PREA AUDIT REPORT ☐ Interim ☒ Final
ADULT PRISONS & JAILS

Date of report: May 12, 2017

<table>
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<tr><td colspan="4">Date of facility visit: April 18–19- 2017</td></tr>
<tr><td colspan="4">Facility Information</td></tr>
<tr><td colspan="4">Facility name: Western Region Detention Center</td></tr>
<tr><td colspan="4">Facility physical address: 220 West C Street, San Diego, CA 92101</td></tr>
<tr><td colspan="4">Facility mailing address: (if different from above) Click here to enter text.</td></tr>
<tr><td colspan="4">Facility telephone number: 619-232-9221</td></tr>
<tr><td rowspan="3">The facility is:</td><td>☐ Federal</td><td>☐ State</td><td>☐ County</td></tr>
<tr><td>☐ Military</td><td>☐ Municipal</td><td>☒ Private for profit</td></tr>
<tr><td colspan="3">☐ Private not for profit</td></tr>
<tr><td>Facility type:</td><td>☐ Prison</td><td colspan="2">☒ Jail</td></tr>
<tr><td colspan="4">Name of facility's Chief Executive Officer: Eric Noonan, Warden</td></tr>
<tr><td colspan="4">Number of staff assigned to the facility in the last 12 months: 321</td></tr>
<tr><td colspan="4">Designed facility capacity: 760</td></tr>
<tr><td colspan="4">Current population of facility: 736</td></tr>
<tr><td colspan="4">Facility security levels/inmate custody levels: High</td></tr>
<tr><td colspan="4">Age range of the population: 18-83</td></tr>
<tr><td colspan="3">Name of PREA Compliance Manager: Nicole Allen</td><td>Title: Programs Director/PREA Compliance Manager</td></tr>
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<tr><td colspan="4">Agency Information</td></tr>
<tr><td colspan="4">Name of agency: The GEO Group Inc.</td></tr>
<tr><td colspan="4">Governing authority or parent agency: (if applicable) Click here to enter text.</td></tr>
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<tr><td colspan="4">Mailing address: (if different from above) N/A</td></tr>
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<tr><td colspan="4">Agency-Wide PREA Coordinator</td></tr>
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AUDIT FINDINGS

NARRATIVE

The PREA on-site audit of the Western Region Detention Facility was conducted on April 18 - 19, 2017, by this Department of Justice Certified PREA Auditor, Barbara Jo Denison. Pre-audit preparation included a thorough review of all policies, procedures, training curriculums, the Pre-Audit Questionnaire and supporting PREA-related documentation provided by the facility to demonstrate compliance to the PREA standards. For each standard, interviews, observations, and review of documentation provided verified that practices are consistent with agency and facility policies and practices. Questions during this review period were answered by Nicole Allen, Programs Director/PREA Compliance Manager.

On the first day of the audit, an entrance meeting was held with the following people in attendance: Eric Noonan, Warden, Nathan Allen, Deputy Warden, Nicole Allen, Programs Director/PREA Compliance Manager, Sean Desmond, Intelligence Officer, Christopher Carney, Chief of Security, Tiffany Carney, ACA Compliance Administrator and Rob Walling, Manager, Contract Compliance PREA. Following the meeting Eric Noonan, Warden, Nathan Allen, Deputy Warden, Nicole Allen, Programs Director/PREA Compliance Manager and Rob Walling, Manager, Contract Compliance PREA accompanied me on a tour of the facility. During the tour, the location of cameras and mirrors, the physical layout of the facility including shower/toilet areas, adequacy of staff supervision and placement of PREA information was observed. PREA information in both English and Spanish is posted in all housing units and day rooms. During the tour 12 detainees and 7 staff were informally interviewed and questioned about their knowledge of the agency/facility's zero-tolerance policy.

During the tour the United States Department of Justice Office of the Inspector General (OIG) was called on a detainee pay phone. When detainees pick up the phone to make any call, they are prompted to dial "0" and then "1" to report an allegation of sexual abuse or sexual harassment. By dialing "0" and then "1" a lengthy automated response instructs the detainee to send a letter to OIG and provides the mailing address for OIG. At the end of the automated response the detainee is instructed to dial "9" to speak to someone. When I followed the prompts, and dialed "9" I asked the person answering the phone the process when detainees dial "9" as instructed to do so. I was told that they would again be given the mailing address for OIG. I asked if an allegation would be verbally accepted and the response was that all allegations are accepted in writing only. Written allegations are forwarded to an OIG criminal investigator who makes a determination to initiate an investigation or refer for investigation by the facility or to local law enforcement.

The number for the San Diego Access and Crisis Line (888-724-7240) was called on a detainee pay phone. The number was unable to be accessed as it required a pin number to be entered. I questioned whether the caller could be identified through their pin number. The facility's phone technician was consulted and found that the number was not set up to be anonymous. He was able to make a change to the number and verified by a test call that calls to that number would remain anonymous. He also set up the number to be accessible to detainees by dialing *555. I

called the San Diego Access and Crisis Line to find out the process if a detainee victim called to report an allegation of sexual abuse. Victims would be instructed to go to a hospital for a forensic exam and to call the local police. They would be offered supportive counseling through referral to the Center for Community Solutions.

The United States Marshal Service (USMS) has an agreement with the Center for Community Solutions to provide victim advocacy services to detainee victims of sexual abuse. The Sexual Assault Victim Advocacy Manager of the Center for Community Solutions was contacted prior to the onsite audit. She shared that services include not only victim advocacy services, but also include referrals for counseling and legal and civil services related to the sexual assault case. The Center for Community Solutions has a Sexual Abuse Response Team (SART) who would be contacted by the forensic nurse when a victim is transported to the hospital for a forensic exam. The agency would send a victim advocate to accompany the victim during the forensic exam. Within 24-48 hours following the forensic exams, the victim advocate would contact the victim to offer support services, resources and referrals. All services provided are confidential and at no cost to the victim.

The Center for Community Solutions has a 24-hour crisis hotline and this number (888-272-1767) was added as a reporting option for detainees to report allegations of sexual abuse. The number was set up to be anonymous and can be accessed by the detainee dialing *444 or dialing 888-272-1767. The revisions to the reporting options for detainees were made to the PREA posters and to the Detainee Handbook before the conclusion of the audit.

Forensic exams are provided by agreement with the USMS and Independent Forensic Services. The owner of Independent Forensic Services was contacted prior to the audit. Law enforcement would contact her when a detainee victim of sexual abuse was in need of a forensic exam. She shared that effective May 1st, the Independent Forensic Services will be closing. The contract with Independent Forensic Services was not renewed and the contract has been awarded to Palomar Health to provide forensic services. This information was shared with the Programs Director/PREA Compliance Manager. She made contact with Palomar Health to discuss the services they will provide to detainee victims of the Western Region Detention Facility after May 1st. She received some information back from Palomar Health and shared this information with her USMS contact person.

The population on the first day of the audit totaled 736. A random selection of 45 detainees from all housing units were interviewed. This number included two detainees identified from initial screening to be at risk for victimization, two detainees identified from initial screening to be at risk for abusiveness, two detainees who self-disclosed at initial screening of being gay, one self-disclosed transgender detainee and fourteen detainees that were Spanish speaking only. At the time of the audit visit, there were no detainees who were blind, had low vision, deaf, hard of hearing and none that had cognitive or other deficits. A large portion of the detainee population is Spanish speaking only; all other detainees were proficient in the English language. Staff interpreters provided translation during interviews of Spanish-speaking detainees.

There were 16 specialized staff interviews conducted, which included three contractors and one

volunteer. Twenty-four security staff were interviewed which included two shift supervisors and six-line staff from each of the three security shifts. All interviewed were knowledgeable of their responsibilities of detecting, preventing, responding and reporting allegations of sexual abuse and sexual harassment. They confirmed receiving PREA refresher training annually and shared that PREA is discussed frequently during shift briefings.

The personnel files of 25 employees, three contractors and two volunteers were reviewed with the Human Resource Manager to determine compliance with required background checks. Documentation was found to be complete with background checks performed prior to employment and every five years thereafter. The same 25 employee training files were reviewed to determine compliance to PREA training mandates. Records reviewed showed annual PREA training completed each year since the last PREA audit and documentation of this training is being maintained by the facility. Security staff receive training on how to conduct cross gender pat searches and searches of transgender and intersex detainees. Documentation of this training is maintained by the facility and was provided for review.

The records of 30 detainees were reviewed to evaluate compliance to initial and 30-day reassessment screenings. All records reviewed showed initial screenings completed upon arrival to the facility and 30-day reassessments completed close to 30 days after arrival. The same 30 detainee files were reviewed for documentation that detainees are receiving PREA information upon arrival to the facility and timely comprehensive PREA education.

In the 12 months preceding the audit, the facility received five PREA allegations, which were administratively investigated in accordance with the PREA standards. The following is a breakdown of those allegations:

Number Received	Description of Compliant	Investigative Results
2	Detainee-on-Detainee Sexual Abuse	1 – Pending Investigation 1 - Unsubstantiated
1	Detainee-on-Detainee Sexual Harassment	1 – Unsubstantiated
2	Staff-on-Detainee Sexual Harassment	1 – Unfounded 1 - Unsubstantiated

Investigative files were reviewed with the Intelligence Officer and the Programs Director/PREA Compliance Manager, who are both trained facility investigators, with Rob Walling, Manager, Contract Compliance PREA present. Investigations were found to be investigated in accordance with the PREA standards.

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with

Eric Noonan, Warden, Nathan Allen, Deputy Warden, Nicole Allen, Programs Director/PREA Compliance Manager and Rob Walling, Manager, Contract Compliance PREA in attendance. During the exit meeting, the facility was informed of the process that would follow the on-site visit and the responsibility of the agency to post the final report on their website. The team was thanked for their cooperation prior to and during the on-site visit. They were complimented on the PREA program they have developed and enhanced and on their willingness to achieve PREA compliance with all 43 of the PREA standards. It was evident that the administrative team and all staff at the Western Region Detention Facility take pride in their PREA efforts and strive to continue to comply and enhance their PREA program.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Western Region Detention Facility (WRDF) is located in downtown San Diego at 220 West C Street. The building was constructed in 1957 and was used and operated by the County of San Diego's Sheriff's Department. The building is attached to the County's Superior Courts and the county jail. There is access to court from the county jail from the third and fourth floors of the facility.

The GEO Group, Inc. finalized arrangements in January 1999 for the renovation and leasing of the building from San Diego County. The renovations included upgrading and reconfiguring the facility, adding central air conditioning and revitalizing the exterior to blend into the downtown décor. In July 2000, GEO Group, Inc. entered into an agreement with the United States Marshal Service (USMS) for detention services and the housing of both male and female federal prisoners. The Western Region Detention Facility received their first detainees July 3, 2000.

The Western Region Detention Facility is an eight-story facility with a capacity to house 760 detainees. The basement of the facility houses the mailroom, laundry, maintenance shop, inmate property, dry food storage and general warehouse. Staff locker and shower rooms are also located in the basement. There are stairways and elevators to move between the floors.

The first floor of the building has administrative offices, a conference room, training room, armory visitation/legal visits and intake/booking area with holding cells. Adjacent to the intake area is a covered, secure vehicle sally port. An intake dorm on this floor provides temporary housing for male detainees for up to a week after their arrival.

Western Region Detention Facility has 37 housing units. Floors two-seven have detainee housing. The second floor has an annex with a staff barbershop, medical triage room and four male dorms, with one shared day room. The third floor houses females and floors four thru seven house male detainees. The sixth floor is divided between male general population detainees, the medical clinic with two negative airflow cells and medical housing beds. Floors two-six have two restricted housing cells on the north end of each of those floors. Floor five has an additional four restricted housing cells located at both entrances of that floor for a total of 10 restricted housing cells.

Correctional Counselor offices, Detainee Records and staff dining and the kitchen are on the seventh floor. The eighth floor has a large outdoor recreation area with isometric equipment, a volleyball net and handball. Also on the eighth floor, there are staff offices, a chapel and a general/law library.

Restrooms and shower areas were observed to afford detainees privacy when toileting and showering. Open bay dorms have a shower room with plastic shower curtains that are clear on the top and the bottom and restroom areas have a partial metal partition and metal portable barriers tethered on one side that detainees can move to provide additional privacy when using the toilets and urinals. Housing units with individual cells have a shower room adjacent to the cell area and a day room with additional toilets and urinals. There are toilets within the cells and detainees are allowed to hang a curtain in front of the toilet when toileting.

PREA information was posted in all housing areas and day rooms. Pay telephones are in each housing unit and posted information makes reporting options accessible to all detainees.

The facility has a total of 194 camera, 174 interior cameras and 20 exterior cameras. DVR's store data for up to 30 days. Cameras are in all hallways and on the tiers, but restroom and shower areas are not captured by tier cameras. There is a total of five counts per day and security staff make housing rounds at a minimum of every 30 minutes. All housing units have a button that detainees can access Correctional Officers in control centers located on each floor. All detainee movement is escorted by security staff.

Western Region Detention Facility has 313 staff with twelve vacancies (9 Correctional Officers, one Correctional Counselor, one Food Service Worker and one RN). There are four medical contractors and nineteen active volunteers.

Western Region Detention Center's Mission Statement:

> "The mission of the Western Region Detention Facility, San Diego is to achieve a level of excellence through professionalism while providing safety and security of the facility and the surrounding community by maintaining the standards of GEO Corrections and Detention and the United States Marshals Service."

GEO's Mission Statement:

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

SUMMARY OF AUDIT FINDINGS

The facility was found compliant with all 43 PREA standards. The following is a summary of the audit findings:

Number of standards exceeded: 7

Number of standards met: 34

Number of standards not met: 0

Number of standards not applicable: 2

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

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A is a written plan mandating zero tolerance towards all forms of sexual abuse and sexual harassment and outlines the agency's approach to preventing, detecting and responding to such conduct. The policy includes definitions of prohibited behaviors and sanctions for those found to participate in these prohibited behaviors (pages 3-5, section II-B). Western Region Detention Center's policy 1300.05 is the facility policy that outlines the facility's approach to the prevention of sexual abuse of detainees. The policy also includes definitions of prohibited behaviors on pages 3-5, section II-B. GEO's policy 5.1.2-A and the Western Region Detention Center's policy 1300.05 both are comprehensive and provide a thorough description of the agency's approach to reduce and prevent sexual abuse and sexual harassment of detainees, exceeding in the requirement of this standard.

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

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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

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

Standard 115.13 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 300.06, pages 2 & 3, section C-5, the agency has developed, documented and made its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect detainees against sexual abuse. The agency took into consideration the physical layout of the facility, the composition of the population and the prevalence of substantiated incidents of sexual abuse and the resources the facility has available to ensure adequate staffing levels in the development of the facility's staffing plan. The facility adheres to the staffing plan stipulated by the United States Marshal Service contract. The staffing plan includes 313.90 allocated positions. Overtime and call-backs are utilized for staff absences ensuring that the staffing plan is always adhered to.

A *PREA Annual Facility Assessment* is completed by the Programs Director/PREA Compliance Manager, along with other administrative team members, and forwarded to the PREA Coordinator and the Corporate Divisional Vice President for review and signature. The *PREA Annual Facility Assessments* completed annually since the last PREA audit noted no deviations from the staffing plan and no recommendations for any changes to the established staffing levels. In interview with the Warden, he stated that in the past 12 months, there have been no deviations to the staffing plan. The Warden monitors compliance to the staffing plan on a daily basis. A staffing analysis is completed by facility leadership annually to review and discuss the established facility staffing plan.

GEO policy 5.1.2-A, page 7, section C-1-f & g, and facility policy 900.15, page 4, section J, state that executive staff and department heads will conduct and document weekly unannounced rounds to deter employee sexual abuse and sexual harassment. These rounds are to be completed on all three shifts and documented on the *Supervisor/Department Head Unannounced Rounds* form. While making rounds, department heads and Shift Supervisors are required to observe for cross-gender viewing, gender announcements, staff-detainee communication and ensuring that PREA signs are posted in housing areas and holding rooms. The facility prohibits staff from alerting other staff of the conduct of such rounds.

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

Standard 115.14 Youthful inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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

The Western Region Detention Facility does not house youthful detainees; therefore, this standard in not applicable.

Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on review of GEO policy 5.1.2-A, pages 16 & 17, section I and facility policy 1300.05, pages 18 & 19, section I, cross gender strip searches and cross-gender visual body cavity searches are prohibited except in exigent circumstances. Facility policy prohibits cross-gender pat-down searches of female detainees, except in exigent circumstances.

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

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

Staff signs a *Cross Gender Pat Searches & Searches of Transgender and Intersex* acknowledgement form upon completion of this training and completion of this training is recorded electronically on the individuals training record in the *Learning Management System (LMS)*. Receipt of this training was verified through review of staff training records and confirmed by staff interviews of security staff who verified receiving this training.

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

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency takes appropriate steps to ensure that detainees with disabilities and detainees that are limited English proficient, as well as those who are deaf, hard of hearing, blind, have low vision, limited reading skills or cognitive disabilities, have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. GEO's policy 5.1.2-A, pages 11 & 12, section E and facility policy 1300.05, pages 12 & 13, section E address the agency/facility responsibilities to provide PREA education to detainees ensuring their understanding of the education they receive. At the time of the on-site visit, there were no detainees who were blind, had low vision, deaf, hard of hearing, with low reading skills or with cognitive deficits.

Detainees receive a *Detainee Handbook* and a *New Inmate Orientation Handout* available in both English and Spanish. All PREA posters are displayed in both languages. Staff members who are proficient in both the English and Spanish language receive PREA Translation Training and are available on all three shifts to provide interpretation for Spanish-speaking detainees. A contract with Language Line Services, Inc. provides translation of any other languages. The PREA *Speak Up* video is shown in both English and Spanish. The facility has a TTY available for deaf detainees.

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

Standard 115.17 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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, facility policy 300.27, pages 1 & 2, section C, interview with the Human Resources Manager and random review of employee files were used to verify compliance to this standard.

GEO and the Western Region Detention Facility do not hire or promote anyone who may have contact with detainees and does not enlist the services of any contractor or volunteer who may have contact with detainees who

has engaged in sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility or other institution who has been convicted of engaging or attempting to engage in sexual activity in confinement settings or in the community. GEO also considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with detainees. All applicants and contractors receive a background check by Aurico and an NCIC background check through the USMS. Criminal background checks are performed by Aurico effective 1/30/17. Prior to that date, criminal background checks were performed through a contract with Accurate Background, Inc. Volunteers have an NCIC background check through the USMS only.

If an applicant answers on their application that they have worked previously in a confinement facility, a *Custom Employment Report* is ordered along with the Aurico background check for PREA verification. Transportation officers receive a driver's license checks annually through a DMV pull notice system. The facility is automatically notified of any motor vehicle violations of transportation officers.

The agency requires that all applicants and employees who may have contact with detainees have a criminal background check and every five years thereafter. In the past 12 months, there were 33 staff hired who had criminal background checks performed. For consideration for promotions or transfers, employees complete a *PREA Disclosure and Authorization Form Promotions-PREA Related Positions* and a criminal background check by Aurico and NCIC is completed. At the time of annual evaluations, employees complete a *PREA Disclosure and Authorization Form-Annual Performance Evaluation*.

By contract with the USMS, a Limited Background Investigation (LBI) is required to be completed on all new employees and contractors within the first year of hire and every five years thereafter. LBI's are completed through contract with Information Discovery Services (IDS). Volunteers receive an Escorted Conditional Waiver annually and are not required to have an LBI.

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

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

Employee, volunteer and contractor personnel files were randomly reviewed and found to be well organized and complete with background checks completed on all new employees and those considered for promotions and annually. The facility performs criminal background checks and the USMS performs NCIC background checks which exceeds the requirements of this standard.

Standard 115.18 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

GEO policy 5.1.2-A, page 8, section C-3 and facility policy 700.01, page 4, section M, state that the facility takes into consideration the effect that any new design, acquisition, expansion or modifications of the physical plant or monitoring technology might have on the facility's ability to protect individuals in a GEO facility or program from sexual abuse.

The Western Region Detention Facility has not acquired any new facility or had any substantial expansion or modification of the existing facility since the last PREA audit (July 2014).

When installing or updating video monitoring systems, electronic surveillance systems or other monitoring technology, the agency considers how such technology may enhance the agency's ability to protect inmates from sexual abuse. In this audit timeframe, the facility has identified blind spots and added additional cameras. The facility has a total of 194 cameras.

Standard 115.21 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-E, pages 6-10, sections III-D-J and facility policy 1400.04, pages 7-12 section D, the facility follows a uniform evidence protocol for the collection and preservation of evidence for administrative and criminal investigations of sexual abuse. Subsection 115.21 (b) is not applicable to this facility as the facility does not house youth.

Forensic exams are not performed at the facility. Victims of sexual abuse are referred for SANE exams to Independent Forensic Services located in La Mesa, California at no cost to the detainee. In the past 12 months, there have been no detainees that required SANE exams.

Victim advocacy and counseling services are provided through the Center for Community Solutions. Upon the detainee victim's request, a victim advocate would provide emotional support throughout the forensic exam as well as offer support services, resources and referrals to the victim.

Standard 115.22 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

GEO policy 5.1.2-E, page 5, section III, A-2 and facility policy 1400.04, page 4, section III A-1 outline the agency's policy and procedure for investigating and documenting incidents of sexual abuse. Per the Comprehensive Secure Detention Services' contract with the GEO Group, Inc., page 14 states that GEO will report all criminal activity to law enforcement and to the United States Marshal Service COTR. The Western Region Detention Facility ensures that all allegations of sexual abuse or sexual harassment are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior.

In the 12 months preceding the audit, the facility received five PREA allegations, which were administratively investigated in accordance with the PREA standards. There were no allegations referred for criminal investigation.

The agency's policy regarding referral of allegations of sexual abuse and sexual harassment is available on the GEO website https://www.geogroup.com/PREA (Documents and Resources Section)

Standard 115.31 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO employees receive training on the agency's zero-tolerance policy for sexual abuse and sexual harassment at pre-service and annually as part of in-service training. GEO policy 5.1.2-A, pages 12 & 13, section F-1 and facility policy 400.01, pages 10 & 11, section W-1, address the agency's training requirements. All employees, contractors and volunteers receive annual PREA refresher training.

The training curriculum was reviewed and found to contain all of the requirements of 115.31 (a)-1 of this standard. In the past 12 months, 351 employees have received PREA training and since the last PREA audit a total of 824 have received PREA training. Upon completion of this training, employees, contractors and volunteers sign a *PREA Basic Training Acknowledgement* form and records of completion are maintained electronically. In the past, some of the in-service training was a combination of classroom and online training. This training now is all classroom training facilitated by the Training Administrator or the Programs Director/PREA Compliance Manager. In addition to general PREA training, all staff receive training on the Limits of Cross Gender Searches and sign a *Cross Gender Pat Searches & Searches of Transgender and Intersex*.

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

All staff interviewed acknowledged receiving PREA training and were knowledgeable of the zero tolerance policy and of their responsibilities related to the prevention, detection, response and reporting of sexual abuse and sexual harassment. They acknowledged receiving training on cross-gender pat searches that included searches of transgender and intersex detainees and were able to respond appropriately to questions asked of them. The facility is doing an excellent job of training all staff as evident in response to interview questions and in the review of random employee training records.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All volunteers and contractors who have contact with detainees are trained and have annual refreshers on their responsibilities regarding sexual abuse/harassment prevention, detection and response as outlined in GEO policy 5.1.2-A, page 14, section G-1 for volunteers and page 14, section H for contractors, facility policy 400.01, page 12, section 4 for volunteers and pages 13 & 14, section 5-C and in facility policy 1300.05, page 15, section G-1 for volunteers and page 16, section H-1 for contractors.

Volunteers and contractors sign a *PREA Basic Training Acknowledgement* form and sign an acknowledgement of completion of the entire volunteer training and a separate acknowledgement for the PREA portion of the training. In the past 12 months, 19 volunteers and 4 contractors were trained in the agency's policies and procedures regarding sexual abuse and sexual harassment.

In interview with three contractors and one volunteer, they confirmed receiving the training and were knowledgeable of the agency/facility's zero-tolerance policy and their PREA-related responsibilities.

Standard 115.33 Inmate education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 12, section E-2 and facility policy 1300.05, pages 13 & 14, section E-2, outline the agency/facility's requirements of detainee education. Incoming detainees receive information explaining GEO's and Western Region Detention Facility's zero-tolerance policies regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. In the past 12 months, 3154 detainees

received PREA information upon intake and during the orientation process.

During the intake process, detainees are given a *Detainee Handbook,* available in English and Spanish. Pages 8-11 of the *Detainee Handbook* provide the detainee with PREA information. Detainees also receive *New Inmate Orientation Handout.* During the orientation process, detainees view the PREA "*Speak Up"* video and sign a *PREA Video Orientation* form acknowledging viewing the video. In addition, they are read the *PREA Comprehensive Education Plan* and sign a *Sexual Abuse/Harassment Orientation* form, which outlines the topics discussed during PREA orientation. Information provided is in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled as well as to detainees who have limited reading skills. Posters, in both English and Spanish, are displayed in every housing unit and day rooms and various common areas, providing continuous PREA information for detainees.

During detainee interviews, detainees acknowledged receiving written PREA information and viewing the *Speak Up* video. They were knowledgeable in the methods of reporting available to them to report allegations of sexual abuse and sexual harassment. In review of 30 detainee records, the facility is doing an excellent job of ensuring that all incoming detainees receive PREA education and documentation of this education is being maintained by the facility. The facility was found to exceed in this standard.

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 14, section F-3 and facility policy 400.01, page 12, section 3, investigators receive specialized training in addition to the general education provided to all employees. This training includes techniques for interviewing sexual abuse victims, proper use of the Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or referral for prosecution.

The agency has 85 trained investigators agency wide. The Western Region Detention Facility has two trained facility investigators, the Intelligence Office and the Programs Director/PREA Compliance Manager, who completed a four-hour webinar, *PREA Specialized Training Investigation Training* facilitated by the agency's PREA Coordinator and received a certificate of completion that is maintained by the facility and documented electronically.

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

Standard 115.35 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 13 & 14, section 2 and facility policy 400.01, page 11 section 2, states that each facility will train all full-time and part-time medical and mental health staff to detect signs of sexual abuse and sexual harassment, preserving physical evidence and responding effectively and professionally to victims of sexual abuse and sexual harassment.

All healthcare staff receive specialized training in addition to general PREA training provided to all staff. All healthcare staff have received GEO's *Medical & Mental Health Specialized PREA* web-based training and received a certificate of completion. Documentation of this training is maintained electronically in the LMS.

Medical staff do not perform SANE exams. SANE exams are performed by referral to Independent Forensic Services.

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

Standard 115.41 Screening for risk of victimization and abusiveness

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, pages 8 & 9, section D-1 and facility policy 1300.05, pages 9 & 10, section D-1, all detainees are assessed during intake for risk of being sexually abused by other detainees or sexually abusive toward other detainees. Correctional Counselors conduct these screenings. The *PREA Risk Assessment* form is used for this purpose. The form was reviewed and found to contain all requirements of 115.241 (b) of this standard and considers prior acts of sexual abuse and prior convictions for violent offenses. Detainees may not be disciplined for refusing to answer any questions or for not disclosing complete information. In addition to the screening form, a thorough review of any available records that can assist in determining risk assessment is completed. If a detainee scores as a potential victim or a potential abuser, the *PREA Risk Assessment* is faxed to medical for a referral to mental health. If a detainee answers "yes" to any of the screening questions, the Correctional Counselor gives a copy of the screening form to one of the Counselors who maintains a binder filed by floors of these forms.

Within a set time, not to exceed 30 days of the detainee's arrival to the facility, detainees are reassessed by their Case Manager or the Classification Supervisor using the *PREA Vulnerability Reassessment Questionnaire* (HWH 38) for their risk for victimization and abusiveness. The Records Clerks track the 30-day reassessment dates. A detainee's risk level will also be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information. Quarterly detainees are reviewed and the *Programs Quarterly Detainee Review* is completed with the detainee being asked questions related to PREA. Upon discharge from the facility, detainees are asked PREA questions on the *PREA Exit Questionnaire*.

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

Standard 115.42 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Guidelines on housing and program assignments and for the management of transgender and intersex detainees are outlined in GEO policy 5.1.2-A, page 10 & 11, section 3 and facility policy 1300.05, pages 11 & 12, section 3. Transgender and intersex detainees are reassessed at least twice per year to review any threats to safety experienced by the detainee as required by this standard and takes into consideration their own views regarding their own safety. Transgender and intersex detainees are given the opportunity to shower alone.

GEO does not place lesbian, gay, bisexual, transgender or intersex residents in dedicated units or wings solely based on such identification. A Transgender Care Committee (TCC) meets to make appropriate housing determinations for transgender and intersex residents within 72 hours of their arrival to the facility. Transgender and intersex detainees may be housed in medical until appropriate housing determination is made by the TCC. The PREA Coordinator may also be consulted. The Warden or designee, the Deputy Warden, Chief of Security, the HSA and/or the Psychologist, a Correctional Counselor and the Programs Director/PREA Compliance Manager make up the TCC. Notes from the TCC meeting are documented on the *Transgender Care Committee Summary* (attachment D) and retained in the resident's institutional file with a copy forwarded to the PREA Coordinator. Housing and programming assignments for transgender and intersex residents shall be reassessed every 6 months using the *PREA Vulnerability Reassessment* form.

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

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

Standard 115.43 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, pages 17 & 18, section K-1 and facility policy 1300.05, page 20, section K-1, involuntary segregated housing may be used only after an assessment of all available housing alternatives has shown that there are no other means of protecting the detainee. If an assessment cannot be made immediately, the detainee may be placed in involuntary segregated housing for no more than 24 hours.

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

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

On interview with the Warden, he confirmed that in the past 12 months, there were no detainees held in involuntary segregated housing and further said if necessary to ensure the safety of a detainee at high risk for victimization, a medial holding cell would be used for this purpose for a short time only.

Standard 115.51 Inmate reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

GEO policy 5.1.2-A, page 18, section L and facility policy 1300.05, pages 20 & 21, section L-1, outline reporting methods available to detainees to report allegations of sexual abuse and sexual harassment. The agency/facility provides multiple ways for detainees to privately report sexual abuse and sexual harassment and retaliation by other detainees or staff for reporting. Detainees are instructed that they can verbally report to the Warden, the Programs Director/PREA Compliance Manager or any staff member, report in writing, by telephone, submit a grievance or sick call or by a third party report.

The facility provides detainees with one way for detainees to report abuse or harassment to a public or private entity or office by giving them the addresses and phone numbers of the Office of the Inspector General and GEO's PREA Coordinator, the Center for Community Solutions and the San Diego Access and Crisis Line. Reporting information is posted in all housing units and day rooms in both English and Spanish, in the *Detainee Handbook* on pages 11 & 12, reviewed in the PREA Education provided to all detainees at orientation and found on page 4 of the *Western Region Detention Facility New Inmate Orientation Handout.*

The agency's policy mandates that staff accept all reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Information concerning the identity of detainee victim's report of sexual abuse or sexual harassment are limited to those who need to know only. Detainees interviewed were aware of the methods available to them to report allegations of sexual abuse and sexual harassment.

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

Standard 115.52 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In review of GEO policy 5.1.1-A, pages 19 & 20, section L-2, facility policy 1300.05, pages 21 & 22, section 2 and facility policy 1400.02, pages 4-6, section 10, there is a procedure in place for detainees to submit grievances regarding sexual abuse and the agency has procedures in place for dealing with these grievances. There is no time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse.

Detainees are informed of the grievance process on pages 11 & 12 of the *Detainee Handbook.* Detainees have a right to submit grievances alleging sexual abuse to someone other than the staff member who is the subject of the complaint. If a third party files a grievance on a detainee's behalf, the alleged victim must agree to have the

grievance filed on his behalf. Emergency grievances may be filed if a detainee feels he is at substantial risk of imminent sexual abuse.

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

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

The Programs Director/PREA Compliance Manager receives all copies of grievances related to sexual abuse or sexual harassment for monitoring purposes. In the past 12 months, the facility has not received any grievances alleging sexual abuse and there were no emergency grievances received.

Standard 115.53 Inmate access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As stated in GEO policy 5.1.2-A, pages 24 & 25, section K and facility policy 1300.05, page 28, section 10, detainees are provided with access to outside victim advocates for emotional support. The USMS have an agreement with the Center for Community Solutions to provide confidential support services to detainee victims of sexual abuse.

Detainees are made aware of the outside confidential support services available to them through posters displayed throughout the facility and in all housing units and day rooms and information provided in the *Detainee Handbook*, pages 10 & 11.

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

Standard 115.54 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 20, section 3, the agency has a method to receive third party reports of sexual abuse and sexual harassment. Family members or other individuals may report verbally or in writing any time they have knowledge or suspect a detainee has been sexually abused, sexually harassed, or requires protection. Information on third party reporting is available on the GEO website at http: www.geogroup.com/PREA (Social Responsibility-PREA Certification Section) and on employee posters located in the front lobby and on staff bulletin boards.

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

Standard 115.61 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 20, section 3, and facility policy 1300.05, pages 22 & 23, section 4, and in review of the employee training curriculum, all staff are to report immediately any knowledge or information regarding an incident of sexual abuse or sexual harassment or any detainee subject to risk of imminent sexual abuse and retaliation or suspected retaliation against detainees or staff. Staff must take all allegations of sexual abuse and sexually harassment seriously. All allegations, including third party and anonymous reports, are reported to supervisors.

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

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

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

Standard 115.62 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

When an agency learns that a detainee is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the detainee. GEO policy 5.1.2-A, pages 20 & 21. section L-1, and facility policy 1300.05, page 23, section M-1 address the procedures related to the agency and facility's efforts to protect detainees who may be at risk for sexual abuse.

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

Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section 5 and facility policy 1300.05, page 27, section 5 were used to verify that there is a procedure in place if an allegation is received that a detainee was sexually abused while confined at another facility. Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the Warden or the Deputy Warden will notify the head of the facility where the sexual abuse was alleged to have occurred and document that notification was provided. This notification should be made as soon as possible, but no later than 72 hours of receiving the allegation and should include all actions taken regarding the incident. Copies of this documentation is then forwarded to the Programs Director/PREA Compliance Manager and the PREA Coordinator.

If a report is received from another facility regarding alleged sexual abuse occurring at Western Region Detention Facility, the allegation will be reported and investigated in accordance with PREA standards. Since the last audit, the facility has not received any reports from other facilities of allegations of sexual abuse or sexual harassment that occurred while a detainee was housed at the Western Region Detention Facility.

In interview with the Warden and documentation provided for review, in the past 12 months the facility received two allegations that a detainee was abused while confined at another facility. Proper notification was made to the Warden

of that facility and documentation of that notification is maintained by the facility.

Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 21-23, sections 2-4 and facility policy 1300.05, page 23 & 24, section 2, were used to verify compliance to this standard. Upon learning that a detainee was sexually abused, the first security staff member to respond to the report is required to separate the alleged victim and the abuser, immediately notify the Duty Warden or the on-call supervisor, preserve and protect the crime scene, not let the victim and abuser take any actions that could destroy physical evidence and not reveal any information related to the incident to anyone other than staff involved with investigating the alleged incident. During PREA training, staff, volunteers and contractors are informed of their response to allegations of sexual abuse.

If the first staff responder is not a security staff member, the responder is required to request the alleged victim not take any actions that could destroy the evidence and notify security staff immediately. All staff carry with them a First Responder Card, which reminds them of the actions to be taken in response to an allegation of sexual abuse.

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

Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Part of the response plan is the requirement of completing a *PREA Incident Checklist for Incidents of Sexual Abuse*

and Harassment to ensure that all steps of the plan are carried out and proper notifications are made. It is the responsibility of the shift lieutenant, the facility investigator, the sergeants and the Programs Director/PREA Compliance Manager 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 or sexual harassment.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

In the past 12 months, there was one allegation of staff-on-detainee sexual harassment that was determined to be unfounded. The staff member alleged in the allegation was removed from his post and assigned to another post until the conclusion of the investigation.

The Western Region Detention Facility does not have any collective bargaining agreements. In interview with the Vice President, Risk Management on 1/27/17, he stated that there are no collective bargaining agreements in any of the agency's facilities that would prohibit removal of an alleged staff sexual abuser from contact with inmates pending an investigation.

Standard 115.67 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 25 & 26, section N-2 and facility policy 1300.05, pages 29 & 30, section 2 were used to verify compliance to this standard. Detainees and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations will be protected from retaliation from other detainees and

staff. Housing changes or transfers for detainee victims or abusers, removal of alleged staff or detainee abusers from contact with victims and emotional support services for detainees who fear retaliation will be protection measures used as per agency and facility policies.

The Programs Manager/PREA Compliance Manager and the Psychologist are responsible for monitoring for retaliation. Weekly monitoring to begin the week following the incident for a minimum of 90 days or longer if warranted will terminate if the allegation is determined to be unfounded. Monitoring for retaliation is documented on the *Protection from Retaliation Log*. Completed logs are retained in the corresponding investigative file.

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

Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency and facility prohibits detainees who have alleged sexual abuse to be placed in involuntary segregated housing. If segregated housing were used, the same provisions as outlined in GEO policy 5.1.2-A, page 24, section 6, facility policy 1300.05, page 20, section K and facility policy 1800.01, page 8, section h would apply. Any use of segregated housing to protect a detainee who alleged to have suffered sexual abuse will be subject to the requirements of standard 115.43.

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

Standard 115.71 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An investigation is completed for all allegations of sexual abuse and sexual harassment at the Western Region Detention Facility, including third party and anonymous reports. The agency's policy governing administrative and criminal investigation of sexual abuse is outlined in GEO policy 5.1.2-E, pages 4 & 5, section III-B-1 and in

facility policy 1400.04, pages 5 & 6, section B.

All allegations of sexual abuse and sexual harassment, including third party and anonymous reports are investigated by one of the two trained facility investigators. All allegations are reported to the USMS COTR and tracked on the *Monthly PREA Incident Tracking Log.* Since the last audit, there were no sustained allegations that appeared to be criminal.

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

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

Investigative files were reviewed and found that all allegations of sexual abuse and sexual harassment are being administratively investigated by the facility in compliance with the PREA standards.

Standard 115.72 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-E, page 6, section 2-d and facility policy 1400.04, pages 5 & 6, section B-1, the facility shall impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

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

Standard 115.73 Reporting to inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Based on GEO policy 5.1.2-E, pages 10 & 11, section K and facility policy 1400.04, pages 13 & 14, section K, the facility ensures that proper notification be given to detainees as to the outcome of the investigation of sexual abuse and sexual harassment allegations if the outcome of the investigation proved to be substantiated, unsubstantiated or unfounded. The Facility Investigator provides a *Notification of Outcome of Investigation* to detainees. At the conclusion of every investigation of sexual abuse, the *Notification of Outcome of Investigation* form is forwarded to the PREA Coordinator for review.

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

In interview with the facility investigators, this process is in place and notifications are being made as required by policy. In review of investigative files, in the past 12 months *Notification of Outcome of Investigation* forms were presented to detainees as per policy.

Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on review GEO policy 5.1.2-A, page 11, section L and facility policy 300.18, pages 10 & 11, section 6-b-3, staff shall be subject to disciplinary action up to and including termination for violating the agency/facility sexual abuse policies. Staff is made aware of the zero-tolerance policy and the penalties for violating that policy in the *2014 Employee Handbook*, page 18. All terminations and resignations for sexual misconduct are reported to Brooks County Sheriff's Office and licensing agencies, unless the activity was clearly not criminal.

If a staff member violates the agency's zero-tolerance policy, he/she will be investigated and if it appears to be criminal in nature, referred for prosecution. In the past 12 months, there have been no staff who violated agency sexual abuse and sexual harassment policies.

Standard 115.77 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

In interview with the Warden and documentation provided for review, in the past 12 months there were no contractors or volunteers reported to law enforcement agencies or licensing bodies for engaging in sexual abuse of detainees.

Standard 115.78 Disciplinary sanctions for inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As per GEO policy 5.1.2-E, page 12, section L-2 and facility policy 1000.01, page 3, section 3, detainees found guilty of engaging in sexual abuse involving other detainees shall be subject to formal disciplinary sanctions. Disciplining a detainee for engaging in sexual activity with an employee is prohibited unless the employee did not consent to the contact.

The disciplinary process may consider whether an individual's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Sanctions will be commensurate with the nature and circumstances of the abuse, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories.
Detainees are informed of the disciplinary process in the *Detainee Handbook,* on pages 22, 23, 26, 28 & 30, including the prohibited acts and the sanctions that will be imposed for violations to the agency/facility's policy on sexual misconduct.

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

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

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

In the past 12 months, 36 detainees disclosed prior victimization during screening and were offered a follow-up meeting with a mental health practitioner. The Psychologist upon interview stated that detainees referred from initial screening for mental health evaluations are seen the day of arrival or the following day.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section 7 and facility policy 1300.05, pages 27 & 28, section 7, were used to verify compliance to this standard. Policies mandate that victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention as directed by medical and mental health practitioners. The evaluation and treatment should include follow-up services, treatment plans and, if necessary, referrals for continued care following a transfer or release.

SANE exams are not performed onsite. SANE exams will be performed by Independent Forensic Services. A victim advocate will be available to be present for the SANE exam. Victims will be offered information about sexually transmitted infections prophylaxis where medically appropriate. All services are provided without cost to the victim. All refusals of medical services will be documented.

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

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 25, section N-1 and facility policy 1300.05, pages 28 & 29, section N-1, mandate that victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention. The evaluation and treatment offered includes follow-up services, treatment plans, and referrals for continued care following a transfer or release if necessary.

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

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

Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, pages 26 & 27, section M-3 and facility policy 1300.05, pages 30 & 31, section 3,

the facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation within 30 days in which the allegation has been determined to be substantiated or unsubstantiated.

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

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

In the past 12 months, incident reviews were completed as per agency policy. In interview with members of the Incident Review Team, they knew their responsibilities as a member of the Incident Review Team.

Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Information on data collection is found on page 27, section O 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 Program 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.* At least annually, the PREA Coordinator aggregates this data. Upon request, or no later than June 30, the agency provides aggregated data information for the previous calendar year to DOJ.

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

Standard 115.88 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 27 & 28, section O-2 and on interview with the Programs Director/PREA Coordinator, the agency reviews all of the data collected from all of its facilities and aggregates that data annually to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. The PREA Coordinator prepares an annual report that provides the problem areas and corrective actions for each facility and the agency as a whole. The report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The Annual PREA Report provides an excellent overview of the agency's efforts in the prevention of sexual abuse and sexual harassment in its facilities, exceeding in this standard.

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

Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 28, section O-3 and facility policy 1300.05, page 32, section N-3, the agency ensures that the data collected is securely retained for at least 10 years according to the Texas State Records Retention Schedule.

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

AUDITOR CERTIFICATION

I certify that:

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

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

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

Barbara Jo Denison ______________________ May 12, 2017 ______________

Auditor Signature Date