PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: July 5, 2017

Auditor Information			
Auditor name: Barbara Jo Denison			
Address: 3113 Clubhouse Drive			
Email: Edinburg, TX 78542			
Telephone number: 956-566-2578			
Date of facility visit: June 13-14, 2017			
Facility Information			
Facility name: Grossman Center			
Facility physical address: 4715 Brewer Place, Leavenworth, KS 66048			
Facility mailing address: N/A			
Facility telephone number: 913-351-0728			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☒ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Christopher Zych, Facility Director			
Number of staff assigned to the facility in the last 12 months: 33			
Designed facility capacity: 146			
Current population of facility: 77			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 22-70			
Name of PREA Compliance Manager: Jovanny Hernandez		**Title:** Social Service Coordinator	
Email address: jovhernandez@geogroup.com		**Telephone number:** 913-351-0728	
Agency Information			
Name of agency: The Geo Group Inc.			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: One Park Place, Suite 700, 621 Northwest 53rd Street, Boca Raton, FL 33487			
Mailing address: *(if different from above)* N/A			
Telephone number: 561-999-5827			
Agency Chief Executive Officer			
Name: George C. Zoley		**Title:** Chairman of the Board, CEO and Founder	
Email address: gzoley@geogroup.com		**Telephone number:** 561-893-0101	
Agency-Wide PREA Coordinator			
Name: Phebia L. Moreland		**Title:** Director, Contract Compliance, PREA Coordinator	
Email address: pmoreland@geogroup.com		**Telephone number:** 561-999-5827	

AUDIT FINDINGS

NARRATIVE

The PREA on-site audit of Grossman Residential Reentry Center was conducted June 13-14, 2017, by this Department of Justice Certified PREA Auditor, Barbara Jo Denison. Pre-audit preparation included a thorough review of agency and facility policies, procedures, training curriculums, Pre-Audit Questionnaire and supporting PREA-related documentation provided by the facility to demonstrate compliance to the PREA standards. Jovanny Hernandez, Social Services Coordinator, who is designated as the facility's PREA Compliance Manager, answered questions during this review period.

On the first day of the audit, a brief entrance meeting was held with Christopher Zych, Facility Director, Jovanny Hernandez, PREA Compliance Manager, Steven Wright, Chief of Security and Jamie Jackson, Program Performance Manager Central Region. Following the meeting those in attendance of the entrance meeting accompanied me on a tour of the facility. During the tour, the location of cameras and mirrors, dorm layout including shower/toilet areas and placement of PREA posters and information was observed. Numerous PREA posters in both English and Spanish are prominently displayed in all common areas as well as on the walls in each living unit. The facility has done an exceptional job of displaying PREA information in an eye-catching format in several areas of the facility. Plastic plaques with reporting numbers are affixed to the walls by all the pay phones in the living areas and in the Employment Lab. Restrooms have individual showers with shower curtains and entry doors to the restrooms have a shower curtain for added privacy.

The facility has done an excellent job of identifying areas where mirrors and cameras were needed. Mirrors in various locations and in various sizes in all dorms assist staff in the supervision of these living areas. It was recommended during the tour that an area that an additional mirror would be beneficial was in Dorm 4. In the far-right hand corner of the Dorm 4, there is area where extra bunks, mattresses and lockers are stored. One section of that storage space was not visible in any of the mirrors and was identified as a blind spot. By the close of the first day of the audit, a mirror was added and when Dorm 6 was revisited, the mirror was found to capture that storage area.

The facility has a Memorandum of Understanding (MOU) with the Alliance Center entered into on 4/11/17. The Criminal Justice Advocate was contacted prior to the audit to confirm and review the MOU. A resident victim of sexual abuse would be transported to the Saint Luke's Cushing Hospital for a forensic exam. When arriving at the hospital, the on-call victim advocate would be contacted and be present during the forensic exam if the victim agreed. The Alliance Center would offer the victim follow-up sexual assault support services. All services provided by the Alliance Center are at no cost to the victim.

The facility also has an MOU with the Guidance Center. The Executive Director of the Guidance Center was contacted prior to the on-site visit to confirm and review the MOU entered into on April 6, 2017. The Executive Director shared that the Guidance Center provides comprehensive mental health services to the residents of the Grossman Center. Services include post mental health services for resident victims of sexual abuse and services for residents who are determined from risk screening to be at risk for victimization or abusiveness. All services are confidential and at no cost to the residents. Every Monday a counselor from the Guidance Center comes to the facility to meet with the Program Review Team. The Team consists of the Facility Director, the PREA Compliance Manager, the Chief of Security, the Job Developer, Case Managers, a Missouri USPO, a Kansas USPO and sometimes a representative from BOP.

During the facility tour, the toll-free number for the RAINN National Hotline Network (1-800-656-4673) was dialed from a resident pay phone. The number was found to be accessible to residents and found to be answered by the Alliance Center. The Alliance Center is another reporting option for residents (1-800-644-1441 or 913-682-9131/9132). That number was also dialed from a resident pay phone and found to be accessible to residents.

The records of 20 residents were reviewed to evaluate compliance to screening procedures and the requirements and documentation of PREA education for residents. All records showed initial screenings being done within 24 hours of arrival to the facility and 30-day screenings being completed between 22 and 30 days of arrival. Review of resident records revealed that documentation on PREA education is being maintained by the PREA Compliance Manager.

The personnel records of 19 staff and two volunteers were reviewed to determine compliance with background check procedures. All files reviewed showed that criminal background checks for pre-employment and after five years of employment are being completed as required. *PREA Disclosure and Authorization Form Promotions – PREA Related Positions* and a required background check were found in all files of staff promoted within the past 12 months. In addition, *PREA Disclosure and Authorization Form – Annual Performance Evaluations* were found for staff annually.

The records of 16 staff were reviewed to determine compliance to annual PREA refresher training for staff. Four of those records were missing acknowledgement forms for 2015 and one was missing for 2016. The PREA Compliance Manager was not responsible for this training at that time. Since he has been designated as the PREA Compliance Manager, a system has been put in place to ensure compliance in the future. The records of the two volunteers were reviewed and showed that PREA training was completed in 2014 and again in 2017, but there was no documentation to show training was completed in 2015 or 2016. The PREA Compliance Manager recognized this when he took over the position and he ensured the two volunteers received the required training for 2017.

On the first day of the audit there were 55 in-house residents and 22 on home confinement. Residents on home confinement have electronic monitoring devices to ensure accountability while in the community. A total of 18 of the in-house residents were interviewed. The number of in-house residents included three residents from each of the six dorms. Of the number of residents interviewed, five were assessed at initial screening to be at risk for victimization and one female resident self-disclosed at initial screening of being bisexual. Male residents identified at risk for victimization are housed in Dorm 2 and males at risk for abusiveness are housed in Dorm 3. Females identified at risk of victimization are housed in the front of the female dorm and those identified at risk for abusiveness are housed in the back of the dorm. There were no residents housed at the facility that were blind, had low vision, deaf, hard of hearing, with cognitive deficits, low reading skills or limited English proficient. There were no residents who self-disclosed at initial screening of being lesbian, gay, transgender or intersex.

Residents interviewed acknowledged receiving written PREA information during the intake process and viewing the *PREA: What You Need to Know* video. They were knowledgeable of the agency/facility's zero-tolerance policy against sexual abuse and sexual harassment and were able to articulate during interview the methods of reporting allegations of sexual abuse and sexual harassment available to them. They shared that Town Hall Meetings are held each week where PREA is discussed at each meeting.

Nine security staff members were interviewed, which included a Shift Supervisor and two Monitor I's from each of the three security shifts. There was a total of nine specialized staff and one volunteer (by telephone) interviewed during the course of the audit. Staff interviewed was knowledgeable of their responsibilities of detecting, preventing, responding and reporting sexual abuse and sexual harassment allegations. They knew their responsibilities of reporting any knowledge or suspicions of sexual abuse and sexual harassment and incidents of retaliation. Staff reported having PREA refresher training annually and attending monthly staff meetings where PREA is discussed and reviewed at each meeting.

Derrick Schofield, Executive Vice President, Continuum of Care & Reentry Services (agency head designee), was interviewed by telephone on 1/19/17 and Phebia L. Moreland, Director, Contract Compliance, PREA Coordinator was interviewed by telephone on 1/22/17.

In the 12 months preceding the audit, there were three allegations of staff-on-inmate sexual abuse. All

were investigated by GEO's Office of Professional Responsibility (OPR) and were determined to be unfounded. Two allegations that were received in 2015 were closed in early 2017 and both were determined to be unsubstantiated. The facility does not have trained facility investigators. Trained investigators from other facilities in the region would be called upon to conduct administrative investigations. Allegations of sexual abuse are referred to BOP or USPO OIG. There is an agreement with the Leavenworth Police Department to conduct criminal investigation and refer for prosecution.

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with Christopher Zych, Facility Director, Jovanny Hernandez, PREA Compliance Manager, Steven Wright, Chief of Security and Jamie Jackson, Program Performance Manager Central Region in attendance, with Jonathon Dressler, Director, Fidelity & Quality Assurance in attendance via telephone.

During the exit meeting, the facility was informed of the process that would follow the on-site audit and the responsibility of the agency to post the final report on the agency website. Early this year the facility underwent changes to their administrative team with the hiring of the new Facility Director, the appointing of the Social Service Coordinator as the PREA Compliance Manager and the promotion of a Shift Supervisor to the Chief of Security position. As a newly formed administrative team, they were able to identify problems with adherence to some of the PREA standards and put systems in place to work towards compliance. A common thread of pride was observed and communicated through conversations with staff. The administrative team was complimented on the outstanding efforts they have made to keep communications with staff and residents ongoing through the sharing of PREA information in staff meetings, town hall meetings and readily accessible through posters prominently displayed throughout the facility.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Grossman Center is a residential reentry center owned by the GEO Group, Inc. The facility is located at 4715 Brewer Place, Leavenworth, Kansas. The facility was constructed in 2001. Male and Female residents may be a direct commitment from a federal correctional facility, referred by a court as a condition of their supervision or admitted to the facility as a result of their U.S. Probation Pre-Trial status. The facility provides employment counseling, job placement, financial management assistance, and other programs and services. As treatment and rehabilitation goals are achieved, residents earn the privilege of decreased structure.

The Grossman Center is a metal structure with two floors. The total rated capacity is 144 beds. On the first day of the audit, the population of the facility was 77 residents with 55 residents in-house and 19 on home confinement. Thirty-six in-house residents were BOP custody and 19 USPO custody. The age range of the population was 22-70. Residents are minimum custody with an average length of stay from 3-6 months.

Entering the north side of the building, there is a lobby area with a TV monitor where PREA information is displayed as well as other information for detainees. PREA posters are also displayed in this lobby area. The front door faces a Monitor Station, which is behind the lobby, and entrance to the rest of the facility is through a secure door. Residents and visitors check in and out from the Monitor Station. Residents scan their ID card and sign in and out on a paper log. This information is also maintained electronically in GEO Track.

There is pat-down area to the left of the Monitor Station where pat searches are performed in view of a camera and documented in GEO Track. A locked restroom in this area is used for conducting UA's. Residents are breathalyzed when they return to the facility from being in the community. Monitor Station staff observe camera monitors and respond to door alarms. All exits door are alarmed. Staff parking is in the front of the building with resident parking in the back. A recreation area in the back of the building has a basketball hoop, picnic tables, a covered pavilion and an open pavilion. There is a locked storage shed in this area that is under a camera and has a light to capture any movement in this area. There are 4 exterior cameras and 17 interior cameras. A DVR stores data for up to 30 days.

There are six dormitory style-housing units in the facility with a total of 7407 square feet of living space. Dorms 1, 2, 3, 5 and 6 are on the first floor. Dorm 1 has 11 bunks for a total of 22 beds, Dorms 2 and 3 have 12 bunks for a total of 24 beds and Dorm 4 has 9 bunks for a total of 18 beds. Dorm 5 is a female dorm with a TV in the dorm and a small laundry room outside of the dorm. Also, on the first floor there in a dining/multipurpose room, a kitchen, employment lab, weight room, a large laundry, a small laundry and staff offices. Male residents use the dining/multipurpose room for watching TV and relaxing. Dorm 4 is on second floor along with an RDAP staff office, a monitor staff office and a resident restroom with a washer and dryer in the restroom. Each dorm has one pay telephone with PREA signage near the phones. Residents are allowed to have their own cell phones. PREA signage was also displayed in many common areas of the facility. All restrooms afforded residents privacy when toileting and showering. Curtains are hung in the entry of each restroom and individual showers have shower curtains for privacy. Signs on entry doors of living areas remind staff to make opposite gender announcements.

The Grossman Center has three security shifts. There are three security officers assigned to each shift with at least one male and one female staff on duty at all times. There are 12 counts in a 24-hour period, as well as several security checks throughout the day and night. The Chief of Security conducts daily count verifications for all three shifts. Current staffing includes 24 full-time staff and 8 part-time staff, with no vacancies. The facility does not utilize the services of contractors and has two active volunteers.

Grossman Center's mission statement is:

> "Provide a safe and secure facility where residents can participate in residential, treatment and educational services. We will work in partnership with contracting agencies, community leaders and families to ensure the residents successful re-entry back to their community. We will also hire staff with proper credentials, training, education and skills to meet the needs of the offender population in our care and provide staff with continued development to ensure growth and improvement of our services."

GEO's mission statement is:

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

SUMMARY OF AUDIT FINDINGS

The following is a summary of the audit findings:

Number of standards exceeded: 5

Number of standards met: 32

Number of standards not met: 0

Number of standards not applicable: 2

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

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2.A and the Grossman Center policy 803-1 are written policies mandating zero tolerance towards all forms of sexual abuse and sexual harassment and outlines the agency's/facility's approach to preventing, detecting and responding to such conduct. Both policies include definitions of prohibited behaviors and sanctions for those found to participate in these prohibited behaviors. Both policies, upon review, were found to be very comprehensive and to include a thorough description of the agency /facility's approach to reduce and prevent sexual abuse and sexual harassment of residents, exceeding in the requirement of this standard.

GEO policy 5.1.2-A, pages 6 & 7, section III, B, 1-3 and facility policy 0504-1, pages 2 & 3, section VI-A, outline the responsibilities of the PREA Coordinator and the PREA Compliance Manager. The agency not only employs an agency-wide PREA Coordinator, but also employs a Director, Fidelity & Quality Assurance who provides oversight to the agency's reentry facilities; therefore, exceeding in the requirements of this section of the standard.

In interview with the agency's PREA Coordinator on 1/22/17 and the PREA Compliance Manager during the on-site audit, both stated that they have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards as required.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ 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 residents; therefore, this standard is not applicable.

Standard 115.213 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 0504-1, pages 3-4, section B-1, the agency has developed and documented a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents 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 commit to ensure adequate staffing levels in the development of the facility's staffing plan.

The facility makes its best efforts to comply with the approved PREA staffing plan. In circumstances where the staffing plan is not complied with, the Facility Director would document and justify all deviations from the plan. The Facility Director monitors the staffing plan by his review of the staffing rosters on a weekly. In interview with the Facility Director, he reported that there was a need identified to increase the number of security monitors on the second and third shifts so that if transports were required there would always be two security monitors remaining at the facility. Staffing on the first shift as not increased due to the fact that during the hours of the first shift, non-security staff can assist as needed. On all three shifts, there are always a male and female Security Monitor on duty. During this audit period, there were no times that there were deviations to the staffing plan. The facility utilizes part-time and on-call monitor staff to fill staff call-ins.

The staffing plan is reviewed annually by the PREA Compliance Manager, the Facility Director and the Chief of Security and documented on the *PREA Annual Facility Assessment* form. This form is then forwarded to the Senior Area Manager, Regional Director, the Director, Fidelity & Quality Assurance, the Divisional Vice President and the Corporate PREA Coordinator for signature and approval of any recommendations made to the established staffing plan to include the deployment of video monitoring systems and other monitoring technologies or the allocations of additional resources to maintain compliance to the plan. *PREA Annual Facility Assessments* since the last PREA audit showed no recommendations made for changes to the established staffing plan. Recommendations were made for additional cameras, including a new facility video surveillance system in 2016.

Per policy, facility management staff and mid-level supervisors conduct unannounced rounds within their respective areas to identify and deter employee sexual abuse and sexual harassment. Management staff are required to complete, at a minimum, unannounced PREA rounds once a shift each month. These rounds are documented on the *Grossman Center - Unannounced PREA Rounds* form. Employees are prohibited from alerting residents or other employees that these supervisory rounds are occurring. Security Monitors conduct 12 counts in a 24-hour period. For increased supervision and monitoring efforts, the agency has in place a count verification procedure to monitor surveillance tapes on a weekly basis to ensure staff are conducting formal resident counts. These verifications, completed by the Chief of Security, are documented on *Resident Count Verification Checklist.* These completed forms are forwarded to the Divisional Vice President of Reentry Services and to the Regional Director each week. The facility exceeds in its monitoring efforts with excellent supervision of its residents.

Documentation provided for review prior to the on-site visit and *Unannounced PREA Rounds* logs reviewed while on site and upon interview with staff and residents and the practice of rounds by facility management staff and supervisory staff confirmed numerous rounds and counts being conducted on all three shifts. The facility was found to exceed in the requirements of this standard.

Standard 115.215 Limits to cross-gender viewing and searches

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on review of GEO policy 5.1.2-A, pages 16 & 17, section 1, and facility policy 0903-1, pages 3 & 4, the facility prohibits strip searches, body cavity searches and cross gender pat searches.

Pat searches are conducted outside of the Monitor Station in view of security cameras. All residents are searched when entering the facility from being in the community and any time a staff deems a search is warranted for the safety and security of the facility. Pat searches are documented electronically in the GEO Track system. Females are not restricted access to regular available programming or outside opportunities in order to comply with this provision. At all times, there is a female and a male staff member on duty.

In addition to general training provided to all employees, security staff receive training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents which is contained in the agency's PREA training curriculum (DOJ2017-In-Service), which was provided for review. This curriculum includes the procedures of conducting cross gender pat searches and searches of transgender and intersex residents. Staff sign a *PREA Basic Acknowledgement* form and a *Cross Gender Pat Searches & Searches of Transgender & Intersex* acknowledgement form upon completion of this training. Receipt of this training was verified through interviews with staff and review of staff training records.

The agency has policies and procedures in place that enable residents to shower, perform bodily functions and change clothing without staff viewing their breast, buttocks or genitalia. Policy requires staff of the opposite gender to announce their presence when they enter resident housing and restroom areas. Signs on the entry doors of living areas remind staff to make this announcement. This practice was observed while on-site and residents and staff interviewed confirmed that this practice is being followed. Residents shared that they feel they have privacy to shower, toilet and change clothing when staff of the opposite gender are in their housing unit. The facility was found to exceed in this standard. They have ensured that residents have privacy and residents interviewed confirmed that they do.

Based on GEO policy 5.1.2-A and facility policy 0903-1, the facility prohibits examining transgender or intersex residents for the sole purpose of determining genital status. Transgender and intersex residents complete a *Statement of Search* form indicating the gender of the staff they prefer to conduct pat searches. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. At the time of the audit, there were no transgender or intersex residents housed at the Grossman Center.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency takes appropriate steps to ensure that residents with disabilities and residents that are limited English proficient have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. GEO policy 5.1.2-A, pages 11& 12, section E-1 and facility policy 1702-1, pages 1 & 2, section V, were used to verify compliance to this standard. Residents receive a *PREA Education Manual for Residents* during the intake process that is available in English and Spanish. PREA posters and a *PREA: What You Need to Know* video is provided in English and Spanish. A contract with Language Line Services, Inc. provides for the translation of any other languages. A TTY is available for deaf residents.

At the time of the audit, there were no residents that were deaf, hard of hearing, blind, with cognitive deficits, low reading skills or who were limited English proficient.

The agency prohibits the use of resident interpreters, resident readers or other types of resident assistants except in limited circumstances. In the past 12 months, there have been no instances where residents were used for these purposes.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, pages 7 & 8, section C-2 and page 16, section 4 and facility policy 0504-1, page 4, section 2, interview with the Office Support Specialist and review of random employee files were used to verify compliance to this standard.

Per policy the agency/facility prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who have engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings or in the community. GEO 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 residents.

The agency requires that all applicants and employees who may have contact with residents have a criminal background check and every five years thereafter. Criminal background checks for all potential employees are completed through a contract with Aurico, as well BOP NCIC clearance for all applicants. If an applicant answers that they have previously worked at a confinement facility, a Custom Employment Report is ordered from Aurico for PREA verification. Employees that are required to drive company vehicles, have driver's license checks by Aurico. In the past 12 months, 12 criminal background checks were completed on applicants. The agency also requires that all contractors and volunteers who have contact with residents have criminal background checks. Page 16, section 4 of the agency policy addresses the requirements of criminal background checks for contractors. The facility does not utilize the services of contractors.

For consideration for promotions or transfers, employees complete a *PREA Disclosure and Authorization Form Promotions – PREA Related Positions* and another background check by Aurico is completed which includes PREA verification through a Custom Employment Report. At the time of annual performance evaluations, employees complete a *PREA Disclosure and Authorization Form – Annual Performance Evaluation.* GEO 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 and/or misconduct to the Facility Director. Unless prohibited by law, GEO Corporate Reentry Services Human Resources Department 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 the individual has applied for work.

Criminal Background checks for all employees are completed every five years by BOP at the time of the contract renewal. Personnel files of random employees and the two volunteers were reviewed and found to contain pre-employment criminal background checks and five-year background checks.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

☐ 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 policy 5.1.2-A, page 8, section C-3 and facility policy 0504-1, page 4, section 3, and documentation provided for review was used to verify compliance to this standard. Per agency and facility policies, the Grossman Center shall consider the effect any new design, acquisition, expansion or modification of physical plant or monitoring technology might have on the facility's ability to protect residents from sexual abuse.

Since the last PREA audit, the facility has not acquired any new facilities or made any substantial expansions or modifications of existing facilities since the last PREA audit. Since the last audit, the facility has added additional cameras and mirrors and installed a new video surveillance system, alarms were added to the doors leading to the exterior of the building with a buzzer feature for the front entrance and a larger video monitor in the Monitor Station for viewing of cameras.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-E, pages 6-10, sections D-I outlines the agency's requirements as it applies to this standard. The BOP, US Probation or the Leavenworth Police Department are responsible for conducting criminal investigations, depending on the custody of the resident and to ensure all forensic evidence is collected and preserved in accordance with evidence protocols established by the Department of Justice (DOJ). The investigating entities follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence and fulfill all requirements of this standard.

The facility does not house youth; therefore, section (b) of this standard is not applicable to this facility.

Victims of sexual abuse have access to forensic medical examinations with the victims consent and without cost to the resident regardless if the victim names the abuser or cooperates with an investigation arising out of incident. Forensic exams are not performed at this facility. Victims of sexual abuse are transported to the St. Luke's Cushing Hospital where SANE exams are performed. The facility entered into a Memorandum of Understanding on 4/11/17 with the Alliance Center, Leavenworth, KS that provides resident victims of sexual assault with SANE exams and victim advocacy services. In the past 12 months, there have been no residents who have required SANE exams or victim advocacy services.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 0803-1, page 7, sections C-2 & 3 outline the agency's policy and procedures for investigating and documenting incidents of sexual abuse. The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment, including resident-on-resident sexual abuse or staff sexual misconduct.

Upon receipt of an allegation of sexual abuse, the supervisor receiving the report immediately notifies the Facility Director. The Facility Director will make immediate notification to the PREA Coordinator, to the Director, Fidelity & Quality Assurance, to GEO's Office of Professional Responsibility (OPR) (if the allegation involved staff), and to the BOP Residential Reentry Manager, the GEO Reentry Services Regional Director and the PREA Coordinator. The facility initiates an administrative investigation and if it is determined that the allegation involved potential criminal activity, a referral is made to the Leavenworth Police Department BOP or USPO who conducts a criminal investigation. It is the responsibility of the investigating agencies to ensure that all forensic evidence is collected and preserved in accordance with evidence protocols established by the Department of Justice.

The agency documents all referral of allegations of sexual abuse or sexual harassment for criminal investigation. All allegations are tracked on the *PREA Monthly Incident Outcome Tracking Log.*

In the past 12 months, there were three allegations of staff-on-inmate sexual abuse received all determined to be unfounded. In 2015, there was one staff-on-inmate sexual harassment allegation determined to be unfounded, one staff-on-inmate sexual abuse that was determined to be unsubstantiated and one inmate-on-inmate sexual abuse that was determined to be unsubstantiated. There were no allegations reported in 2016. No allegations were referred for criminal investigation. All staff-on-inmate sexual abuse and sexual harassment allegations were referred to GEO's OPR. The agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the GEO website http://www.geogroup.com/PREA (Documents and Resources Section).

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 GEO's zero-tolerance policy (5.1.2-A) for sexual abuse and sexual harassment at pre-service and annually at in-service. The agency's requirement of this training is found on pages 12 & 13, section F-1. Between trainings, PREA is reviewed and discussed during monthly staff meetings. The pre-service and in-service training curriculums were reviewed and found to address all elements of 115.231 (a) as required by this standard. The DOJ 2017 PREA curriculum includes training on cross gender pat searches and searches of transgender and intersex residents. The PREA Compliance Manager facilitates PREA training. Employees sign a training roster and a *PREA Basic Acknowledgement* form that they have received and understood the training they received. The PREA Compliance Manager maintains documentation of training for employees. PREA information is reviewed once a month during staff meetings.

In the past 12 months, all Grossman Center staff have received this training as verified by review of employee training files. Some documentation of training completed in 2015 and 2016 was not found and due to the replacement of the former PREA

Compliance Manager, could not be located. In interview with staff, they were able to confirm receiving this training and knew their responsibilities for preventing and responding to allegations of sexual abuse and sexual harassment.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 states that all contractors and volunteers shall receive training on the agency's policy on zero tolerance for sexual abuse and sexual harassment. Guidelines on volunteer training can be found on page 14, section G-1 and contractor training on page 15, section H-1. The Grossman Center does not utilize the services of contractors. The facility currently has two volunteers. Volunteers receive the same PREA training that staff receive and sign a *PREA Basic Acknowledgement* form upon the completion of this training.

In review of the volunteers training record, both volunteers have received PREA training in 2017. Prior to that date, volunteers did not receive annual PREA training. When the current PREA Compliance Manager took over his position, he ensured training was provided to them. When interviewed by telephone, a volunteer acknowledged receiving the training this year and knew his responsibilities if a resident alleged sexual abuse to him.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 12, section E-2 and facility policy 1702-1, pages 4, *Documentation* section, all residents receive information at time of intake and if transferred from another facility about the zero-tolerance policy and how to report incidents of sexual abuse or sexual harassment, their rights to be free from retaliation for reporting such incidents and are informed of the agency policy and procedures for responding to such incidents.

In the past 12 months, 338 residents admitted to the facility and 27 residents transferred from another community confinement facility received PREA education. Spanish speaking staff are available for Spanish translation and Language Line Services, Inc. is used for the translation of any other languages. At the time of the audit, there were no residents that were limited English proficient.

Residents acknowledge by their signature on a *Prison Rape Elimination Act (PREA) Education Manual for Residents Acknowledgment* form that they have received a copy of the *PREA Education Manual for Residents*. They also sign another acknowledgement form acknowledging viewing the *PREA: What You Need to Know* video, receiving training on the zero-tolerance policy, their right to report and their right to free medical and mental health care. The PREA Compliance Manager

maintains this documentation in individual PREA resident files, which contains all PREA-related forms.

When interviewed, residents were knowledgeable of the zero-tolerance policy and the methods of reporting available to them. It was evident that the facility has done an excellent job of informing residents and makes PREA information continuously accessible at all times on posters, on the TV monitor in the front entry and during town hall meetings. The PREA Compliance Manager maintains PREA documentation in an orderly and efficient manner ensuring completion of each step of the PREA process for residents. The facility exceeds in the requirements of this standard.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 14, section F-3, in addition to general education provided to all employees, GEO ensures that facility investigators receive training on conducting sexual abuse investigations in confinement settings. In review of the training curriculum, the 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.

Within the agency, there are 85-trained investigators. The agency's PREA Coordinator provides a four-hour specialized training webinar for investigators. There are no trained facility investigators as the Grossman Center. The Facility Director would consult with the PREA Coordinator to assign a trained investigator from another agency community confinement facility in the region to conduct administrative investigations of allegations of sexual abuse and sexual harassment as needed.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ 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.

Grossman Center does not employ medical or mental health staff; therefore, this standard is not applicable.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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 1701-1, pages 2 & 3, section VI-B, all residents placed at the Grossman Center are assessed for their risk of being sexually abused or sexually abusive towards others within 24 hours of arrival to the facility by the PREA Compliance Manager or their Case Manager. 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. Residents may not be disciplined for refusing to answer any questions or for not disclosing complete information. In addition to the screening form, a thorough review of any available records that can assist in determining risk assessment is completed. In the past 12 months, 338 residents were screened for their risk of sexual victimization or risk of abusiveness upon arrival to the facility.

Within a set time, not to exceed 30 days of the resident's arrival to the facility, their Case Manager using the *PREA Vulnerability Reassessment Questionnaire* (HWH 38) for their risk for victimization and abusiveness reassesses residents. A resident's risk level will also be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information. The PREA Compliance Manager maintains the *PREA Risk Assessments and PREA Vulnerability Reassessment Questionnaires*. To maintain confidentiality only the Facility Director, PREA Compliance Manager, Chief of Security and Case Managers have access to this information.

In interview with the PREA Compliance Manager and Case Managers and review of 20 random resident records, this process is in place and the facility is doing an excellent job in screening residents for risk of victimization and abusiveness in a timely manner.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 uses the information from the risk screening form to make housing, bed, work, education and program assignments with the goal of separating residents at high risk of being sexually victimized from residents with those at high risk of being sexually abusive. Individualized determinations are made about how to ensure the safety of each resident. GEO policy 5.1.2-A, pages 10 & 11, section D-3 and facility policy 1701-1, page 3, section 2, explains the use of PREA screening information. On interview with the Facility Director and the PREA Compliance Manager, they explained how the facility utilizes screening information from the *PREA Risk Assessment* form for this purpose.

Residents who score at risk of victimization or abusiveness are referred for further evaluation to the Guidance Center using the *Grossman Center Resident Referral Verification* form. Residents have an option of refusing these services. Those identified to be at risk are tracked on an "*At-Risk" Log*. Residents tracked on the *At-Risk Log* are housed separating potential victims from potential predators.

GEO does not place lesbian, gay, bisexual, transgender or intersex residents in dedicated units or wings solely based on such identification. Housing and programming assignments for transgender and intersex residents shall be reassessed every 6 months using the *PREA Vulnerability Reassessment* form. Transgender and intersex residents are given the opportunity to shower alone. At the time of the on-site visit, there were no transgender or intersex residents housed at the facility.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 18, section L-1 and facility policy 1702-1, page 4, last paragraph, outline the agency/facility's responsibility for providing residents methods of reporting. The agency provides multiple ways for residents to privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse and sexual harassment and any staff neglect or violation of responsibilities that may have contributed to such incidents.

The facility provides multiple ways for residents to report sexual abuse, sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. Residents are made aware of methods of reporting available to them through the *PREA Education Manual for Residents* (pages 8 & 9) provided to them upon intake, on the *Resident Reporting Options* poster and continuously through other posters and brochures displayed throughout the facility. Residents are made aware that they can verbally inform any staff member or the Facility Director, the PREA Compliance Manager or GEO's PREA Coordinator by phone or in writing. The agency has a policy mandating that staff accept reports of sexual abuse or sexual harassment made verbally, in writing, anonymously and from third parties.

Residents are informed that they can contact the RAINN National Hotline Network at 1-800-656-4673, 24 hours a day, 7 days a week. They are also given the number for the BOP RRM Office at 913-551-1115 and the Alliance Center at 1-800-644-1441 or 913-682-9131/9132. Residents 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.

Residents can also file a grievance and information on sexual abuse grievances and emergency grievance procedures are found in the *PREA Education Manual for Residents.*

Staff must take all allegations of sexual abuse and harassment seriously whether they be made verbally, in writing, anonymously and from third parties and are required to document all reports.

Staff have access to private reporting by calling the Employee Hotline at 866-568-5425 or the Corporate PREA Coordinator at 561-999-5827. Information for resident and staff reporting can be found on the GEO website (http://www.geogroup.com/PREA(Social Responsibility Section). Page 4, section I of the *Employee Handbook* inform employees of their responsibility of reporting sexual abuse and sexual harassment. Staff carry with them a Sexual Abuse First Responder Card affixed to their badges, which has the employee hotline number and the website address for anonymous reporting.

Residents and staff interviewed were well versed in the methods of reporting available to them.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In review of GEO policy 5.1.2-A, pages 19 & 20, section K-2, and facility policy 0805-1, pages 4 & 5, there is a procedure in place for residents to submit grievances regarding sexual abuse and the agency has procedures for dealing with these grievances. Instructions on how to file grievances are provided on page 8 of the *PREA Education Manual for Residents.*

There is no time limit when a resident can submit a grievance regarding sexual abuse. Residents are not required to use any informal grievance process or attempt to resolve this type of grievance prior to submission. Residents 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 resident's behalf, the alleged victim must agree to have the grievance filed on his behalf.

Emergency grievances may be filed if a resident feels he is at substantial risk of imminent sexual abuse. A final decision will be issued on the merits or portion of the grievance alleging sexual abuse within 90 days of the initial filing of the grievance. A resident can be disciplined for filing a grievance related to alleged sexual abuse if it is determined that the resident filed the grievance in bad faith.

The PREA Compliance Manager receives all copies of grievances relating to sexual abuse or sexual harassment for monitoring purposes. In the past 12 months, there have been no grievances filed related to sexual abuse or sexual harassment.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 24 & 25, section N-8 and facility policy 0803-1, page 11, section H-6, addresses the agency's policy on providing residents with access to outside victim advocates for emotional support services related to sexual abuse. Residents are given the telephone numbers to the Alliance Center. The facility has an MOU with the Alliance Center that provides victims of sexual abuse with victim advocacy services. The facility also has an MOU with the Guidance Center. The Guidance Center provides mental health services for residents who victims of sexual abuse or harassment as well as mental health services for residents determined through screening to be at risk for victimization or abusiveness. Information about the Alliance Center and the Guidance Center is provided to residents in the *PREA Education Manual for Residents* and on posters displayed throughout the facility. Residents 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.

When interviewed, residents were aware of the outside confidential support services available to them and how to access them.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 20, section L-3, the agency has a method to receive third-party reports of sexual abuse and sexual harassment on behalf of individuals in a GEO facility or program. Information on third-party reporting is found on facility postings and is made available on the GEO website at http://www.geogroup.com/PREA (Social Responsibility-PREA Certification Section). Third-party reports can be made in person, in writing, anonymously or by contacting the agency's PREA Coordinator. Residents interviewed were aware of this method of reporting.

During the past 12 months, there have been no reports of sexual abuse or sexual harassment made to the facility by a third party.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency's requirement on staff reporting duties can be found on page 20, section N-4 and facility policy 0803-1, pages 5 & 6, section VII-B. Staff must take all allegations of sexual abuse and sexual harassment seriously. All staff are required to report immediately to their supervisor any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment and any retaliation against residents or staff who reported such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations, including third party and anonymous reports, are reported to supervisors. The supervisor receiving the report immediately notifies the Facility Director. For an allegation of sexual abuse, the Facility Director will make notification to the PREA Coordinator, the Director, Fidelity & Quality Assurance and the BOP Residential Reentry Manager. If the allegation involves staff, notification is made to GEO's OPR.

Volunteers and contractors also have a duty to report and information on volunteer reporting can be found on page 14, section G-2 and contractor reporting on page 15, section H-2 in the agency policy.

In reference to element 115.261 (c) of this standard, the facility does not have medical or mental health personnel on staff.

Grossman Center houses adult male and female residents only, none of whom according to their classified level of care are considered vulnerable adults under the State Vulnerable Persons Statue.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident according to GEO policy 5.1.2-A, pages 20 & 21, section M-1.

In interview with the Facility Director and documentation provided, there were no times during the past 12 months that it was necessary for the facility to take immediate action in regards to a resident being in substantial risk of sexual abuse. Staff interviewed were aware of their responsibilities if they felt a resident was at risk for sexual abuse.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section 5 and facility policy 0803-1, page 9, section G were used to verify compliance to this standard. Upon receiving an allegation that a resident was sexually abused while confined at another facility, the allegation will be documented and the Facility Director or his designee shall notify the head of the facility where the sexual abuse was alleged to have occurred and document that notification was provided. This notification is to occur 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 will be forwarded to the PREA Coordinator and the PREA Compliance Manager.

In interview with the Facility Director and in review of documentation provided, in the past 12 months, four residents of Grossman Center alleged that sexual abuse had occurred while they were confined to another facility. Proper notifications were made to the facilities that the abuse was alleged to have occurred and documentation was provided for review.

If a report is received from another facility regarding alleged sexual abuse occurring at the Grossman Center the allegation will be reported and investigated according to PREA standards. In interview with the Facility Director, in the past 12 months there were no allegations of sexual abuse received from other facilities alleged to have occurred while a resident was assigned to the Grossman Center.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

GEO policy 5.1.2-A, pages 21-23, section L-2-4 outlines the procedure for first responders to follow for allegations of sexual abuse and sexual harassment whether that person is a security or non-security staff member. Per policy, upon learning of an allegation of sexual abuse, the first security staff member to respond to the report is to separate the alleged victim and abuser, immediately notify the on-duty or on-call supervisor, preserve and protect the crime scene, not let the alleged victim or abuser take any actions that could destroy physical evidence and not reveal to anyone information related to the incident to anyone other than staff involved with investigating the alleged incident.

If the first responder is not a security staff member, the responder is to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff. All staff carry with them a Sexual Abuse First Responder Card affixed to their badges reminding them of the steps to take if they are the first responders to an allegation of sexual abuse or sexual harassment. In the past 12 months, there were three allegations of sexual abuse received. In all cases, a security staff member responded to the report of sexual abuse.

Random interviews with security and non-security staff revealed that they knew the policy and 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 knew how to preserve the crime scene and preserve the physical evidence.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 6, section A-4 and review of the Grossman Center's *PREA Coordinated Response Plan* were used to verify that there is a plan in place to coordinate actions to be taken in response to an incident of sexual abuse. The plan provides written guidance to staff and administration regarding actions to take and notifications to be made. A *PREA After-Action Checklist for Incidents of Sexual Abuse and Harassment* is completed to ensure that all steps of the plan and proper notifications are made. This checklist is filed with the completed investigative packet. The Facility Director, the PREA Compliance Manager and the Chief of Security are responsible to ensure compliance to the plan. 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.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, pages 5 & 6, section III-A-3 was used to verify compliance to this standard. In all cases where the alleged abuser is an employee, contractor or a volunteer, there will be no contact between the alleged abuser and the alleged victim pending the outcome of an investigation. Facility policy 0803-1, page 8, section 5-e, states that if the suspect is a staff member, the staff member shall be reassigned to a post with no resident contact or placed on administrative leave pending the outcome of an investigation. In all cases, the abuser would be subject to disciplinary sanctions for violating GEO policies on sexual abuse and sexual harassment.

Grossman Center does not have a collective bargaining unit. In interview with the Executive Vice President Continuum of Care & Reentry Services on 1/19/17, he shared that there are no collective bargaining agreements for any of the agency's reentry facilities. GEO would not enter into any collective bargaining agreement at any of its facilities that would limit the facility's ability to remove an alleged sexual abuser from contact with residents pending the outcome of an investigation.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO has as policy to protect residents who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff as outlined in policy 5.1.2-A, pages 25 & 26, section N-2 and in facility policy 0803-1, pages 10 & 11, section H. The agency has multiple protection measures, such as housing changes or transfers for residents, victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. If any other individual who cooperates with an investigation expresses a fear of retaliation, appropriate measures to protect that individual against retaliation are put in place.

The PREA Compliance Manager is responsible for weekly monitoring for retaliation for at least 90 days and longer if there is a continuing need. Resident monitoring is documented on the *Protection from Retaliation Log* for residents and employee monitoring is documented on the *Employee Protection from Retaliation Log.* Completed logs are filed in the corresponding investigative file.

There were three allegations of sexual abuse reported in the past 12 months. Retaliation monitoring began within the first week after the allegation was reported and conducting each week thereafter. There were no incidents of retaliation that occurred. When interviewed, the PREA Compliance Manager knew her responsibilities for monitoring for retaliation per policy. In review of investigative files, retaliation monitoring forms are being maintained in investigative files.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

An administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment at the Grossman Center including third party and anonymous reports. The facility does not have trained facility investigators. When needed, trained investigators from other facilities in the region would be called upon to conduct administrative investigations. The agency's policy on administrative and criminal investigations is outlined in GEO policy 5.1.2-E, pages 4-6, section III-B-1.

The supervisor receiving the report of an allegation of sexual abuse or sexual harassment immediately notifies the Facility Director and PREA Compliance Manager who notifies the PREA Coordinator and the Director, Fidelity & Assurance and the BOP Residential Reentry Manager. The BOP, USPO or the Leavenworth Police Department pursuant to the requirements of this standard investigates criminal investigations. If an allegation involves a staff member, notification is made to GEO's OPR. All allegations of sexual abuse and sexual harassment are documented on the *Monthly PREA Incident Tracking Log.*

The administrative investigation will include an effort to determine whether staff actions or failures to act contributed to the abuse. The administrative investigation shall be documented in a written report and include a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings.

The facility shall cooperate with outside investigators and remain informed of the progress of the investigation through communication with outside investigators. A criminal investigation 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 resident or staff. A resident who alleges sexual abuse is not required to submit to a polygraph examination. GEO 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.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2, -E, page 6, section B-2-d, the agency/facility shall impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Since the last PREA audit, the facility has received three allegations of staff-on-inmate sexual abuse. All three allegations were determined to be unfounded.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

GEO policy 5.1.2-E, pages 10 & 11, section III-K and facility policy 0803-1, pages 11 & 12, section J were used to verify compliance to this standard. The policies indicate that following an investigation of sexual abuse of a resident, the resident shall be informed as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded. The PREA Compliance Manager is responsible to present to the resident the *Notification of Outcome of Allegation* form which the resident signs. This form is retained in the investigative file of the corresponding PREA incident.

If the facility did not conduct the investigation, the facility shall request the relevant information from the investigative agency in order to inform the resident. The policy further states that following a resident's allegation that an employee has committed sexual abuse against the resident the facility is required to inform the resident of the outcome of the investigation, unless the facility has determined that the allegation was unfounded. Following a resident's allegation that another resident sexually abused him, the agency shall inform the resident of the outcome of the investigation. The facility's obligation to notify the resident shall terminate if the resident is released from custody.

Since the last PREA audit *Notification of Outcome of Allegation* were presented as required. Based on interview with the PREA Compliance Manager, the process of providing notification to resident victims at the conclusion of an investigation is in place and *Notification of Outcome of Allegation* forms are being maintained in the investigative files.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse policy as outlined in policy GEO policy 5.1.2-E, page 11, section L and facility policy 803-1, page 13, section M-1. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. All terminations for violations of the agency's policies on sexual abuse and sexual harassment, or resignations, shall be reported to law enforcement and licensing agencies unless the activity was clearly not criminal. In the *2014 GEO Employee Handbook,* provided to all staff, pages 16 & 17 explain the zero-tolerance policy for employees and the sanctions that would be imposed for violations of that policy.

In the past 12 months, no staff has been disciplined or terminated for violating the agency's sexual abuse or sexual harassment policy.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on review of GEO policy 5.1.2.A, page 12, section G-3 and page 15, section H-3, any volunteer or contractor who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies and licensing boards, unless the activity was clearly not criminal.

Grossman Center does not utilize the services of contractors. The facility has two volunteers who have not violated the agency/facility's zero-tolerance policies. In interview with the Facility Director, any volunteer who violated the agency/facility's zero-tolerance policy would be restricted access to the facility.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-E, page 12, section 2 and facility policy 0803-1, page 13, section M-2, the BOP and/or the USPO are the supervising authorities over all residents at the Grossman Center. If a resident is found guilty of engaging in sexual abuse involving another resident, it will be reported to the BOP Residential Reentry Manager who will determine whether to subject the offender to formal disciplinary sanctions. Residents are made aware of sexual misconduct they will be disciplined for and the sanctions that will be imposed on pages 45, 46 and 48 of the *Residential Program Handbook*.

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.

The BOP or the USPO will determine if the resident will be required to participate in counseling or other interventions designed to address the reasons or motivations for the abuse. Disciplining a resident for sexual contact with an employee is prohibited unless it is found that the employee did not consent to the contact. The agency prohibits all sexual activity between residents. Facilities may not deem that sexual activity between residents is sexual abuse unless it is determined that the activity was coerced. The agency prohibits all sexual activity between residents. The PREA Compliance Manager will receive copies of all disciplinary reports regarding sexual activity and sexual abuse for monitoring purposes.

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

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 24, section 7 and facility policy 0803-1, pages 7 & 8, section 5. Resident victims are referred to the St. Luke's Cushing Hospital for SANE exams at no cost to the resident. Counseling and victim advocacy services would be provided by referral to the Guidance Center.

Resident victims are offered information about access to emergency contraception and sexually transmitted infections prophylaxis, where medically appropriate. All services are provided without financial cost to the victim, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

In the past 12 months, there have been no referrals for emergency medical or mental health services required.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility will offer ongoing medical and mental health care to all the residents of the Grossman Center who have been victimized by sexual abuse. According to GEO policy 5.1.2-A, page 25 section N-1, the evaluation and treatment will include follow-up services, treatment plans and referrals for continued care upon transfer or release consistent with the community level of care.

Victims will also be offered tests for sexually transmitted infections. Female victims of sexually abusive vaginal penetration shall be offered pregnancy tests. If pregnancy results shall receive timely and comprehensive information about access to all lawful pregnancy-related medical services. All services will be provided without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. An MOU with the Guidance Center provides victims of sexual abuse mental health services. The facility attempts to conduct a mental health evaluation of all known abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate.

In the past 12 months, there were no residents who required ongoing medical or mental health treatment due to being victimized by sexual abuse.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, pages 26 & 27, section N-3 and facility policy 0803-1, page 12, section K, the facility is required to conduct a sexual abuse incident review within 30 days of every sexual abuse investigation in which the allegation has been determined to be substantiated or unsubstantiated.

The Facility Director, the PREA Compliance Manager and the Chief of Security make up the facility's Incident Review Team, with input from the line supervisors and Case Managers. The team meets and the PREA Coordinator may attend via telephone or in person. The 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 may have contributed to the abuse, whether monitoring technology should be deployed or augmented and whether the staffing levels at the time of the incident were adequate.

Incident reviews are documented on a *PREA after Action Review Report* and forwarded to the PREA Coordinator no later than 10 working days after the review. The facility will implement the recommendations for improvement, or document its reasons for not doing so. The Facility Director/PREA Compliance Manager maintains copies of all completed *PREA after Action Review Reports* and a copy is retained in the corresponding investigative file.

In the past 12 months, there were two incident reviews completed. Both of those were completed at the conclusion of investigations of allegations received in 2015 with the investigations completed in early 2017. The three allegations received in the 12 months preceding the audit were all determined to be unfounded. When interviewed, all members of the incident review team knew their responsibilities as they relate to the review of sexual abuse incidents.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Information on data collection is found on page 27, section O-1 of GEO policy 5.1.2-A. 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 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* (attachment D of policy 5.1.2-A) and annually on the *Annual PREA Incident Tracking Log.* At least annually, the PREA Coordinator aggregates this data. Upon request, or no later than June 30th, 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 residents.

Standard 115.288 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Based on GEO policy 5.1.2-A, pages 27 & 28, section O-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 and therefore, exceeds in the requirements of this standard.

The PREA Coordinator forwards the annual report to the Vice President of Operations for signature and approval. The report is then made public on the GEO website (https://www.geogroup.com/PREA). Before making aggregated sexual abuse data public, all personal identifiers are redacted.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 28, section O-3, the agency ensures that the data collected is securely retained for at least 10 years or longer if required by state statue.

GEO makes all aggregated sexual abuse data, from facilities under its direct control readily available to the public annually on their website at https://www.geogroup.com/PREA. 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 July 5, 2017

Auditor Signature Date