PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: April 13, 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: March 28-29, 2017			
Facility Information			
Facility name: Leidel Comprehensive Sanction Center			
Facility physical address: 1819 Commerce St., Houston, TX 77002			
Facility mailing address: N/A			
Facility telephone number: 713-224-0964			
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: Johnathan Hardy, Facility Director			
Number of staff assigned to the facility in the last 12 months: 30			
Designed facility capacity: 190			
Current population of facility: 135			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 20-67			
Name of PREA Compliance Manager: Johnathan Hardy		**Title:** Facility Director	
Email address: jxhardy@geogroup.com		**Telephone number:** 713-224-0984, ext. 303	
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 Leidel Comprehensive Sanction Center was conducted March 28-29, 2017, by this Department of Justice Certified PREA Auditor, Barbara Jo Denison. The facility is also referred to as the Leidel Residential Reentry Center (Leidel RRC) or the Leidel Center. In this report, the facility will be referred to as the Leidel Center. 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. Questions during this review period were answered by Johnathan Hardy, Facility Director who is designated as the facility's PREA Compliance Manager.

On the first day of the audit, a brief entrance meeting was held with Johnathan Hardy, Facility Director/PREA Compliance Manager and Jonathon Dressler, Director, Fidelity & Quality Assurance in attendance. Following the meeting Johnathan Hardy, Facility Director, John Rollins, Assistant Director of Security, Wendy Bingham, Assistant Director of Programs and Jonathon Dressler, Director, Fidelity & Quality Assurance accompanied me on a tour of the facility. During the tour, the location of cameras, 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 excellent job of making PREA information continuously available to residents and staff.

The facility has made attempts to enter into a Memorandum of Understanding (MOU) with the Houston Area Women's Center. The Manager of Counseling and Advocacy was contacted prior to the on-site visit to discuss services that the Houston Area Women's Center currently provide residents of the Leidel Center, even though they have not secured an MOU. The Houston Area Women's Center provides a toll-free 24-hour reporting hotline for residents. They have a PREA Counselor on staff who will come to the facility to provide resident victims of sexual abuse counseling services. Victim advocacy services can be provided by the resident calling the hotline number to request those services or if the victim is referred to the Ben Taub Hospital for a forensic exam, the hospital would contact the Houston Area Women's Center to request an advocate meet the resident victim at the hospital. The Manager of Counseling and Advocacy stated that the facility could contact her directly to discuss entering into an MOU with the agency. This information was shared with the Facility Director/PREA Compliance Manager and on the first day of the audit, the Facility Director/PREA Compliance Manager contacted the Manager of Counseling and Advocacy of the Houston Area Women's Center. A meeting was scheduled with the Senior Outreach Counselor & Survivors with Disabilities who will come to the facility to meet with the Facility Director/PREA Compliance Manager to review and discuss an MOU.

The Bridge Over Troubled Waters, Inc. agency was contacted to discuss sexual assault services that they provide to victims of sexual assault. The Hotline Manager reported that besides being a reporting hotline, the agency can provide counseling, support groups and victim advocacy services. If a resident victim of sexual abuse was referred to the LBJ Hospital for a SANE exam, the hospital would contact their agency to request victim advocacy services. Because of the distance from Ben Taub Hospital (40 minutes away), they would not be called from the Ben Taub Hospital. Counseling and support groups would be available at their location, but sex offenders would not be able to receive these services as children reside at their shelter. The Facility Director contacted the Counseling Service Director to discuss entering into an MOU with the facility. The Facility Director forwarded a draft of the MOU to her and after her review of the MOU, a meeting will be scheduled to discuss the terms of the MOU.

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 answered by the Houston Area Women's Shelter. It was noted that the *Resident Reporting Options*

poster listed the reporting number for the Houston Area Women's Center as 713-528-7273. The website for the Houston Area Women's Shelter also listed a toll-free hotline number (800-256-0661) and a TDD hotline number (713-528-3691). It was suggested that those numbers be added to the *Resident Reporting Options* poster. Before the end of the first day of the audit, the Assistant Director of Programs revised the posters and reposted them.

The records of 25 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 upon arrival to the facility and 30-day screenings being completed close to 30 days of arrival. Review of resident information on PREA education was found to be complete and documentation is being maintained by the Assistant Director of Programs.

The personnel files of 18 staff 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. In addition, BOP conducts NCIC/NLETS background checks on all employees every two years.

Included in the personnel files are the documentation of PREA education for staff and training on cross gender and transgender pat searches. Some of the acknowledgement forms for training on cross gender searches and transgender pat searches were missing from the personnel files. The Facility Director/PREA Compliance Manager was able to find sign-in rosters which listed the names of the staff that this documentation was missing. It was recommended to the facility to have acknowledgement forms available upon completion of staff training to be signed at the same time the training roster is signed and ensure the documentation is filed in the staff's personnel file.

A total of 28 in-house residents and three home confinement residents were interviewed. The number of in-house residents included a random selection from each of the dorms. Of the number of in-house residents interviewed, two were assessed at initial screening to be at risk for victimization, three were assessed at initial screening to be at risk for abusiveness, one resident had low vision, one resident self-disclosed being transgender and two residents were Spanish speaking only. At the time of the audit, there were no residents who were blind, deaf, hard of hearing, with cognitive deficits or low reading skills. There were no residents who self-disclosed at initial screening of being lesbian, gay, bisexual or intersex.

Residents interviewed acknowledged receiving written PREA information during the intake process and attending PREA orientation where they viewed the *PREA: What You Need to Know* video. They were familiar with 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.

A total of 21 staff members and one volunteer (interviewed by telephone) were interviewed during the course of the audit. Of the 21 staff members interviewed, eight were security staff and 13 were specialized staff. The Facility Director/PREA Compliance Manager and the Assistant Director of Programs, who serve in multiple roles, were asked multiple questions as they related to the responsibilities of those roles. Staff interviewed were knowledgeable of their responsibilities of detecting, preventing and responding to 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 training not only annually, but often throughout the year.

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 past 12 months, there was one allegation of staff-on-resident sexual abuse received in February 2017 which is currently being investigated by the Federal Bureau of Prisons (BOP). There were no allegations reported in 2015 or 2016. 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 the BOP for investigation and if an allegation appears to be prosecutable, the allegations is referred to the Houston Police Department.

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with Johnathan Hardy, Facility Director/PREA Compliance Manager, Wendy Bingham, Assistant Director of Programs, John Rollins, Assistant Director of Security and Jonathon Dressler, Director, Fidelity & Quality Assurance in attendance, with Phebia Moreland, Director, Contract Compliance, PREA Coordinator in attendance via telephone.

The facility was found to comply all 39 of the PREA standards. During the exit meeting, the facility was informed of the process that would follow the on-site visit and the responsibility of the agency to post the final report on the agency website. The administrative team was complimented on the outstanding efforts they have made to continue to improve and perfect their PREA program since their last PREA audit. It was evident that the team and all of the Leidel Center staff have worked hard as a team to comply with the PREA standards.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Leidel Comprehensive Sanction Center is located at 1819 Commerce Street, Houston, Texas. The GEO Group, Inc. took over the ownership and operation of the Leidel Center in 2010 when they acquired the Cornell Corporation, who owned and operated the facility from 1995-2010. The Federal Bureau (BOP) and the United States Probation Office (USPO) contracts with the GEO Group, Inc. to provide community confinement services to their offenders. The residents all have previously served time in secure institutions. Residents are offered programs which includes Transition Skills, Living Skills and Substance Abuse Education. HIV/AIDS counseling is offered twice a month by a volunteer from Montrose Counseling, Houston, TX.

On the first day of the audit, the population of the facility was 135 residents with 120 of them in BOP custody and 15 USPO. There were 59 residents on home confinement. The age range of the population was 20-67. Residents are minimum custody with an average length of stay from 3-6 months.

The facility is a one-level, concrete building that was built in 1995 with a small addition connected to the main building by a breezeway that was added in 2005. The original structure houses administration, a Control Center, Dorms A, B, C, and D, case management offices, classrooms and food service.

The newer addition houses Dorm H and case management offices. During the audit, Dorm H was closed. Metal bunks have been ordered to replace the wooden bunks in Dorm H and when received, the dorm will be reopened and house male residents.

Entering the front of the building, the front door faces the Control Center. Residents and visitors check in and out from the Control Center. Residents scan their ID card and sign in and out on a paper log. This information is also maintained electronically. There is pat-down area to the left of the Control Center 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 and these are tracked in a *BA Book* and electronically in GEO Track. Control Center staff observe camera monitors and respond to door alarms.

Bulletin boards are in the front lobby area with PREA information posted in both English and Spanish. A main hallway behind the Control Center leads to living areas. There are 17 pay phones on one side of the hallway resident reporting options listed. There are four lines that rotate between the 17 pay phones. Residents are allowed to have their own cell phones as well. Locked mail boxes are in this hallway for mail for case managers. Large bulletin boards in the mail hallway have PREA and other information displayed.

There is a laundry room for the use of residents in Dorms A, C and D in the mail hallway and an Employment Room with several computers and desks for Employment Specialists.

Normally Dorms A & B are female dorms. Because of the temporary closure of Dorm H, during the audit females were housed in Dorm B only. At this time, Dorm A was being used to house male residents and has eight bunks for the capacity of 16 residents. A restroom to the right of the dorm has two individual showers with shower curtains, two toilet stalls and three sinks, with a washer and dryer in the restroom. Dorm B, is an open bay dorm with 10 bunks for a capacity of 20 female residents.

Dorm C is a male dorm and is the largest dorm with 70 beds. There are half walls between cubicles with five bunks per cubicle all having open doorways. There is a large shower with ten shower heads and an individual handicapped shower. The restroom has 12 sinks, six toilet stalls and two urinals. Dorm D is a male dorm with cubicles with the capacity to house 45 residents. In all housing unit showers have shower curtains with clear tops affording the residents privacy when showering and toilet stalls have doors. There appeared to be no issues with potential for cross-gender viewing in any of the restroom or

shower areas.

From Dorms D and H there are exit doors that lead to Logan's Garden, an outdoor recreation area. The area is fenced and has benches and a basketball hoop and has camera surveillance. Male and female residents are not allowed in this area at the same time.

The Main/Dining area has a large open area with microwave ovens on one wall and vending machines on another. There is a food prep area, a laundry room for Dorm D male residents, a male dining room/classroom/visit room. Across from the laundry room is a male TV room with tables used for dining. There is also a male weight room in this area. Also in this area is a female TV room/weight room/visit room/dining room. Food is catered by the South Texas Transitional Center (STTC), another GEO facility, with two cold meals and one hot meal delivered to the Leidel Center daily.

From Logan's Garden there is a breezeway between the older building and the newer addition. There are case manager's offices on both sides of the entry to this area and male Dorm H. A restroom and laundry room are on the far end of the dorm.

The facility has thirty staff and one volunteer. Currently seven vacancies include four Security Monitors, one maintenance Technician and two Case Managers. The facility does not utilize the services of contractors.

Security monitors conduct four counts per shift and record these counts on a *Housing Count Roster.* The Assistant Director of Security performs count verifications once per week to ensure that counts are being conducted as required and documents them on the *Resident Count Verification Checklist* In addition to the required counts, hourly security checks are made and documented on the *Hourly Security Checklist Form.* PREA unannounced rounds are conducted three times per week (once each shift). To augment staff supervision and monitoring of its residents, the facility has 45 cameras. A DVR stores surveillance video for approximately 15 days. The camera monitors were viewed with the Facility Director/PREA Compliance Manager and were found to be strategically placed to capture all common areas and entries to living areas and common areas.

Leidel Center's mission statement is: "Leidel Residential Reentry Center (RRC) offers an alternative to incarceration and an effective method to transition offenders from correctional facility back into society. In order to successfully transition residents back into society, Leidel RRC maintains qualified staff, volunteers, community resources and contacts, as well as a physical plant conducive to offering effective programs, accountability measures and resident services.

The mission of the Leidel RRC is to return responsible, productive men and women to their families and communities through comprehensive Offender Community Reentry Plan (OCRP). The OCRP begins at the time the offender is referred to the facility. All community reentry plans focus on the needs of the individual resident, cover the entire length of placement and address all areas of concern. In addition, OCRP emphasize decreasing levels of external supervision and increasing levels of personal responsibility. All goals have a time schedule for achievement. Examples of preliminary goals include: (1) obtaining valid government-issued identification; (2) opening a savings account; and/or (3) contacting a supportive family member. Leidel RRC ensures that all programs, services and opportunities are provided to each resident without discrimination based on race, sex, creed or national origin. In addition, the Leidel RRC maintains open channels of communication between all levels of staff and the residents, including a BOP grievance policy."

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: 7

Number of standards met: 29

Number of standards not met: 0

Number of standards not applicable: 3

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 Leidel Residential Reentry 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 Facility Director/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)

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

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 0504-1, pages 2 & 3, 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's staffing plan provides a minimum-security staff-to-resident ratio of 1:63. In most instances, this requirement is exceeded to 1:38 or more.

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 reviewed staff rosters, observing cameras and checking KRONOS. Monthly employee rosters are forwarded to BOP for their review. In interview with the Facility Director, in this audit period there were no times that there were deviations to the staffing plan. Staff vacancies are filled by the use of staff overtime to ensure the correct staff-to-resident ratio.

The staffing plan is reviewed annually by the Facility Director/PREA Compliance Manager, the Assistant Director of Security and the Assistant Director of Programs and documented on the *PREA Annual Facility Assessment* form. This form is then forwarded to the 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. In the 2015 and 2016 *PREA Annual Facility Assessments,* no recommendations were made for changes to the established staffing plan.

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. There are four counts per shift, which are documented on the *Housing Count Roster.* Management staff are required to complete, at a minimum, unannounced PREA rounds once a shift each month. These rounds are documented on the *Unannounced PREA Rounds Log*. Employees are prohibited from alerting residents or other employees that these supervisory rounds are occurring. 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 Assistant Director 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 *Hourly Security Checklist Forms, Housing Count Rosters* 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 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 15 & 16, section I, and facility policy 0903-1, pages 2 & 3 the facility prohibits strip searches, body cavity searches and cross gender pat searches.

Pat searches are conducted in the Lobby/Control area in view of security cameras. All residents are searched when entering the facility from being in the community, when leaving onsite work facility assignments 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. The agency's *Guidance in Cross Gender and Transgender Pat Searches* curriculum was provided for review. Staff sign a *Cross Gender Pat Searches & Searches of Transgender & Intersex* acknowledgement form upon completion of this training and sign a *Training Record Sign In Log*. 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. 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.

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 was one transgender resident housed at the facility. She reported that she is allowed to shower alone and prefers being pat searched by female staff.

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 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. The facility did not have a Spanish version of the *PREA: What You Need to Know* video. The Director, Fidelity & Quality Assurance will ensure they receive a copy. It was recommended that the two Spanish speaking residents view the video when it is received. Two staff members are proficient in the Spanish language and provide translation for Spanish speaking residents. A contract with Language Line Services, Inc. provides for the translation of any other languages. A TTY is available for deaf residents and there is an amplified telephone for residents who are hard of hearing. One staff member is available to provide sign language interpretation.

At the time of the audit, there were no residents that were deaf, hard of hearing, blind, with cognitive deficits or low reading skills. Two Spanish speaking residents were interviewed with translation provided by the Office Support Specialist. They

reported receiving all written PREA information in Spanish. There was one resident with low vision, but upon interview he stated that he was able to read and understand the PREA information provided to him.

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)

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 7 & 8, section C-2 and page 15, section H-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/NLETS 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. The agency also requires that all contractors and volunteers who have contact with residents have criminal background checks.

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 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 at the time of the contract renewal. BOP performs NCIC/NCLETS background checks on employees every two years. Personnel files of random employees and the one volunteer were reviewed and found to contain pre-employment criminal background checks and five-year background checks as well as BOP NCIC/NLETS background checks every two years.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ 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 Leidel 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 or installed or updated the video monitoring system, electronic surveillance system or other monitoring technology since the last PREA audit; therefore, this standard is not applicable to this facility.

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)

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 6-9, sections D-I and facility policy 0803-1, pages 6 & 7, section 2, outlines the agency's requirements as it applies to this standard. 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 Houston Police Department and BOP are responsible for conducting criminal investigations 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 provided through the Harris County Health District and referred to the Ben Taub General Hospital or to the LBJ General Hospital, both located in Houston, TX. The Harris County Health District will not enter into a Memorandum of Understanding with the Leidel Center, but provides SANE exams to its residents. In the past 12 months, there have been no residents who have required SANE exams.

The facility has attempted to enter into a Memorandum of Understanding with the Houston Area Women's Center for crisis intervention and victim advocacy services. The Facility Director/PREA Compliance Manager has made contact with this agency and plans are in place to meet and discuss the terms of an MOU. Plans are also in place to secure an MOU with the Bridge Over Troubled Waters. Both the Houston Area Women's Center and the Bridge Over Troubled Waters provide services to the residents of the Leidel Center.

Residents are made aware of the confidential emotional support services available to them in the *PREA Education Manual for Residents,* page 9 and on PREA posters displayed throughout the facility. When interviewed, residents were aware of the

confidential emotional support services available to them and how to access them.

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 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 and the GEO Reentry Services Regional Director. The facility initiates an administrative investigation and if it is determined that the allegation involved potential criminal activity, a referral is made to the Houston Police Department or BOP 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 was one allegation of staff-on-resident sexual abuse reported. The allegation was referred to OPR and to BOP for investigation. The outcome of the investigation is pending completion of the investigation. 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) 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, the facility has Director's Monthly Staff Meetings where PREA is reviewed and discussed. 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 Facility Director/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. Staff also receive the *Guidance in Cross-Gender and Transgender Pat Searches* training and sign a training roster and a *Cross Gender & Pat Searches & Searches of Transgender and Intersex* form upon completion of this training. The Facility Director/PREA Compliance Manager maintains documentation of annual PREA training for employees.

In the past 12 months, all Leidel Center staff have received this training as verified by review of employee training files. 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. The facility exceeds in this standard as was evident by review of the training curriculums, review of staff training records and the overall knowledge of staff in response to interview questions.

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 13, section G-1 & 2, and contractor training on page 14, section 1 & 2. Reality house does not utilize the services of contractors. The facility currently has The training curriculum *Sexually Abusive Behavior Prevention and Intervention Program (PREA Orientation and Training 2013*) was provided for review. Volunteers are trained on their responsibilities under GEO's sexual abuse and harassment prevention, detection and response policies and procedures including their responsibility and method of reporting any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment. The facility has one volunteer. The facility does not utilize the services of contractors.

In review of the volunteers training record, he signed a *PREA Basic Acknowledgement* form acknowledging that he received and understood the training provided to him. When interviewed by telephone, he acknowledged receiving the training 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 3 & 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. The Assistant Director of Programs provides comprehensive resident PREA education Wednesday of each week to new arrivals.

In the past 12 months, 627 residents admitted to the facility and one resident 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.

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 Assistant Director of Programs maintains this documentation in individual PREA resident files, which contains all PREA-related forms. The files have color-coded labels identifying potential victims, potential predators and transgender residents by different colored labels. Ongoing PREA information is provided on numerous posters, both in English and Spanish, prominently displayed in numerous locations throughout the facility.

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. The Assistant Director of Programs 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 1, 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 for investigators. There are no trained facility investigators as the Leidel 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.

Leidel 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 Leidel Center are assessed for their risk of being sexually abused or sexually abusive towards others within 24 hours of arrival to the facility by 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.

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 Risk Assessments* and *PREA Vulnerability Reassessment Questionnaires* are filed in the individual PREA resident files maintained by the Assistant Director of Programs. To maintain confidentiality, only the Facility Director/PREA Compliance Manager, the Assistant Director of Programs, the Assistant Director of Security and Case Managers have access to this information.

In interview with the Case Managers and the Assistant Director of Programs and in review of 25 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, exceeding in the requirements of this standard.

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/PREA Compliance Manager, he 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 MHMRA or to Cross Creek if they are referred previously by BOP. 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 in the first cubicle as you enter the dorms or in the bunks closest to the door in open bay dorms to be more visible to staff, 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 was one transgender female housed at the facility. When interviewed she stated that she was not housed any differently because of her sexual orientation and she is allowed to shower alone.

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 803-1, page 5, section VII-A 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/PREA Compliance Manager immediately 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.

On page 6 of the *PREA Education Manual for Residents,* residents are provided the phone number and mailing addresses of the Residential Reentry Manager and the Oversight Specialist that they may contact. In addition, residents are informed that they can call 911 to report allegations of sexual abuse.

The *Residents Reporting Options* poster informs residents 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 Houston Area Women's Center (713-528-7273) and the Bridge over Troubled Waters (713-472-0753). It was brought to the facility's attention that the website for the Houston Area Women's Center also listed a toll-free number (800-256-0661) and a TDD hotline number (713-528-3691). These numbers were added to the *Residents Reporting Options* posters. All numbers are available to residents 24 hours a day, seven days a week and they may remain anonymous if they wish to. 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 on page 8 in the *PREA Education Manual for Residents* and new residents are given a copy of the *Resident Grievance Procedures* and receive orientation on the grievance procedure.

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 Facility Director/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 Houston Area Women's Center and to the Bridge Over Troubled Waters where advocates are available 24 hours a day, seven days a week. This information is provided to residents in the *PREA Education Manual for Residents* and on the *Resident Reporting Options* 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.

The facility attempted to secure an MOU with the Houston Area Women's Center that provide crisis intervention and victim advocacy services to the Leidel Center. The facility also is interested in securing an MOU with the Bridge Over Troubled Waters that also provides crisis intervention and victim advocacy services to the residents of the Leidel Center. The Facility Director/PREA Compliance Manager has recently reached out to both agencies and plans are in place to meet to further discuss entering into an MOU with these agencies. (See *Narrative* section, page 2, paragraph 3, for details)

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 18, section 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 page 20, section L-4 of GEO policy 5.1.2-A. The facility's requirement on staff reporting duties can be found on pages 5 & 6 of facility policy 0803-1, section VII-B. Staff must take all allegations of sexual abuse and sexual harassment seriously. All staff are required to report immediately to the Facility Director/PREA Compliance Manager 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 of sexual abuse and sexual harassment, 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.

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

Leidel 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 and facility policy 803-1, section VI.

In interview with the Facility Director/PREA Compliance Manager and documentation provided, there were no times during the past 12 months that it was necessary for the agency to take immediate action in regards to a resident being in substantial risk of sexual abuse. Staff interviewed 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 10, 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 Facility Director/PREA Compliance Manager.

In interview with the Facility Director/PREA Compliance Manager and in review of documentation provided, in the past 12 months, no residents of Leidel Center alleged that sexual abuse had occurred while they were confined to another facility.

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

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 and facility policy 0803-1, pages 6 & 7, section C, 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.

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. In the past 12 months, there have been no PREA incidents that required implementing first responder duties.

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 III-A-4 and review of Leidel 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/PREA Compliance Manager, the Assistant Director of Security and the Assistant Facility Director - Programs 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.

Leidel 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 10-12, section I. 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 Facility Director/PREA Compliance Manager is responsible for weekly monitoring for retaliation for at least 90 days and longer if there is a continuing need. 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 no allegations reported in 2015 or 2016. There was one allegation of sexual abuse received in February 2017 from a resident who had been discharged from the facility when the report was received. When interviewed, the Facility Director/PREA Compliance Manager knew his responsibilities for monitoring for retaliation per policy.

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 Leidel 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.

The supervisor receiving the report of an allegation of sexual abuse or sexual harassment immediately notifies the Facility Director who notifies the PREA Coordinator and the Director, Fidelity & Assurance and the BOP Residential Reentry Manager. According to the BOP Statement of Work for Residential Reentry Centers, pages 18 & 19, the facility is not allowed to conduct any investigation of misconduct without the Contracting Officer's Technical Representative's (COTR's) approval. Criminal investigations are investigated by the BOP or by the Houston Police Department pursuant to the requirements of this standard. 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.

Since the initial PREA audit, there were no allegations of sexual abuse that were referred for criminal investigation. There were no allegations received in 2015 and 2016. One allegation of staff-on-resident sexual abuse was received in February 2017 from a resident who had been discharged from the program. That investigation is ongoing by the BOP.

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 did not receive any allegation of sexual abuse or sexual harassment in 2015 or 2016. One allegation received in February 2017 is ongoing and being investigated by BOP.

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, page 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 Facility Director/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 no notification of the outcome of an investigation were required. The one sexual abuse allegation received is ongoing by the BOP. The resident who made the allegation was released from the program prior to reporting the allegation. Based on interview with the Facility Director/PREA Compliance Manager, the process of providing notification to resident victims at the conclusion of an investigation is in place and being followed.

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.

Leidel Center does not utilize the services of contractors. The facility has one volunteer who has not violated the agency/facility's zero-tolerance policies.

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 facility policy 0803-1, page 13, section N-2, the BOP and the USPO are the supervising authorities over all residents at the Leidel 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 in the *Resident Handbook,* Chapter 202.

Based on GEO policy 5.1.2-E, page 12, section 2, 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. Residents are informed of the prohibited acts of sexual misconduct and the sanctions imposed for violating those acts on page 28 of the *BOP Residential Program Handbook.*

The BOP 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.

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, page 8, section 4-e & h. Resident victims are referred to the Harris County Hospital District (Ben Taub or LBJ Hospitals) for SANE exams at no cost to the resident. Counseling and victim advocacy services would be provided by referral to the Houston Area Women's Center or the Bridge Over Troubled Waters.

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 Leidel Center who have been victimized

by sexual abuse. According to GEO policy 5.1.2-A, page 25 section M-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. Referrals are made to the Ben Taub or LBJ Hospitals for emergency and ongoing medical 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. Mental health services are provided by referral to MHMRA or to Cold Creek.

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 3 and facility policy 0803-1, pages 12 & 13, 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/PREA Compliance Manager and the Assistant Director of Programs make up the facility's Incident Review Team. 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 no incident reviews required. When interviewed, the Facility Director/PREA Compliance Manager and the Assistant Director of Programs 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 Facility Director/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). 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 (www.geogroup.com). 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 www.geogroup.com. Before making aggregated sexual abuse data publicly available, all personal identifiers are redacted.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Barbara Jo Denison April 13, 2017

Auditor Signature Date