**PREA AUDIT REPORT ☐ Interim ☒ Final**

**COMMUNITY CONFINEMENT FACILITIES**

**Date of report:** July 27, 2015

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|---|---|---|---|
| **Auditor Information** | | | |
| **Auditor name:** Barbara Jo Denison | | | |
| **Address:** 3113 Clubhouse Drive, Edinburg, TX 78542 | | | |
| **Email:** denisobj@sbcglobal.net | | | |
| **Telephone number:** 956-566-2578 | | | |
| **Date of facility visit:** July 22 – 23, 2015 | | | |
| **Facility Information** | | | |
| **Facility name:** El Monte Center | | | |
| **Facility physical address:** 11750 Ramona Blvd., El Monte, CA 91732 | | | |
| **Facility mailing address:** *(if different from above)* | | | |
| **Facility telephone number:** 626-454-4593 | | | |
| **The facility is:** | ☐ Federal | ☐ State | ☐ County |
| | ☐ Military | ☐ Municipal | ☒ Private for profit |
| | ☐ Private not for profit | | |
| **Facility type:** | ☐ Community treatment center<br>☒ Halfway house<br>☐ Alcohol or drug rehabilitation center | ☒ Community-based confinement facility<br>☐ Mental health facility<br>☐ Other | |
| **Name of facility's Chief Executive Officer:** Alexandra Bonilla, Acting Facility Director | | | |
| **Number of staff assigned to the facility in the last 12 months:** 19 | | | |
| **Designed facility capacity:** 70 | | | |
| **Current population of facility:** 63 in house and 18 on home detention | | | |
| **Facility security levels/inmate custody levels:** Minimum | | | |
| **Age range of the population:** 18 - 76 | | | |
| **Name of PREA Compliance Manager:** Alexandra Bonilla | | **Title:** Acting Facility Director/PREA Compliance Manager | |
| **Email address:** abonilla@geogroup.com | | **Telephone number:** 626-454-4593, ext. 4 | |
| **Agency Information** | | | |
| **Name of agency:** The GEO Group, Inc. | | | |
| **Governing authority or parent agency:** *(if applicable)* | | | |
| **Physical address:** One Park Place, Sute 700, 621 Northwest 53rd St., Boca Raton, Florida 33487 | | | |
| **Mailing address:** *(if different from above)* | | | |
| **Telephone number:** 561-999-5827 | | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** George C. Zoley | | **Title:** Chairman of the Board, CEO and Founder | |
| **Email address:** gzoley@geogroup.com | | **Telephone number:** 561-893-0101 | |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** Phebia L. Moreland | | **Title:** Director, Contract Compliance, PREA Coordinator | |
| **Email address:** pmoreland@geogroup.com | | **Telephone number:** 561-999-5827 | |

## AUDIT FINDINGS

### NARRATIVE

The PREA audit of the El Monte Center was conducted on July 22 - 23, 2015 by this Certified PREA Auditor, Barbara Jo Denison. Prior to the audit, the facility provided the auditor with agency and facility policies and supporting documentation related to each standard for review. The auditor was supplied also with a list of staff sorted by title and shift and a list of residents sorted by housing unit, a list of residents identified through the PREA screening process to be at high risk for victimization and abusiveness and the name of a resident who self disclosed at initial screening to be bisexual. From these lists, residents and staff were randomly selected to be interviewed. At the time of the audit there were no residents with visual, hearing or cognitive impairments, none who had self-disclosed being lesbian, transgender or intersex and no limited English proficient residents.

On the first day of the audit an entrance meeting was held at 2:20 p.m. – 2: 45 p.m. with the following people in attendance: Alexandra Bonilla, Acting Facility Director/PREA Compliance Manager (the Facility Director is out on extended leave); Jorge Quezada, Social Services Coordinator; and, Jonathon Dressler, Program Fidelity Manager, Reentry Services PREA Divisional Coordinator, followed by a tour of the facility. All housing units and all areas that residents are allowed access to were toured. During the tour, nine residents were informally interviewed and questioned about their knowledge of reporting methods available to them. The population of the facility on the first day of the audit was 63 residents in house and 18 on home detention. One resident from each room and one male on home detention were formally interviewed for a total of 16 residents. Of that number, there was one female resident who self disclosed upon initial screening to be bisexual, one identified as a potential predator and one identified as a potential victim. All residents interviewed were knowledgeable of the agency's zero-tolerance policy and the methods available to them to report sexual abuse and sexual harassment. Numerous PREA posters, in both English and Spanish, were displayed throughout the facility in various locations.

A total of 12 staff members were interviewed throughout the course of the audit. Of that number, five were specialized staff and 7 were security staff. Specialist staff interviewed included: the Acting Facility Director/PREA Compliance Manager; two Case Managers; the Social Services Coordinator; and, the Office Support Specialist. The Acting Facility Director/PREA Compliance Manager is responsible for investigations, retaliation monitoring and is part of the incident review team and was asked those questions as well as questions for the PREA Compliance Manager. The Social Services Coordinator is responsible for intake screenings and is a member of the incident review team and was asked those questions. Random security staff selected to interview were two Security Monitor II's and five Security Monitor I's which included security staff from all three shifts. Staff interviewed was well versed in their responsibilities in reporting sexual abuse and suspected sexual abuse. When questioned about evidence preservation, staff responses reflected agency policies and standard requirements. The PREA Coordinator and the Agency Head were not in attendance at the audit, but were interviewed at an earlier date. There are no SANEs at the facility. Referrals for SANE examinations are made to the Santa Monica Rape Treatment Center at UCLA Medical Center in Santa Monica, CA

In the past 12 months, there was one staff-on-inmate allegation of voyerisum reported on 6/23/15. The allegations was administratively investigated and submitted to OPR on 7/23/15. The resident was returned to custody on 6/23/15 due to circumstances unrelated to the allegation. The resident had an existing appointment for mental health services scheduled prior to reporting the allegation. The facility is awaiting a disposition from OPR.

At the conclusion of the on-site vist, an exit meeting was held with Alexandra Bonilla, Acting Facility Director/PREA Compliance Manager, Jorge Quezada, Social Services Coordinator, Jonothon Dressler, Program Fidelity Manager, Reentry Services PREA Divisional Coordinator and Sara Woehler, GEO Reentry Services, Area Manager Southern California and Nevada in attendance. There were no standards that required corrective action. The auditor explained the process that follows the on-site audit. The final report will be made available to the pubic on the GEO website. The auditor acknowledged the willingness of all staff involved to accomplish PREA compliance as a team.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The El Monte Center is located at 11750 Romona Blvd, El Monte, California. The city of El Monte is approximately 12 miles east of downtown Los Angeles, near the intersection of interstates 10 and 65. The city's populations is approximately 120,000. The facility is located on a heavily traveled street in a mixed retail/office zoned area. The El Monte Center is operated by the GEO Group, Inc. since 1993.

The physical plant consists of a single, one-story, wood frame structure. Construction appears to date to the early 1970's with the original use being a convalescent center. There are 15 resident rooms, housing between two to nine residents each. The majority of rooms house four residents. With only two exceptions, each room includes a toilet and sink. Showers are located in common areas. The female sleeping rooms and shower facilities are located in a wing visible from the control center and the area is marked with red tape to designate the area as off limits to male residents. Sureveillance cameras are used to monitor any unauthorized movement. Contractual requirements require one female and one male staff to be on duty at all times.

Referrals to the El Monte Center come almost exclusively from the Federal Bureau of Prisons (BOP). The major of referrals are pre-release transfers from BOP facilities and are serving the remainder of the sentence in the community. A smaller number of residents are public law cases and are serving federal sentences of less than one year. Referrals also include residents under supervision by the United States Probation Office and the U.S. Pre-Trial office.

The El Monte Center also operates a home confinement component. Residents are eligible for home confinement after reaching their pre-release preparation date and having successfully completed all previous levels of the pre-release program. At the time of the audit, 18 residents were participating in the home confinement component.

The Mission Statement of the El Monte Center is as follows: "It is the mission of the GEO Group El Monte Center to provide transitional services in a supervised environment to offenders as they move from prison to the community. Our goal is to assist each offender in obtaining employment or schooling; to help them establish and re-establish family relationships; and, to reenter their indiviaul communities with a positive purpose and a desire to reinvest in their community. Our services are provided for offenders in the custody of the Federal Bureau of Prisons, United States Attorney General, or under the supervision of the United States Probation Office (USPO)".

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

## SUMMARY OF AUDIT FINDINGS

The following is a summary of the audit findings:

Number of standards exceeded: 4

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 4

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

**Standard 115.212 Contracting with other entities for the confinement of residents**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.213 Supervision and monitoring**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 2014-1, pages 3 & 4, section B-1, the agency has developed, documented and made its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents against sexual abuse. A PREA Annual Facility Assessment is completed by the Acting Facility Director/PREA Compliance Manager and forwarded to the agency's PREA Coordinator and the Corporate Divisional Vice President for review and approval. The last annual assessment was completed on 10/14/14. That assessment noted that there were three Security Monitor and one Lead Monitor vacancies that were being filled by overtime of current Security Monitor staff. Since all vacant positions were being filled by the use of overtime, there were no deviations to the established staffing plan and no recommendations were made for any changes to the current staffing levels. Those vacancies since have been filled per interview with the Acting Facility Director/PREA Compliance Manager.

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

### Standard 115.215 Limits to cross-gender viewing and searches

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

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

GEO policy 5.1.2-A, pages 15 & 16, section I, 1-10 and facility policy 2014-4, pages 2 & 3, section VI, address resident pat searches, strip searches, body cavity searches and the limits to cross-gender viewing and searches. All staff receive training in pre-service and in annual in-service training on how to conduct searches, including searches of transgender and intersex residents. This information is also reviewed at monthly staff meetings. The facility staff do not conduct cross gender pat down searches, strip searches or visual body cavity searches. A staff member of the same gender conduct pat searches and these searches are documented on a pat search log. Female residents interviewed reported that at no time have they been denied access to programs because a female staff member was not available to pat search them.

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

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

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

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

**corrective actions taken by the facility.**

The agency takes appropriate steps to ensure that residents with disabilities and residents that are limited English proficient have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and harassment. GEO policy 5.1.2-A, page 10, section E and facility policy 2014-2, pages 1 & 2, section V, were used to verify compliance to this standard. The" PREA Education Manual for Residents" is available in both English and Spanish and is also available in large print in both languages for residents with visual impairments. PREA posters, a GEO PREA brochure, a PREA video and all PREA educational materials are provided in both English and Spanish. A Language Line Service is available for the translation of any other languages. A TTY is available for hearing impaired residents. At the time of the audit there were no residents with hearing, visual or cognitive impairments, nor any limited English proficient residents. The agency does not use residents as interpreters, readers or other types of resident assistants.

## Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In review of policy 5.1.2-A, pages 7 & 8, section C-2, and page 15, section H-4, the facility is prohibited from hiring or promoting anyone who may have contact with residents who has engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in a confinement setting or the community. Criminal background checks are conducted for all potential employees through a contract with Accurate Background, Inc. as well as BOP clearance for all staff both through NCIC and the Civilian Application System. Applicants who answer on their application that they have worked in a confinement setting previously, receive a a PREA Verification by Accurate Background, Inc. The El Monte Center does not have contractors or volunteers. For consideration for promotions or for transfers, employees complete a "PREA Disclosure and Authorization Form Promotions – PREA Related Positions" and another background check by Accurate Background Inc. is completed. At the time of annual performance evaluations, employees complete a "PREA Disclosure and Authorization Form Annual Performance Evaluation" form. Background checks for all employees are completed every five years when the BOP contract is renewed. All current employees had a background check in 2013. Twelve random staff employee files were reviewed with the Office Support Specialist. Of the 12 records reviewed, one was a staff transfer from another reentry facility, two promotions and four new hires. The remaining records were of staff employed at the facility for five years or longer. Drivers license checks are completed on all employees annually.

## Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, page 8, section C, 3 and facility policy 2014-1, page 4, section B, 3, state that the facility takes into consideration the effect that any new design, acquisition, expansion or modificatioins of the physical plan or monitoring technology might have on the facility's ability to protect residents from sexual abuse. The facility has not acquired any new facilities or made any expansions or modifications to the existing facility in the past 12 months. There have been camera upgrades which included the installation of seven security cameras, a new power supply for the camera system and a 24-channel DVR with increased hard drive space. Currently, the total number of cameras is 23, which includes interior and exterior cameras.

### Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Forensic examinations are not performed at this facility. Victims of sexual abuse are referred to the Santa Monica Rape Treatment Center at UCLA Medical Center is Santa Monica, CA for SANE examinations at no cost to the resident. In the past 12 months, there have been no residents that required SANE exams.

The facility has made multiple attempts to secure MOU's to provide victim advocacy services and their efforts are ongoing. At the current time, referrals for victim advocacy services are made to the Rape Treatment Center, Santa Monica-UCLA Medical Center, the Rosa Parks Sexual Assault Crisis Center, Los Angeles, CA or to the Peace Over Violence, Los Angelos, CA.

### Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, page 4, section III, A and facility policy 2014-6, page 7, section C, 2 & 3, outline the agency's policy and procedure for investigating and documenting incidents of sexual abuse. The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment including inmate-on-inmate sexual abuse or staff sexual misconduct. All allegations of staff sexual abuse are referred to the agency's Office of Professional Responsibility (OPR) and the BOP. All allegations of sexual abuse and sexual harassment by staff and residents are referred to the PREA Coordinator, the Program Fidelity Manager, Reentry Services PREA Divisional Coordinator and to BOP. The El Monte Police Department is responsible for conducting criminal investigations. The agency's policy regarding referral of allegations for sexual abuse and sexual harassment for criminal investigations is available on the

GEO website There were no allegations referred to the El Monte Police Department for criminal investigation. There was one staff-on-inmate allegation of voyeurism which was administratively investigated and did not require a criminal investigation.

**Standard 115.231 Employee training**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

**Standard 115.232 Volunteer and contractor training**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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El Monte Center does not utilize contractors or volunteer; therefore this standard is not applicable.

**Standard 115.233 Resident education**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

GEO policy 5.1.2-A, page 11, section E-2 and facility policy 2014-2, page 4, were used to verify compliance to this standard. Within 24 hours of arrival, incoming residents are provided with educational information explaining the zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents of sexual abuse and sexual harassment. Residents receive a "PREA Education Manual for Residents"and a GEO PREA brochure by their assigned Case Manager. All residents view a PREA video which is shown during their Transitional Class. Residents sign an acknowledgement of receiving the manual and GEO brochure and sign another form that they have viewed the video. All information is provided in both English and Spanish. Weekly Town Hall Meetings are held and PREA topics are discussed. Random review of ten residents' files showed this documentation is maintained by the Social Services Coordinator in excellent order. When interviewed, residents acknowledged receiving the PREA training information and were knowledgeable of the agency's zero-tolerance policy and how to report incidents of sexual abuse and sexual harassment.

### Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Based on GEO policy 5.1.2-A, page 13, section F-3, the facility's investigators receive specialized training in addition to the general education provided to all staff. The agency's PREA Coordinator provides a four-hour webinar specialized training for investigators. There are 30 investigators throughout the division. At the El Monte Center the Acting Facility Director and the Facility Director, who is currently out on medical leave, are trained investigators who received their training on 10/21/14. The facility mantains documentation that the investigators have received this training. Upon interview of the Acting Facility Director/PREA Compliance Manager, she was knowledgeable of her responsibilities in conducting sexual abuse investigations.

### Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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El Monte Center has no medical or mental health staff on site. Off site providers are used for medical and mental services; therefore this standard is not applicable.

**Standard 115.241 Screening for risk of victimization and abusiveness**

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**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 pages 2 & 3, section VI, B-1, the agency requires that residents be screened upon admission for risk of sexual abuse victimization or sexual abusiveness toward other residents. A "PREA Risk Assessment" form is used to screen residents upon admission and was found to contain all requirements of this standard. Residents may not be disciplined for refusing to answer any questions or for not disclosing complete information. In addition to the screening form, a thorough review of any available records which can assist in determining risk assessment is required. Within 30 days of arrival, a "PREA Vulnerablity Reassessment Questionnaire" is completed to reassess the risk of victimization or abusiveness of all residents and reassessments are completed due to a referral, request, incident of sexual abuse or receipt of additional information. The Case Managers are responsible for initial and 30-day reassessment screenings. The Social Services Coordinator tracks completion dates and Case Managers retrieve this information from a shared file. Review of 10 residents' files confirmed that screening upon intake and reassessments within 30 days of arrival are being completed timely and per policy. In interview with two Case Managers, they were able to explain their responsibilities of the screening process. The facility's efforts for compliance to this standard is outstanding with documentation, including referral information, maintained in binders by the Social Services Coordinator. This information is securely maintained in the Facility Director's office with access to the room allowed only by the Acting Facility Director/Compliance Manager and the Social Services Coordinator to ensure confidentiality.

**Standard 115.242 Use of screening information**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency uses the information from the risk screening form to make housing, bed, work and program assignments wih the goal of separating residents at high risk of being sexually victimized from residents at high risk of being sexually abusive. Upon interview with the Acting Facility Director/PREA Compliance Manager, she explained how the facility utilizes the information from the "PREA Risk Assessment". Male residents identified to be at risk for abusiveness are housed in the rooms at the far end of the male wing and male residents identified to be at risk for victimization are housed at the opposite end of that wing. The same is true of female residents identified to be at risk for abusiveness and victimization, they are housed in the female wing at opposite ends of the female wing.

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

**Standard 115.251 Resident reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 17, section K-1 and facility policy 2014-2, page 4, last paragraph and page 5, section VI, outline the procedure for resident reporting methods. The agency provides multiple ways for residents to privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse and sexual harassment. Residents are made aware that they can inform a staff member immediately, contact the Acting Facility Director/PREA Compliance Manager, put their allegation in writing, or call one of three crisis hotline numbers. Those numbers access the RAINN National Hotline Network (1-800-656-4673 – toll free), Peave over Violence Rape & Crisis Center, Pasadena, CA (626-584-6191), East Los Angeles Women's Center, for women only, (323-526-5819). Calling any of these numbers allows the residents to remain anonymous upon request. The RAINN National Hotline Network was called during the audit on one of the residents' pay phone and found it to be accessible to residents. Residents can also call the BOP Residential Reentry Management Branch (310-732-5179), to report an allegation of abuse. Information on resident reporting options are posted throughout the facility at various locations in both English and Spanish. The "PREA Educational Manual for Residents", received upon arrival, provides the residents with methods of reporting available to them. Residents are provided with addresses for reporting in writing and are informed that they can verbally report to any staff member.

Staff have access to private reporting by calling the Employee Hotline at (866-568-5425) or the Corporate PREA Director at (561-999-5827). Information for resident and staff reporting is available on the GEO website and posted throughout the facility in numerous locations. The agency's policy mandates that staff accept all reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Resident and staff interviewed were well versed in the methods of reporting available to them.

**Standard 115.252 Exhaustion of administrative remedies**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.253 Resident access to outside confidential support services**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As stated in GEO policy 5.1.2-A, page 23, section N-8 and facility policy 2014-6, page 11, section H-6, residents are provided with access to outside victim advocates for emotional support. The facility has made multiple attempts to secure MOU's from community agencies with no success. They continue in these efforts, but at the present time victims requesting advocacy services will be referred to the Rape Treatment Center Santa Monica-UCLA Medical Center, the Rosa Parks Sexual Assault Crisis Center or to Peace Over Violence. Residents are given mailing addresses and telephone numbers and the facility informs residents prior to giving them access of the extent to which such communications will be monitored. Instructions on how to access these agencies are provided to residents in the "PREA Education Manual for Residents" and on posters displayed throughout the facility. When interviewed, residents were knowledgeable about the outside confidential support services available to them.

**Standard 115.254 Third-party reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.261 Staff and agency reporting duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

As outlined in GEO policy 5.1.2-A, pages 13 & 14, section G- 2, page 14, section H-2 and pages 18 & 19, section K-4, and facilty policy 2014-6, pages 5 & 6, section VII, B, all staff, contractors and volunteers are to report immediately any knowledge or information regarding an incident of sexual abuse or sexual harassment. The facility does not have contractors or volunteers. Any retaliation or suspected retaliation against residents or staff is also to be reported immediately. Interviews with staff revealed that they are very aware of their reporting responsibilies and know not to reveal any information about sexual abuse incidents to anyone other than to the extent necessary. In the past 12 months, there have been no incidents that required reporting according to the Vulnerable Persons State Statue.

### Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.264 Staff first responder duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.265 Coordinated response**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section M-2 and facility policy 2014-6, page 11, section 9, state that residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations will be protected from retaliation from other residents and staff. Housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents who fear retaliation will be protection measures used as per policy. The Acting Facility Director/PREA Compliance Manager is responsible for weekly monitoring for retaliation. These meetings will be recorded on the "Protection from Retaliation Log". Monitoring will continue for at least 90 days and longer if needed. When interviewed, the Acting Facility Director/PREA Compliance Manager knew her responsibilities of this process per policy. In the past 12 months, there has been no retaliation monitoring required. Of the one reported allegation received in the past 12 months, the resident did not remain at the facility following the allegation and therefore did not require monitoring.

### Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has policies governing administrative and criminal investigations of sexual abuse as outlined in agency policy 5.1.2-A, pages 4 – 6, section III, B, 1 & 2. The Acting Facility Director/PREA Compliance Manager is responsible for administrative investigations at the facility. When interviewed she was knowledgeable of her responsibilities in conducting administrative investigations of allegations of sexual abuse and sexual harassment. An OPR referral form is completed and submitted to OPR for all staff-on-inmate allegations of sexual abuse and e-mail notification is made to the BOP. All allegations of sexual abuse and sexual harassment are referred to the PREA Coordinator, the Program Fidelity Manager, Reentry Services PREA Divisional Coordinator and to BOP. The El Monte Police Department is the agency responsible for conducting criminal investigations of sexual abuse. In the past 12 months, there have been no allegations of sexual abuse that required a criminal investigation.

**Standard 115.272 Evidentiary standard for administrative investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-E, page 6, section B, 2-d, the facility shall impose no standard higher than the preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated. When the Acting Facility Director/PREA Compliance Manager, who is responsible for conducting administrative investigations, was interviewed and asked what standard of evidence was used in determining if an allegation is substantiated, she confirmed the agency policy.

**Standard 115.273 Reporting to residents**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.276 Disciplinary sanctions for staff**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Staff shall be subject to disciplinary sanctions up to and including termination for violating the agency's sexual abuse policy as outlined in GEO policy 5.1.2-E, page 11, section L, and facility policy 2014-6, page 13, section M-1. All terminations and resignations for sexual misconduct shall be reported to the El Monte Police Department. An Employee Handbook, given to all staff, explains the zero-tolerance policy. In the past 12 months, there were no staff that required disciplinary sanctions for violation of the agency's policy related to sexual abuse or sexual harassment.

### Standard 115.277 Corrective action for contractors and volunteers

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

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

GEO policy 5.1.2-A, page 12, section 3, states that any contractor or volunteer who engages in sexual abuse or sexual harassment shall be prohibited from contact with residents and shall be reported to law enforcement agencies. The facility does not utilize the services of contractors or volunteers; therefore this standard is not applicable.

### Standard 115.278 Disciplinary sanctions for residents

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

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

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

### Standard 115.282 Access to emergency medical and mental health services

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

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

Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 23, section 7, and facility policy 2014-6, page 7, section 5-f and page 8, section 5-h. The El Monte Center does not have medical or mental health staff on site; therefore referrals are made to off site providers for all medical and mental health services. Residents are referred to the for emergency medical and mental health services to the Rape Treatment Center, Santa Monica-UCLA Medical Center in Santa Monica, CA or to the LAC & USC Medical Center in Los Angeles, CA. Additional mental health services are provided by the Augustus Hawkins, Los Angeles, CA or DTR in Diamond Bar, CA. These services are provided to every victim without financial cost to them. In the past 12 months, there have been no off site referrals for emergency medical or mental health services due to sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Per GEO policy 5.1.2-A, pages 25, section 3 and facility policy 2014-6, page 12, section K, facilities are required to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation in which the allegation has been determined to be substantiated or unsubstantiated. The incident review team at El Monte Center includes the Acting Facility Director/PREA Compliance Manager and the Social Services Coordinator. A "PREA After Action Review Report" is completed and forwarded to the PREA Coordinator. The Assistant Director/PREA Compliance Manager maintains copies of all completed review forms in the corresponding investigative file.

**Standard 115.287 Data collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.288 Data review for corrective action**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.289 Data storage, publication, and destruction**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**AUDITOR CERTIFICATION**

I certify that:

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

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

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

Barbara Jo Denison July 27, 2015

Auditor Signature Date