunteers sign a *PREA Basic Training Acknowledgement* form and records of completion are maintained electronically.

In addition to general PREA training, all staff receive training on the Limits of Cross Gender Searches and sign a *Cross Gender Pat Searches & Searches of Transgender and Intersex*. Some of the training is classroom training provided by the Training Director, in addition to online training.

In review of the employee training records, it was confirmed that staff are receiving the mandated training and acknowledging receiving and understanding the training by their signature on the *PREA Basic Training Acknowledgement* form as well as documentation of this training in the employee's electronic training record. Between trainings, the employees are provided with information about current policies regarding sexual abuse and sexual harassment during shift briefings and staff meetings.

All staff interviewed acknowledged receiving PREA training and were knowledgeable of the zero tolerance policy and of their responsibilities related to the prevention, detection, response and reporting of sexual abuse and sexual harassment. They acknowledged receiving training on cross-gender pat searches that included searches of transgender and intersex detainees and were able to respond appropriately to questions asked of them. The facility

is doing an excellent job of training all staff as evident in response to interview questions and in the review of random employee training records.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All volunteers and contractors who have contact with detainees are trained and have annual refreshers on their responsibilities regarding sexual abuse/harassment prevention, detection and response as outlined in GEO policy 5.1.2-A, page 13, section G-1 for volunteers and page 14, section H for contractors and in facility policy 1300.05, page 15, section G-1 for volunteers and page 16, section H-1 for contractors.

The PREA training for volunteers is part of an *8-hour Volunteer Orientation Academy* that is provided by the Warden. Volunteers sign a *PREA Basic Training Acknowledgement* form and sign an acknowledgement of completion of the entire volunteer training and a separate acknowledgement for the PREA portion of the training. The Administrative Secretary maintains the volunteer records. Medical contractors receive CCS training as well as GEO training.

In the past 12 months, five volunteers, one contracted commissary worker and fourteen medical contractors have received PREA training. In interview with three contractors and one volunteer by telephone, they confirmed receiving the training and were knowledgeable of the agency/facility's zero-tolerance policy and their PREA-related responsibilities.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 11, section E-2 and facility policy 1300.05, pages 13 & 14, section B, outline the agency/facility's requirements of detainee education. Incoming detainees receive information explaining GEO's and Brooks County Detention Center's zero-tolerance policies regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

During the intake process, the classification staff provides all detainees with a *Detainee Handbook* and a *Sexual Assault and Awareness* brochure. Pages 15-17 of the *Detainee Handbook* contains information on the facility's zero tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, and their right to be free from sexual abuse, sexual harassment and retaliation for reporting such incidents. Detainees initial an *Offender Handbook Receipt* acknowledging receiving the *Detainee Handbook.* The *PREA: What You Need to Know* video is shown during intake in both English and Spanish.

During the intake process, detainees are given the *Detainee Handbook* and view the *PREA: What You Need to Know* video. Information provided is in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled as well as to detainees who have limited reading skills. Detainees sign a *Comprehensive PREA Education* form acknowledging receiving the information and viewing the video. Posters, in both English and Spanish, are prominently displayed in various locations throughout the facility, including in every housing area, providing continuous PREA information for detainees.

During detainee interviews, several detainees reported that they had not viewed the *PREA: What You Need to Know* video and others reported not receiving the *Detainee Handbook.* In review of detainee files, documentation showed that by detainee signatures on required forms, they had received the handbook and had viewed the video. In discussion with facility staff, it was discovered that these forms were being signed at intake at the beginning of the intake process before the detainee receives the handbook or views the video. Due to information obtained through detainee interviews and the information obtained from review of detainee files as well as discussion with facility staff, the facility did not meet the requirements of standard 115.33, *Inmate Education*, necessitating a corrective action by the facility.

Recommended Corrective Action:

In order for the facility to bring this standard into compliance, the facility must establish a procedure to ensure all detainees receive comprehensive PREA education. Once the procedure is established, intake staff will need to be trained on the new procedure and sign a training roster as proof of completion of this training. When PREA training is provided to the detainees, detainees will sign the *Offender Handbook Receipt* and the acknowledgement of PREA education form. Staff providing this training will forward documentation of this training weekly to the PREA Compliance Manager for her review. The PREA Compliance Manager will forward this information to the PREA Coordinator for 60 days for her review. At the end of 60 days (4/30/17), the PREA Coordinator will forward this information to me.

On 2/14/17, the PREA Coordinator forwarded me the facility's Corrective Action Plan. The plan includes reassigning one intake officer from the day shift to the night shift who will be responsible for detainee education. That intake officer will conduct a PREA class every evening for the detainees who arrived at the facility that day. The *PREA: What You Need to Know* video will be shown at that class and the comprehensive PREA education lesson plan will be reviewed by the intake officer. Detainees will sign a training roster and all necessary documentation as proof of that training.

Corrective Action Taken:

During the corrective action period, the classification and intake department staff received training on the intake procedure changes for providing comprehensive education to detainees. Those in attendance signed a training roster, which was forwarded to me for my review. Two intake officers from the day shift were reassigned to the second shift, Monday-Friday (2-10 pm). Once reassigned, these two intake officers and other intake and classification staff who did not attend the first training session received the training.

The two intake officers newly assigned to the second shift are responsible for conducting comprehensive PREA

education Monday thru Friday for every detainee processed that day. The day shift intake staff are responsible for conducting this class on the weekends for any new arrivals, but in the event detainees who arrive over the weekend do not receive this training, those detainees will be provided PREA training on Monday during the regular scheduled PREA class. The class includes detainees viewing the *PREA: What You Need to Know* video, facilitated by intake staff who provide a narrative of the video. After viewing the video, detainees sign an acknowledgement form acknowledging receipt of a PREA handout received during intake and acknowledging viewing the video. They also sign a class roster acknowledging watching the PREA video and that they have received the PREA pamphlet and the comprehensive PREA education training. Detainees also sign a *PREA Comprehensive Education Acknowledgement Form* that also includes a section on the bottom of the form that they initial acknowledging that they have received a copy of the *Detainee Handbook.*

The facility provided for my review GEO track arrival rosters as well as copies of the class rosters that corresponded to the GEO track arrival rosters for a period of 60 days. Documentation showed that comprehensive PREA education is being provided to detainees on the day of arrival to the facility or no later than 72 hours of arrival. Based on the review of the documentation forwarded to me at the conclusion of the corrective action period, I determined that the facility has achieved compliance with standard 115.33.

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective 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 13, section F-3 and facility policy 1300.05, page 15, section 3, investigators receive specialized training in addition to the general education provided to all employees. This training includes techniques for interviewing sexual abuse victims, proper use of the Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or referral for prosecution.

The agency has 85 trained investigators agency wide. The Brooks County Detention Center has four trained facility investigators who completed a four-hour webinar, *Specialized Training Investigating Sexual Abuse in Correctional Settings* facilitated by the agency's PREA Coordinator and received a certificate of completion that is maintained by the facility and documented electronically.

When interviewed, facility investigators acknowledged receiving specialized investigations training and were knowledgeable of their duties in conducting investigations, sexual abuse evidence collection and the evidence required to substantiate a case for administrative action or prosecution referral.

Standard 115.35 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 12, and 13, section 2 and facility policy 1300.05, page 15 section 2, states that each facility will train all full-time and part-time medical and mental health staff to detect signs of sexual abuse and sexual harassment, preserving physical evidence and responding effectively and professionally to victims of sexual abuse and sexual harassment.

All medical and mental health staff receive specialized training in addition to general PREA training provided to all staff. The facility has 14 contracted Correct Care Solutions (CCS) staff who completed CCS PREA training and received a certificate of completion. Documentation of this training is maintained by the facility and documented electronically.

Medical staff do not perform SANE exams. SANE exams are performed by referral to Doctor's Regional in Corpus Christi, TX.

Medical and mental health staff interviewed verified receiving this training and knew their responsibilities in responding to victims of sexual abuse, proper reporting and how to preserve the physical evidence.

Standard 115.41 Screening for risk of victimization and abusiveness

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in 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, pages 8 & 9, section D-1 and facility policy 1300.05, pages 9 & 10, section D-1, all detainees are assessed during intake within 12 hours for risk of being sexually abused by other detainees or sexually abusive toward other detainees. Case Managers conduct these screenings. The *PREA Risk Assessment* form is used for this purpose. The form was reviewed and found to contain all requirements of 115.241 (b) of this standard and considers prior acts of sexual abuse and prior convictions for violent offenses. Detainees 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 that can assist in determining risk assessment is completed.

Within a set time, not to exceed 30 days of the detainee's arrival to the facility, detainees are reassessed by their Case Manager or the Classification Supervisor using the *PREA Vulnerability Reassessment Questionnaire* (HWH 38) for their risk for victimization and abusiveness. The Classification Supervisor tracks the 30-day reassessment dates. A detainee's risk level will also be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information.

A *PREA Vulnerability Reassessment Questionnaire* is completed on all transgender and intersex detainees every six months to ensure their placement is appropriate and determine any threats to safety experienced by the individual.

PREA Risk Assessment forms and *PREA Vulnerability Reassessment Questionnaire* forms are maintained in detainee files that are kept locked in the Records Room. To maintain confidentiality to this information, only the Case Managers, the PREA Compliance Manager, the Warden and the Records Clerks have access to these forms. In review of 20 detainee files, initial and 30-day reassessments are timely and completed as required exceeding in the requirements of this standard.

Standard 115.42 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency/facility uses information from the risk screening to make housing, bed, work, education and program assignments to keep detainees at high risk of being sexually victimized from those at high risk of being sexually abusive. GEO policy 5.1.2-A, page 10, section 3 and facility policy 1300.05, page 12, section 4, explains the use of the PREA screening information.

Guidelines on housing and program assignments and for the management of transgender and intersex detainees are outlined in GEO policy 5.1.2-A, page 10, section 3-d. Transgender and intersex detainees are reassessed at least twice per year to review any threats to safety experienced by the detainee as required by this standard and takes into consideration their own views regarding their own safety. Transgender and intersex detainees are given the opportunity to shower alone.

The agency does not place lesbian, gay, bisexual, transgender or intersex detainees in housing units solely based on their sexual orientation and these detainees are tracked on an *LGBTI Log.* Two lesbian detainees interviewed reported that they were not housed based on their sexual orientation and shared that they feel safe at this facility.

Detainees identified from screenings to be potential victims or potential predators are tracked on a *PREA Tracking Log*. In review of detainee files, referrals from initial screenings for mental health evaluations are being made and detainees at risk for victimization or abusiveness are housed appropriately. The facility is doing an excellent job of ensuring the sexual safety of its detainees.

Standard 115.43 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.1-A, page 16, section J-1 and facility policy 1300.05, page 27, section 6, involuntary segregated housing may be used only after an assessment of all available housing alternatives has shown that there are no other means of protecting the detainee. If an assessment cannot be made immediately, the detainee may be placed in involuntary segregated housing for no more than 24 hours.

GEO policy 5.1.2-A further states that if involuntary segregated housing is used for the safety of the detainee as a means of separation, it can be used for no more than 30 days and a review will be completed every 30 days to determine whether there is a continuing need for separation from the general population.

The *Sexual Assault/Abuse Available Alternatives Assessment* form is used to document the assessment if involuntary segregation is used. All completed forms are reviewed and signed by the Warden or the Assistant Warden upon completion. If segregated housing is used, the detainee will have all access to programs and services he/she is eligible for, and the facility shall document and justify any restrictions imposed.

On interview with the Warden, he confirmed that in the past 12 months, there were no detainees held in involuntary segregated housing.

Standard 115.51 Inmate reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 17, section K-1 and facility policy 1300.05, pages 19 & 20, section J-1, outline reporting methods available to detainees to report allegations of sexual abuse and sexual harassment. The agency/facility provides multiple ways for detainees to privately report sexual abuse and sexual harassment and retaliation by other detainees or staff for reporting. Detainees are instructed that they can verbally report to the PREA Compliance Manager or any staff member, report in writing, by telephone, submit a grievance or sick call or by a third party report.

The facility provides detainees with one way for detainees to report abuse or harassment to a public or private entity or office by giving them the addresses and phone numbers of the Office of the Inspector General and GEO's PREA Coordinator. They also are informed that they can call the Women's Shelter of South Texas. This information is posted in the housing units in both English and Spanish and is also contained in the *Detainee Handbook* and reviewed in the Comprehensive PREA Education.

A *Sexual Assault Awareness* brochure informs detainees that they can inform the ICE staff members, the PREA Compliance Manager or any staff member, put it in writing, have a friend or relative report for them or file a grievance. They are given the address and toll-free reporting number of DHS Office of Inspector General and ICE Headquarters and are instructed to call or write their consular official.

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. Information concerning the identity of detainee victim's report of sexual abuse or sexual harassment are limited to those who need to know only. Detainees interviewed were aware of the methods available to them to report allegations of sexual abuse and sexual harassment.

Staff can privately report sexual abuse and sexual harassment of detainees in writing or by calling the Employee Hotline or telephoning, emailing or in writing to the GEO PREA Coordinator. Information on staff reporting is available on the GEO website (http://www.geogroup.com/reporting_sexual_abuse_prea, in the Employee Handbook, and in the PREA training curriculum. Staff interviewed were knowledgeable of methods of privately reporting available to them.

Standard 115.52 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In review of GEO policy 5.1.1-A, pages 17 & 18, section K-2 and facility policy 1300.05, pages 20 & 21, section 2-a & b, there is a procedure in place for detainees to submit grievances regarding sexual abuse and the agency has procedures in place for dealing with these grievances. There is no time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse.

Detainees are informed of the grievance process on page 16 of the *Detainee Handbook.* Detainees have a right to submit grievances alleging sexual abuse to someone other than the staff member who is the subject of the complaint. If a third party files a grievance on a detainee's behalf, the alleged victim must agree to have the grievance filed on his behalf. Emergency grievances may be filed if a detainee feels he is at substantial risk of imminent sexual abuse.

The agency does not require a detainee to use any informal grievance process or attempt to resolve with staff an alleged incident of sexual abuse. A final decision will be issued on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing date. The facility may claim an extension of time to respond, up to 70 days, and shall notify the detainee of the extension in writing.

A detainee may file an emergency grievance if he/she is subject to substantial risk of imminent sexual abuse. The Warden or his designee will take immediate corrective action to protect the alleged victim upon receiving an emergency grievance of this nature. An initial response will be issued to the detainee filing an emergency grievance within 48 hours and final decision will be provided within five calendar days. The agency may discipline a detainee for filing a grievance related to alleged sexual abuse if the agency determines that the detainee

filed the grievance with malicious intent.

The PREA Compliance Manager receives all copies of grievances related to sexual abuse or sexual harassment for monitoring purposes. In the past 12 months, Brooks County Detention Center received one grievance alleging sexual abuse, which was investigated in accordance with PREA standards. There were no emergency grievances received.

Standard 115.53 Inmate access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As stated in GEO policy 5.1.2-A, pages 23 & 24, section 8 and facility policy 1300.05, page 29, section 9, detainees are provided with access to outside victim advocates for emotional support. The facility entered into a Memorandum of Understanding (MOU) on 9/21/16 with the Women's Shelter of South Texas. The terms of the MOU provide victims of sexual abuse with emotional support services as well as a 24-hour hotline. Detainees are instructed that they may call the Women's Shelter of South Texas by accessing voice prompt #2 on the pay phone or write a letter to them at 813 Buford St, Corpus Christi, TX 78355.

Detainees are made aware of the outside confidential support services available to them through posters displayed throughout the facility and information provided in the *Detainee Handbook*. Also posted in each housing unit is contact information for detainees detained solely for civil immigration purposes for consular officials and officials at the Department of Homeland Security.

Detainees are informed of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Detainees interviewed were aware of the confidential support services available to them and how to access them.

Standard 115.54 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 18, section 3 and facility policy 1300.05, page 21, section 3, 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 detainee has been sexually abused, sexually harassed, or requires protection. Information on third party reporting is available on the GEO website at http: www.geogroup.com/PREA (Social Responsibility-PREA Certification Section).

Detainees interviewed were aware of this reporting method. In the past 12 months, the facility has not received any reports of allegations of sexual abuse or sexual harassment from a third party.

Standard 115.61 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, pages 18 & 19, section 4, and facility policy 1300.05, page 22, section 4, and in review of the employee training curriculum, all staff are to report immediately any knowledge or information regarding an incident of sexual abuse or sexual harassment or any detainee subject to risk of imminent sexual abuse and retaliation or suspected retaliation against detainees or staff. Staff must take all allegations of sexual abuse and sexually harassment seriously. All allegations, including third party and anonymous reports, are reported to supervisors.

GEO policy 5.1.2-A, page 13, section G-2, and facility policy 1300.05, pages 16 & 17, section G-2, outline the responsibilities of volunteers to report and GEO policy 5.1.2-A, page 14, section H-2 and facility policy 1300.05, page 17, section H-2, the responsibilities of contractors to report.

Interviews with staff, contractors and volunteers revealed that they are aware of their reporting responsibilities and know not to reveal any information about sexual abuse incidents to anyone other than to the extent necessary.

Brooks County Detention Center houses adult male and female detainees, none of whom according to their classified level of care are considered vulnerable adults under the Texas State Vulnerable Persons Statue.

Standard 115.62 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

When an agency learns that a detainee is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the detainee. GEO policy 5.1.2-A, page 19, section L-1, and facility policy 1300.05, pages 22 & 23, section K-1 address the procedures related to the agency and facility's efforts to protect detainees who may be at risk for sexual abuse.

In interview with the Warden, there were no times in the past 12 months that it was necessary to take immediate action in regards to a detainee being in substantial risk of sexual abuse. He further stated that the detainee at risk for sexual abuse would immediately be removed from the area. Staff interviewed was aware of their responsibilities if they felt a detainee was at risk for sexual abuse. They reported that they would isolate the detainee and report to their supervisor immediately.

Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 22 and 23, section 5 and facility policy 1300.05, pages 223 & 24, section 5 were used to verify that there is a procedure in place if an allegation is received that a detainee was sexually abused while confined at another facility. Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the Warden or the Assistant Warden will notify the head of the facility where the sexual abuse was alleged to have occurred and document that notification was provided. This notification should be made as soon as possible, but no later than 72 hours of receiving the allegation and should include all actions taken regarding the incident. Copies of this documentation is then forwarded to the PREA Compliance Manager, the PREA Coordinator and ICE AFOD or designee, if the incident involved an ICE detainee.

If a report is received from another facility regarding alleged sexual abuse occurring at Brooks County Detention Center, the allegation will be reported and investigated in accordance with PREA standards.

In interview with the Warden and documentation provided for review, in the past 12 months the facility received one allegation that an inmate was abused while confined at another facility. Proper notification was made to the Warden of that facility. In the past 12 months, there were no allegations of sexual abuse received from other facility that were alleged to have occurred at the Brooks County Detention Center.

Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 19 & 20, section III, L-2 and facility policy 1300.05, page 22 & 23, section H-2, were used to verify compliance to this standard. Upon learning that a detainee was sexually abused, the first security staff member to respond to the report is required to separate the alleged victim and the abuser, immediately notify the Duty Warden or the on-call supervisor, preserve and protect the crime scene, not let the victim and abuser take any actions that could destroy physical evidence and not reveal any information related to the incident to anyone other than staff involved with investigating the alleged incident. If the incident involves an ICE detainee, the ICE AFOD or designee must be notified.

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. All staff carry with them a First Responder Card, which reminds them of the actions to be taken in response to an allegation of sexual abuse.

Security and non-security staff interviewed were knowledgeable of the policy and the practice to follow if they were the first responder to an allegation of sexual abuse or sexual harassment. They reported that they knew that the alleged victim and abuser must be separated and how to preserve the crime scene and the physical evidence.

In the past 12 months, there no allegation of sexual abuse reported that required implementing first responder duties by security staff.

Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 5 & 6, section III-A-4 and facility policy 1300.05, page 6, section 4, verify that there is a plan in place to coordinate actions to be taken in response to an incident of sexual abuse. The facility's Coordinated Response plan was provided for review, it clearly defines the roles and responsibilities of each person involved, and the procedures to be followed in detail as well as notifications required to be made. The PREA Compliance Manager is required to participate and the PREA Coordinator may be consulted as part of the coordinated response.

Part of the response plan is the requirement of completing a *PREA Incident Checklist for Incidents of Sexual Abuse and Harassment* to ensure that all steps of the plan are carried out and proper notifications are made.

Staff interviewed confirmed that they are knowledgeable of the plan and the necessary actions to be taken in response to an allegation of sexual abuse or sexual harassment.

Standard 115.66 Preservation of ability to protect inmates from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 5, section A-3, and facility policy 1300.05, pages 5 & 6, section IV-A-3, GEO and the Brooks County Detention Center shall not enter into or renew any collective bargaining agreement or other agreement that limits a facility's ability to remove alleged employee sexual abusers from contact with detainees of GEO facilities or program pending the outcome an investigation.

A Collective Bargaining Agreement entered into between LCS Corrections Services, Inc. (former owner of Brooks County Detention Center until 2/15) and the National Federation of Federal Employees, Federal District 1, IAMAW, ALF-CIO, effective 5/1/14 thru 8/31/18. Page 31, section 9 of that agreement states that during an investigation of any misconduct, the employee shall be placed on unpaid administrative leave. The employer will have seven days to either suspend or terminate, or notify the employee that no discipline will be taken.

In interview with the Vice Pdetainee, Risk Management on 1/27/17, he stated that there are no collective bargaining agreements in any of the agency's facilities that would prohibit removal of an alleged staff sexual abuser from contact with inmates pending an investigation.

Standard 115.67 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 24 & 25, section 2 and facility policy 1300.05, page 30, section 2 were used to verify compliance to this standard. Detainees 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 detainees and staff. Housing changes or transfers for detainee victims or abusers, removal of alleged staff or detainee abusers from contact with victims and emotional support services for detainees who fear retaliation will be protection measures used as per agency and facility policies.

The PREA Compliance Manager, for a minimum of 90 days, conducts weekly monitoring for retaliation with the alleged victim, or longer if warranted. Monitoring will terminate if the allegation is determined to be unfounded.

Monitoring for retaliation is documented on the *Protection from Retaliation Log.* Completed logs are retained in the corresponding investigative file.

In the past 12 months, there were no incidents of retaliation that occurred. In interview with the PREA Compliance Manager, she was knowledgeable of the procedure for monitoring and in review of investigative files, verified this process is being followed.

Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency and facility prohibits detainees who have alleged sexual abuse to be placed in involuntary segregated housing. If segregated housing were used, the same provisions as outlined in GEO policy 5.1.2-A, page 23, section 6 and facility policy 1300.05, page 27, section 7 would apply. Any use of segregated housing to protect a detainee who alleged to have suffered sexual abuse will be subject to the requirements of standard 115.43. If the incident involves an ICE detainee, the ICE AFOD or designee will be notified.

On interview with the Warden and staff assigned to restrictive housing units, they revealed that involuntary segregated housing has not been used for this purpose in the past 12 months.

Standard 115.71 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An investigation is completed for all allegations of sexual abuse and sexual harassment at the Brooks County Detention Center, including third party and anonymous reports. The agency's policy governing administrative and criminal investigation of sexual abuse is outlined in GEO policy 5.1.2-E, pages 4-6, section III-B and in facility policy 1300.05, page 33, section M-1.

All allegations of sexual abuse and sexual harassment, including third party and anonymous reports are investigated by one of the four trained facility investigators. All allegations are tracked on the *Monthly PREA Incident Tracking Log.* If an allegation appears to be criminal, the agency/facility has an agreement with the Brooks County

Sheriff's Office to conduct all criminal investigations and refer for prosecution.

The facility shall cooperate with outside investigators and remain informed of the progress of the investigation through communication with the Brooks County Sheriff's Department. All administrative and criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial and documentary evidence.

The credibility of an alleged victim, suspect or witness is assessed on an individual basis and is not determined by the person's status as detainee or staff. A detainee who alleges sexual abuse is not required to submit to a polygraph examination. The agency/facility retains all written reports pertaining to administrative investigations of sexual abuse and sexual harassment for as long as the alleged abuser is incarcerated or staff member is employed by the agency plus five years.

All investigative files were reviewed and found that all allegations of sexual abuse and sexual harassment are being investigated by the facility and substantiated allegations that appear to be criminal are referred to the Brooks County Sheriff's Department.

Standard 115.72 Evidentiary standard for administrative investigations

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

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

According to GEO policy 5.1.2-E, page 6, section E and facility policy 1300.05, page 33, section M-2, the facility shall impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

When facility investigators were interviewed and asked what standard of evidence was used in determining if an allegation is substantiated, they confirmed the agency/facility policy.

Standard 115.73 Reporting to inmates

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

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

Based on GEO policy 5.1.2-E, pages 10 & 11, section K and facility policy 1300.05, pages 31 & 32, section 4, the facility ensures that proper notification be given to detainees as to the outcome of the investigation of sexual abuse and sexual harassment allegations if the outcome of the investigation proved to be substantiated, unsubstantiated or unfounded. The Facility Investigator provides a *Notification of Outcome of Investigation* to detainees. At the conclusion of every investigation of sexual abuse, the *Notification of Outcome of Investigation* form is forwarded to the PREA Coordinator for review. If the incident involves an ICE detainee, the ICE AFOD or designee also receives a copy.

Following the completion of an investigation that an employee has committed sexual abuse against a detainee, the facility is required to inform the detainee of the outcome of the investigation, unless the facility has determined that the allegation was unfounded. Following a detainee's allegation that he was sexually abused by another detainee, the agency shall inform the detainee of the outcome of the investigation. The facility's obligation to notify the detainee will terminate if the detainee is released from custody. If the facility did not conduct the investigation, relevant information from the investigating agency will be requested in order to inform the detainee.

In interview with the facility investigators, this process is in place and notifications are being made as required by policy. In the past 12 months, there were no notifications made to detainees as to the outcome of an investigation as in all cases, the detainees were release prior to the investigation being completed. In review of investigative files, it was recommended to the facility that even if a detainee is released prior to the completion of the investigation, a *Notification of Outcome of Investigation* should be completed and filed in the investigative file with a notation that the detainee was released and the notice was not given to him/her.

Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective 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 review GEO policy 5.1.2-A, page 11, section L and facility policy 1300.05, page 32, section L-1, staff shall be subject to disciplinary action up to and including termination for violating the agency/facility sexual abuse policies. Staff is made aware of the zero-tolerance policy and the penalties for violating that policy in the *2014 Employee Handbook*, pages 17 & 18. All terminations and resignations for sexual misconduct are reported to the Brooks County Sheriff's Office and licensing agencies, unless the activity was clearly not criminal.

If a staff member violates the agency's zero-tolerance policy, he/she will be investigated and if it appears to be criminal in nature, referred for prosecution to the Brooks County Sheriff's Office.

In the past 12 months, there have been no staff who have violated agency sexual abuse and sexual harassment policies.

Standard 115.77 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, page 12, section 3, and facility policy 1300.05, pages 16 &17, section 3 for volunteers and page 18, section 3 for contractors, state that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees and shall be reported to law enforcement agencies and licensing boards, unless the activity was clearly not criminal.

In interview with the Warden and documentation provided for review, there is one open investigation involving a CCS medical contractor who is suspended pending the outcome of the investigation.

Standard 115.78 Disciplinary sanctions for inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As per GEO policy 5.1.2-E, pages 11 & 12, section L-2 and facility policy 1300.05, pages 32 & 33, section L-2, detainees found guilty of engaging in sexual abuse involving other detainees shall be subject to formal disciplinary sanctions. Disciplining a detainee for engaging in sexual activity with an employee is prohibited unless the employee did not consent to the contact.

The disciplinary process may consider whether an individual's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Sanctions will be commensurate with the nature and circumstances of the abuse, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories.

Detainees are informed of the disciplinary process in the *Detainee Handbook*, on pages 23-26, including the prohibited acts and the sanctions that will be imposed for violations to the agency/facility's policy on sexual misconduct.

In the past 12 months, there were no disciplinary sanctions for detainees related to sexual misconduct.

Standard 115.81 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Upon intake, mental health staff will see any detainee who is assessed to be at risk for sexual victimization or abusiveness or who has previously experienced prior sexual victimization or previously perpetrated sexual abuse. GEO policy 5.1.2-A, pages 9 & 10, section D-2 and facility policy 1300.05, page 11, section 3, outline the requirements of referrals to mental health for further evaluation.

During the initial intake assessment, any detainee who has experienced prior sexual victimization, whether in an institution setting or in the community or any detainee who has perpetrated sexual abuse in an institution setting or the community will be referred to mental health and will see a mental health practitioner within 14 days of the initial intake screening. This information is also reported to the PREA Compliance Manager.

Medical and mental health staff obtain informed consent from detainees before reporting information about prior sexual victimization that did not occur in an institution setting.

Any information related to sexual victimization or abusiveness in an institutional setting is limited only to medical and mental health practitioners and other employees as necessary to inform about treatment plans, security and management decisions or otherwise required by federal, state or local law.

In the past 12 months, 37 detainees disclosed prior victimization during screening and were offered a follow-up meeting with a mental health practitioner. The Mental Health Professional upon interview stated that detainees referred from initial screening for mental health evaluations are seen the day of arrival or the following day.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective 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 23, section 7 and facility policy 1300.05, pages 27 & 28, section 8, were used to verify compliance to this standard. Policies mandate that victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention as directed by medical and mental health practitioners. The evaluation and treatment should include follow-up services, treatment plans and, if necessary, referrals for continued care following a transfer or release.

SANE exams will be performed at Doctor's Regional in Corpus Christi, TX. A victim advocate will be available to

be present for the SANE exam. Victims will be offered information about sexually transmitted infections prophylaxis where medically appropriate. All services are provided without cost to the victim. All refusals of medical services will be documented.

Interviews with the Health Services Administrator and the Mental Health Professional confirmed this practice and that the requirements of this standard are adhered to.

In the past 12 months, there has been no access to emergency medical and mental health services required.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section M-1 and facility policy 1300.05, pages 29 & 30, section 11, mandate that victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention. The evaluation and treatment offered includes follow-up services, treatment plans, and referrals for continued care following a transfer or release if necessary.

Victims will be offered information about sexually transmitted infections prophylaxis where medically appropriate. Female victims are provided pregnancy tests and all lawful pregnancy-related medical services. SANE exams will be performed by referral to Doctor's Regional, Corpus Christi, TX. All services are provided without cost to the victim regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall attempt to conduct a mental health evaluation on all known detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by Mental Health Practitioner. All refusals of services will be documented.

In interview with the Health Services Administrator and the Mental Health Professional, they confirmed compliance with the requirements of this standard. In the past 12 months, there have been no detainees who required ongoing medical or mental health treatment due to being victimized by sexual abuse.

Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Based on GEO policy 5.1.2-A, page 25, section M-3 and facility policy 1300.05, pages 30 & 31, section 3, the facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation within 30 days in which the allegation has been determined to be substantiated or unsubstantiated.

The Incident Review Team consists of the Warden, the Assistant Warden, the PREA Compliance Manager, the HSA, the Acting Major and the Investigator assigned to the investigation, with the PREA Coordinator sometimes attending via telephone or in person. The Incident Review Team considers whether the incident was motivated by race, ethnicity, gender identity, perceived status or gang affiliation. The team examines the area where the incident was alleged to have occurred and assesses whether physical barriers in the area, whether monitoring technology should be deployed or augmented and whether the staffing levels at the time of the incident were adequate. A *PREA After-Action Review Report* is used to document the incident review and upon completion is forwarded to the PREA Coordinator no later than 10 working days after the review. The PREA Compliance Manager maintains copies of all completed *PREA After-Action Review Reports* and a copy is maintained in the corresponding investigative file. If the incident involved an ICE detainee, the ICE AFOD or designee is provided with a copy.

The Incident Review Team makes recommendations based on their review of the incident and the facility shall implement the recommendations for improvement, if any, or shall document its reasons for not doing so.

In the past 12 months, there was one alleged sexual abuse investigation completed followed by a sexual abuse incident review. In interview with members of the Incident Review Team, they knew their responsibilities as a member of the Incident Review Team.

Standard 115.87 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.

Information on data collection is found on page 25, section N-1 of GEO policy 5.1.2-A and on page 34, section N-1 of facility policy 1300.05. GEO collects uniform data for every allegation of sexual abuse at all facilities under their control. The data collected, will be at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Bureau of Justice Statistics (BJS). The findings are presented to the Field Office Director and ICE/ERO headquarters for use in determining whether changes are needed to existing policies and practices to further the goal of eliminating sexual abuse.

The PREA Compliance Manager ensures that the data is compiled and forwarded to the PREA Coordinator on a monthly basis on the *Monthly PREA Incident Tracking Log.* If any incidents involve an ICE detainee, a copy of the monthly report will be forwarded to the ICE COTR. At least annually, the PREA Coordinator aggregates this data. Upon request, or no later than June 30, the agency provides aggregated data information for the previous calendar year to DOJ.

Element (e) of this standard is not applicable to this facility. The agency does not contract for the confinement of

its detainees.

Standard 115.88 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.

Based on GEO policy 5.1.2-A, page 25 & 26, section N-2 and facility policy 1300.05, page 34, section 2, and on interview with the PREA Coordinator, the agency reviews all of the data collected from all of its facilities and aggregates that data annually to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. The PREA Coordinator prepares an annual report that provides the problem areas and corrective actions for each facility and the agency as a whole. The report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The Annual PREA Report provides an excellent overview of the agency's efforts in the prevention of sexual abuse and sexual harassment in its facilities, exceeding in this standard.

The PREA Coordinator forwards the annual report to the Vice President of Operations for signature and approval and a copy of the report is forwarded to ICE. The report is then made public on the GEO website (www.geogroup.com). The most current report is posted on the GEO website for 2015 data. Before making aggregated sexual abuse data public, all personal identifiers are redacted.

Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 36, section N-3 and facility policy 1300.05, page 34, section N-3, the agency ensures that the data collected is securely retained for at least 10 years according to the Texas State Records Retention Schedule.

GEO makes all aggregated sexual abuse data, from facilities under its direct control readily available to the public annually on their website at www.geogroup.com. Before making aggregated sexual abuse data publicly available, all personal identifiers are redacted

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 — May 15, 2017

Auditor Signature — Date