PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: April 17, 2017

Auditor Information			
Auditor name: Barbara Jo Denison			
Address: 3113 Clubhouse Drive			
Email: Edinburg, TX 78542			
Telephone number: 956-566-2578			
Date of facility visit: January 25-26, 2017			
Facility Information			
Facility name: Marvin Gardens Center			
Facility physical address: 9411 S. Central Ave., Los Angeles, CA 90002			
Facility mailing address: N/A			
Facility telephone number: 323-563-1126			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☒ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Carl Duron, Facility Director			
Number of staff assigned to the facility in the last 12 months: 16			
Designed facility capacity: 66			
Current population of facility: 70			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 21-65			
Name of PREA Compliance Manager: Delia Garcia		**Title:** Acting Social Service Coordinator/Acting PREA Compliance Manager	
Email address: degarcia@geogroup.com		**Telephone number:** 323-563-1126	
Agency Information			
Name of agency: The Geo Group Inc.			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: One Park Place, Suite 700, 621 Northwest 53rd Street, Boca Raton, FL 33487			
Mailing address: *(if different from above)* N/A			
Telephone number: 561-999-5827			
Agency Chief Executive Officer			
Name: George C. Zoley		**Title:** Chairman of the Board, CEO and Founder	
Email address: gzoley@geogroup.com		**Telephone number:** 561-893-0101	
Agency-Wide PREA Coordinator			
Name: Phebia L. Moreland		**Title:** Director, Contract Compliance, PREA Coordinator	
Email address: pmoreland@geogroup.com		**Telephone number:** 561-999-5827	

AUDIT FINDINGS

NARRATIVE

The PREA on-site audit of the Marvin Gardens Center was conducted January 25-26, 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, Pre-Audit Questionnaire and supporting PREA-related documentation provided by the facility to demonstrate compliance to the PREA standards. Questions during this review period were answered by Delia Garcia, Acting Social Service Coordinator/Acting PREA Compliance Manager.

On the first day of the audit, an entrance meeting was held with Carl Duron, Facility Director, Delia Garcia, Acting Social Service Coordinator/Acting PREA Compliance Manager and Rob Walling, Manager, Contract Compliance PREA in attendance. Those in attendance of the entrance meeting and Terry Ballard, Chief of Security accompanied me on a facility tour following the conclusion of the meeting. During the tour, the location of cameras and mirrors, dorm layout including shower/toilet areas and placement of PREA posters and information was observed.

PREA posters are prominently displayed in all common areas as well as on the walls in each resident room. The number for the YWCA Sexual Assault Crisis Line and the number for the Santa Monica-UCLA Medical Center-Rape Treatment Center were called on a resident pay telephone. Both agencies are outside reporting lines for residents and both numbers were found not to be accessible. After the tour, the Facility Director contacted both agencies to obtain the correct telephone numbers and revised the posters with the correct information. A recommendation was made to the Facility Director that reporting information should be posted by the telephones for easy access for residents. By the close of the audit this information was posted as recommended. The same reporting information is provided to residents in the *PREA Education Manual for Residents* and a correction was made to reflect the correct telephone numbers for the two agencies. It was recommended that the facility hold a Town Hall Meeting with residents to make them aware of the changes made to this posted information. This meeting was scheduled for the evening of the closing day of the audit.

During the tour, it was noted that in Rooms 4 & 5 there were four lockers next to the wall as you enter these rooms. The restroom in both of these rooms were located on the far side of these lockers and obstructed staffs' vision to this area when entering those rooms. When this was pointed out, the Facility Director immediately suggested that a corner mirror could be ordered and installed in the far corner of each room, opposite the restroom entrance. The mirrors were ordered, received and installed before the close of the on-site visit. Also, noted during the facility tour was that a walk-in broom closet did not have a lock on it. A lock was installed on the door before the conclusion of the on-site visit.

The records of 15 residents were reviewed to evaluate compliance to screening procedures. All records showed initial screenings being done upon arrival to the facility and 30-day screenings being done very timely. The PREA training records of the same 15 residents were reviewed and documentation of comprehensive PREA education was not found. Proper acknowledge forms are not being used and in some cases training rosters were found showing the PREA video was viewed, but not within the 72-hour required time frame. The facility was found to be non-compliant with the requirements of standard 115.233. (see narrative of standard 115.233 for

details)

The personnel files of all staff were reviewed to determine compliance with background check procedures. All files reviewed showed that criminal background checks for pre-employment and after five years of employment are being completed as required. At the time of annual evaluations, employees complete a *PREA Disclosure and Authorization Form – Annual Performance Evaluation.* Some of the files were missing the annual performance evaluations for 2016 and the corresponding *PREA Disclosure and Authorization Form – Annual Performance Evaluation.* The Office Support Specialist was able to retrieve and print all missing information from a corporate human resource site and met compliance to the standard and to agency policy. It was recommended during the file review that organization of the files in a consistent format would assist her in tracking required information to ensure the files remain complete. During the exit meeting, the Facility Director reported that the Office Support Specialist will be creating a binder with copies of information from the personnel files filed in the binder for easy access of this information and ease of tracking completion of this information.

Documentation of annual PREA training for staff is filed by year in a binder maintained by the Acting Social Service Coordinator/Acting PREA Compliance Manager. Training documentation for this audit period was reviewed and found to be complete.

A total of 17 in-house residents and 2 home confinement residents were interviewed. The number of in-house residents included two from each resident room, with the exception of one room where three residents were interviewed. Of the number of in-house residents interviewed, one was a female who self-disclosed at initial screening to be bisexual and one was a female resident screened to be at risk for victimization. At the time of the audit, there were no residents who were blind, had low vision, deaf, hard of hearing or with cognitive deficits, assessed at initial screening at risk for abusiveness and none that were limited English proficient. There were no residents who self-disclosed at initial screening of being gay, lesbian, transgender or intersex.

All of the residents interviewed acknowledged receiving PREA training with written information during the intake process. They were familiar with the agency/facility's zero-tolerance policy against sexual abuse and sexual harassment and were able to articulate during interview the methods of reporting allegations of sexual abuse and sexual harassment available to them. Residents consistently indicated that they feel safe at this facility.

A total of 14 staff members were interviewed during the course of the audit. Of the 14 staff members interviewed, six were security staff and the remaining eight were specialized staff. The Facility Director and the Acting Social Service Coordinator/Acting PREA Compliance Manager have multiple roles and were asked multiple questions as they related to the responsibilities of those roles. Staff interviewed were all knowledgeable of their responsibilities of detecting, preventing and responding to sexual abuse and sexual harassment allegations.

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

The agency/facility has made attempts to enter into a Memorandum of Understanding with the

Santa Monica-UCLA Medical Center-Rape Treatment Center. Prior to the on-site visit, the Assistant Director of the Rape Treatment Center was contacted to discuss the pending Memorandum of Understanding (MOU). Although the facility does not have an MOU with the agency, through a verbal agreement resident victims of Marvin Gardens Center can be referred for forensic exams as well as receive medical care, counseling, education, victim advocacy and psychotherapy services.

The YWCA Sexual Crisis Division was also contacted prior to the on-site visit to discuss the services that agency has verbally agreed to provide to the residents of the Marvin Gardens Center. The Licensed Marriage and Family Therapist of the YWCA Sexual Crisis Division shared that residents can call the 24-hour hotline to report sexual assault and request victim advocacy services and counseling. The facility continues to pursue an MOU with this agency.

In the past 12 months, there have been no allegations of sexual abuse or sexual harassment. If allegations are reported, the Facility Director and the Acting Social Service Coordinator/Acting PREA Compliance Manager are trained facility investigators responsible for conducting administrative investigations. Criminal investigations are referred to the Los Angeles Police Department.

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with Carl Duron, Facility Director, Delia Garcia, Acting Social Service Coordinator/Acting PREA Compliance Manager and Rob Walling Manager, Contract Compliance PREA in attendance and Sara Woehler, GEO Area Manager in attendance via telephone. During the exit meeting, the facility was informed of the process that would follow the on-site visit including corrective measures for standard 115.233. The standard was reviewed with the team along with recommendations for bringing the standard into compliance. The Facility Director and the Acting Social Service Coordinator/Acting PREA Compliance Manager were complimented for their pro-active approach to all recommendations made and complimented on their cooperation prior to the audit and during the on-site visit and their willingness to achieve PREA compliance.

The initial audit revealed that the facility did not meet compliance to standard 115.233, which triggered a corrective action period for a duration of 60 days. During the corrective action period, the facility staff and the PREA Coordinator worked together on a plan of action to achieve compliance to this standard as detailed in the narrative of standard 115.233.
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DESCRIPTION OF FACILITY CHARACTERISTICS

Marvin Gardens Center is located at 9411 S. Central Ave., Los Angeles, CA 90002. Marvin Gardens Center is owned and operated by the GEO Group, Inc. The Federal Bureau (BOP) and the United States Probation Office (USPO) contracts with the GEO Group, Inc. to provide community confinement services to their offenders. The residents all have previously served time in secure institutions.

At the time of the audit, the population was 70 in-house residents (59 males and 11 females) and 34 residents on home confinement. Five of the in-house residents were classified as Public Law and the remaining residents were in BOP custody. During the past 12 months, there were 298 residents admitted to the facility. The age range of the current population was 21-65, with an average length of stay of 3-6 months.

The Marvin Garden Center is currently undergoing an expansion that began in November 2016 and is slated for completion in July 2017. The expansion will include an additional building adjacent to the existing facility and modifications to the existing building. The bed space in the existing building will increase by thirteen. At this time, administrative offices are in a portable trailer adjacent to the existing building. Administrative offices will be in the new building with additional office space added.

There are 15 staff employed at the Marvin Gardens Center. Which includes a Facility Director, a Chief of Security, an Acting Social Service Coordinator/Acting PREA Compliance Manager, two Case Managers, a Job Developer, three Monitor II's, four Monitor I's, an Office Support Specialist and a Maintenance Technician. The facility does not utilize the services of contractors or volunteers. Due to the facility expansion, three Security Monitors, one Case Manager and one Job Developer will be added to the current staffing levels.

The facility is a one-story light brown stucco building with cinder block privacy walls. The building faces Central Avenue and the entrance of the building is in an alley in the back of the building. The back entrance is monitored by an exterior camera and there are two other exterior cameras covering the back of the building where residents and visitors enter the building. Limited parking is provided for staff and residents in front of the entrance of the building.

A Security Booth is to the left of the entrance where there are four pay telephones, a magazine rack containing PREA brochures in English and Spanish and PREA posters are displayed. Visitors and residents sign in and out at the Security Booth. The *PREA What You Need to Know* video is played in closed caption continuously on a television located across from the Security Booth and on another television located in a hallway opposite the laundry area. A visitor's restroom is located across from the Security Booth. Employee locked boxes are on the wall opposite the Security Booth for resident communications to staff.

Camera monitors are located in the Security Booth. Pat searches and breathalyzers are performed in the Security Booth in view of cameras and are documented on the *Alco-Sensor Testing Log.* The facility has 18 cameras and one DVR that stores data up to 30 days. Four of the cameras have audio capabilities and can be monitored on the Facility Administrator's desktop computer monitor. Mirrors are also used in various locations to aid staff in their monitoring efforts. All staff carry a radio with them at all times. Random urine tests are performed on each resident four times per month.

The facility has eight resident rooms. There are two female rooms (Rooms 8 & 9) with 10 beds in each room. There are two female showers with one shower stall in each. Male resident occupy the

remaining six rooms (Rooms 1-6). Each of these rooms have eight beds. There are two male shower rooms. One shower room has four showers and one sink and the other has five showers (one handicapped) and one sink. All resident rooms have a restroom within them with a toilet and sink, with the exception of Room 9. Females in that room have a restroom in the hall. All showers have shower curtains with clear tops. PREA signage is posted on the wall of each resident room as well as in common areas throughout the facility. A sign on all resident room doors reminds staff to make the opposite gender announcement.

A large dining/multipurpose room in located on one side of the building. In this room there are tables, computers for residents' use, a small library, tables, vending machines and a storage area holding individual bins for storing of non-perishable food items. The large dining/multipurpose room is monitored by camera surveillance. A door on the side of the dining/multipurpose room opens into a fenced in patio area that has tables, weight equipment and a smoking area. This area is also monitored by a camera. The dining/multipurpose room is used for dining, visitation, media, probation officers' visits and relaxation. The facility does not have a recreation area, but residents are allowed a pass to walk to the Ted Watkins Memorial Park located approximately ½ mile from the facility to exercise for one hour between the hours of 8 a.m. – 11 a.m.

Meals are provided by Catering Services, a local catering company. Two cold meals and one hot meal are delivered to the facility each day.

The facility does not employ medical or mental health staff. Forensic exams are performed at the Santa Monica-UCLA Medical Center-Rape Treatment Center. Mental health services are provided offsite by referral to Santa Monica-UCLA Medical Center, the Los Angeles County & University of Southern California Medical Center, Augustus Hawkins or Exodus Recovery.

Marvin Gardens Center's mission statement is: "The mission of the Marvin Gardens Center is to provide transitional services in a supervised environment in order to assist offenders in becoming employed, law-abiding citizens and to (re) establish family and/or community ties in their respective communities. 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: "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

At the conclusion of a 60-day corrective action period (3/31/17), the facility was found in compliance with all elements of standard 115.233. The following is a summary of the audit findings:

Number of standards exceeded: 6

Number of standards met: 29

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.A and Marvin Gardens Center's policy 2014-6 are written policies mandating zero tolerance towards all forms of sexual abuse and sexual harassment and outlines the agency's/facility's approach to preventing, detecting and responding to such conduct. Both policies include definitions of prohibited behaviors and sanctions for those found to participate in these prohibited behaviors. Both policies, upon review, were found to be very comprehensive and to include a thorough description of the agency /facility's approach to reduce and prevent sexual abuse and sexual harassment of residents, exceeding in the requirements of this standard.

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 not only employs an agency-wide PREA Coordinator, but also employs a Director, Fidelity & Quality Assurance who provides oversight to the agency's reentry facilities; therefore, exceeding in the requirements of this section of the standard.

Currently, the Acting Social Service Coordinator is also the Acting PREA Compliance Manager, a position she assumed in late November when the position was vacated. In interview with the agency's PREA Coordinator on and the Acting Social Service Coordinator/Acting PREA Compliance Manager during the on-site audit, both stated that they have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards as required.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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

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

Standard 115.213 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 2014-1, pages 3 & 4, section B-1, the agency has developed and documented a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents against sexual abuse. The agency took into consideration the physical layout of the facility, the composition of the population and the prevalence of substantiated incidents of sexual abuse, and the resources the facility has available to commit to ensure adequate staffing levels in the development of the facility's staffing plan. The facility's design capacity is 66 residents and the staffing plan was developed based on that number.

The facility makes its best efforts to comply with the approved PREA Staffing Plan. At all times, there must be a male and a female staff person on duty. In circumstances where the staffing plan is not complied with, the Facility Director would document and justify all deviations from the plan. The Facility Director reviews the staffing schedules weekly to ensure compliance. In review of documentation provided by the facility and upon interview with the Facility Director and the Acting PREA Compliance Manager, in this audit period there were no times that there were deviations to the staffing plan. Staff vacancies are filled by the use of staff overtime to ensure the correct staff ratio.

The staffing plan is reviewed annually by the Facility Director and the PREA Compliance Manager, and documented on the *PREA Annual Facility Assessment* form. This form is then forwarded to the Regional Director, Director, Fidelity & Quality Assurance, Divisional Vice President and the Corporate PREA Coordinator for signature and approval of any recommendations made to the established staffing plan to include the deployment of video monitoring systems and other monitoring technologies or the allocations of additional resources to maintain compliance to the plan. On the 2015 *PREA Annual Facility Assessment* and the 2016 *PREA Annual Facility Assessment,* no recommendations were made for changes to the established staffing plan. In interview with the Facility Director, he reported that he completes the weekly Security Monitor schedules. He and the Chief of Security check on a weekly basis that the schedule is being adhered. BOP makes random visits and every 6 months and 12 months and review staffing.

Per policy, facility management staff and mid-level supervisors conduct unannounced rounds within their respective areas to identify and deter employee sexual abuse and sexual harassment. Shift Supervisors conduct rounds during their shift and these rounds are documented on the *Post Orders* form. Sixteen security checks are required to be performed per shift by Security Monitors, no less than twice each hour, and are documented on the *Security Check Log.* The Facility Director, the Chief of Security and the Acting Social Service Coordinator are required to complete, at a minimum, unannounced PREA rounds once a shift each month. These rounds are documented on the *Unannounced PREA Rounds* form. Employees are prohibited from alerting residents or other employees that these supervisory rounds are occurring. For increased supervision and monitoring efforts, the agency has in place a count verification procedure to monitor surveillance tapes on a weekly basis to ensure staff are conducting formal resident counts. The Chief of Security performs these verifications and documents them on the *Resident Count Verification Checklist.* When interviewed, the Chief of Security reported that he completes three verifications for each shift weekly and forwards the completed forms to the Divisional Vice President of Rentry Services and to the Regional Director.

Documentation provided for review, review of *Post Order* forms*, Security Check Logs, Unannounced PREA Rounds*

forms and in interview with staff and residents, the practice of rounds by facility management staff and supervisory staff confirmed numerous rounds being conducted on all three shifts exceeding in the requirement of this standard.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on review of GEO policy 5.1.2-A, pages 15 & 16, section I, and facility policy 2014-4, page 3, sections on *Offender/Resident "Pat" Searches*, *Offender/Resident "Strip" Searches*, *"Body Cavity" Searches*, and *Limits to Cross-Gender Viewing and Searches*, the facility prohibits cross-gender strip searches and cross-gender visual body cavity searches except in exigent circumstances or when performed by medical practitioners. Facility policy requires that all cross-gender strip searches and body cavity searches be documented. Resident strip searches and body cavity searches are prohibited at the Marvin Gardens Center. If at any time there is cause to strip search a resident, the Facility Director or designee will contact the nearest correctional institution to arrange and have the search conducted at the local institution. In the past 12 months, there were no cross-gender strip or cross-gender visual body cavity searches performed.

Pat searches are conducted in the Security Booth in view of cameras. Searches are documented on the *Alco-Sensor Testing Log* with the signatures of the staff member conducting the search and the resident. Females are not restricted access to regular available programming or outside opportunities in order to comply with this provision. At all times, there is a female and a male staff member on duty.

In addition to general training provided to all employees, security staff receive training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents. The agency's *Guidance in Cross Gender and Transgender Pat Searches* curriculum was provided for review. The curriculum was found to instruct staff on how to effectively and professionally conduct cross gender searches of all residents. Staff sign a *Cross Gender Pat Searches & Searches of Transgender & Intersex* acknowledgement form upon completion of this training. Receipt of this training was verified through interviews with staff and in review of staff training records.

The agency has policies and procedures in place that enable residents to shower, perform bodily functions and change clothing without staff viewing their breast, buttocks or genitalia. Policy requires staff of the opposite gender to announce their presence when they enter resident housing and restroom areas. Signs are on doors of all resident rooms remind staff to make opposite gender announcements before entering rooms. This practice was observed while on-site and residents and staff interviewed confirmed that this practice is being followed. Residents shared that they feel they have privacy to shower, toilet and change clothing when staff of the opposite sex are in their housing unit. Each resident room has a restroom with a solid door. Female shower rooms have a single shower with a solid door. Male shower rooms have multiple shower stalls with privacy shower curtains.

Based on GEO policy 5.1.2-A and facility policy 2014-4, the facility prohibits examining transgender or intersex residents for the sole purpose of determining genital status. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. In the past 12 months, there were no transgender or intersex residents housed at the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency takes appropriate steps to ensure that residents with disabilities and residents that are limited English proficient have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. GEO policy 5.1.2-A, page 10, section E and facility policy 2014-2, pages 1 & 2, section V, were used to verify compliance to this standard. Residents receive a *PREA Education Manual for Residents* during the intake process which is available in English, Spanish and in large print for residents with low vision. PREA posters and a *PREA What You Need to Know* video is available in both English and Spanish. Staff members proficient in the Spanish language provide interpretation to Spanish speaking residents. A contract with Language Line Services, Inc. provides for the translation of any other languages, including sign language. A TTY is available for residents who are deaf or hard of hearing and video remote interpretation is available through the Language Line Services, Inc. At the time of the on-site visit, there were no residents who were limited English proficient and none that were deaf, hard of hearing, blind, had low vision or who had cognitive disabilities. One resident when interviewed stated that he was dyslexic and has some difficulties reading so the Acting Social Service Coordinator/Acting PREA Compliance Manager read PREA information to him.

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

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, pages 7 & 8, section C-2 and page 15, section H-4 and facility policy 2014-1 page 4, section 2, interview with the Office Support Specialist and review of all employee files were used to verify compliance to this standard.

Per policy the agency/facility prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who have engaged in, been

convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings or in the community. GEO considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The agency requires that all applicants and employees who may have contact with residents have a criminal background check and every five years thereafter. Criminal background checks for all potential employees are completed through a contract with Accurate Background, Inc. as well BOP clearance for all applicants through NCIC and the Civilian Application System. The agency also requires that all contractors and volunteers who have contact with residents have criminal background checks. Marvin Gardens Center does not utilize the services of contractors or volunteers.

Applicants who answer on their application that they have worked in a confinement setting previously receive a PREA Verification by Accurate Backgrounds, Inc. For consideration for promotions or transfers, employees complete a *PREA Disclosure and Authorization Form Promotions – PREA Related Positions* and another background check by Accurate Background, Inc. is completed, including a PREA Verification. At the time of annual evaluations, employees complete a *PREA Disclosure and Authorization Form – Annual Performance Evaluation.* GEO policy mandates that material omissions regarding sexual misconduct and the provision of materially giving false information, are grounds for termination as required by this standard. Employees have a continuing affirmative duty to disclose any sexual misconduct and/or misconduct to the Facility Director. Unless prohibited by law, GEO Corporate Human Resources Department will provide information on substantiated allegations of Sexual Abuse or Sexual Harassment involving a former employee upon receiving a request from an institutional employer for whom the individual has applied for work.

Criminal Background checks for all employees are completed every five years when the BOP contract is renewed. This year the contract is up for renewal and all employees will have criminal background checks. Personnel files of all current staff were reviewed with the Office Support Specialist and found to contain pre-employment criminal background checks and background checks of staff who were employed at the time of the last contract renewal in 2012.

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)

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 2014-1, page 4, section 3, and documentation provided for review was used to verify compliance to this standard. Per agency and facility policies, Marvin Gardens Center shall consider the effect any new design, acquisition, expansion or modification of physical plant or monitoring technology might have on the facility's ability to protect residents from sexual abuse. The facility is currently undergoing an expansion that is cited to be completed in April 2017. The new building was designed taking into consideration the sexual safety of its residents. During the construction phases, evaluation for any PREA-related concerns were evaluated.

In 2016 the facility installed high definition, picture quality cameras in order to improve video quality throughout the facility. Audio recording surveillance was strategically installed around the facility in order to ensure full audio

quality of common areas. Additional camera upgrades are pending. Currently there are a total of 18 cameras. With the facility expansion, an additional 14 cameras will be added.

In interview with the Executive Vice President Continuum of Care & Reentry Services, he explained that every reentry facility that is acquired or that is planning modifications, an assessment is made by the operations team along with the construction staff taking into consideration the facility's ability to protect residents' sexual safety. He further stated that when installing or updating monitoring technology, a constant assessment is made by the PREA Coordinator and her team assessing for blind spots and cameras to improve the staff's monitoring efforts for the protection of residents from sexual abuse.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, pages 6-9, sections D-I and facility policy 2014-6, pages 6 & 7, section 2, outlines the agency's requirements as it applies to this standard. The Facility Director and the Acting Social Services Coordinator/Acting PREA Compliance Manager are the facility's trained investigators responsible for conducting administrative investigations of allegations of sexual abuse and sexual harassment. It is the responsibility of the Los Angeles Police Department to conduct all criminal investigations and to ensure all forensic evidence is collected and preserved in accordance with evidence protocols established by the Department of Justice (DOJ). The investigating entities follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence and fulfill all requirements of this standard.

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

Victims of sexual abuse have access to forensic medical examinations. Forensic exams are not performed at this facility. Victims of sexual abuse are referred to the Santa Monica-UCLA Medical Center- Rape Treatment Center for SANE exams at no cost to the resident. The facility has attempted to enter into a Memorandum of Understanding (MOU) with the Santa Monica-UCLA Medical Center-Rape Treatment Center. The hospital has given verbal permission to the facility to transport any resident victim of sexual abuse via ambulance to their facility for a forensic exam. The Rape Treatment Center will ensure a victim advocate is present during the SANE exam. In the past 12 months, there have been no residents who have required SANE exams.

Counseling and psychotherapy, victim advocacy and education programs are also available to resident victims through the Santa Monica-UCLA Medical Center-Rape Treatment Center. Additionally, an agreement with the YWCA Sexual Crisis Division is also an option for victim advocacy services and counseling upon request.

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

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, page 4, section III-A-1 and facility policy 2014-6, page 7, sections 2 & 3 outline the agency's policy and procedures for investigating and documenting incidents of sexual abuse. The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment, including resident-on-resident sexual abuse or staff sexual misconduct. All allegations of staff sexual abuse are referred to the agency's Office of Professional Responsibility (OPR) and the BOP Residential Reentry Manager.

Upon receipt of an allegation of sexual abuse, the supervisor receiving the report immediately notifies the Facility Director. The Facility Director will make immediate notification to the PREA Coordinator, to the Director, Fidelity & Quality Assurance and to GEO's Office of Professional Responsibility (OPR) (if the allegation involved staff), the BOP Residential Reentry Manager and the GEO Reentry Services Regional Director. The facility initiates an administrative investigation and if it is determined that the allegation involved potential criminal activity, a referral is made to the Los Angeles Police Department who conduct a criminal investigation.

The agency documents all referral of allegations of sexual abuse or sexual harassment for criminal investigation. A *Serious Incident Report* is completed for all allegations of sexual abuse. All allegations are tracked on the *PREA Monthly Incident Outcome Tracking Log.* In this audit period, there were no allegations of sexual abuse or sexual harassment reported.

The agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the GEO website http://www.geogroup.com/reporting_sexual_abuse-prea.

Standard 115.231 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO employees receive training on GEO's zero-tolerance policy (5.1.2) for sexual abuse and sexual harassment at pre-service and annually at in-service. The agency's requirement of this training is found on pages 11 & 12, section F-1. Between trainings, the facility has monthly staff meetings where PREA is reviewed and discussed. The pre-service and in-service training curriculums were reviewed and found to address all elements of 115.231 (a) as required by this standard. The Facility Director and the Acting Social Service Coordinator/Acting PREA Compliance Manager provide staff PREA training. Employees sign a *PREA Basic Acknowledgement* form that they have received and understood the training they received. Staff also receive the *Guidance in Cross-Gender and Transgender Pat*

Searches training and sign a *Cross Gender & Pat Searches & Searches of Transgender and Intersex* form upon completion of this training. Documentation of annual PREA training for employees is maintained in employee personnel files and copies filed in a binder that is maintained by the Acting Social Service Coordinator/Acting PREA Compliance Manager.

Since the last audit, all Marvin Gardens Center's staff have received annual PREA training as verified by review of employee training files. In interview with staff, they were able to confirm receiving this training and knew their responsibilities for preventing and responding to allegations of sexual abuse and sexual harassment. The facility exceeds in this standard as was evident by review of the training curriculums, review of staff training records and the overall knowledge of staff in response to interview questions.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ 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 Marvin Gardens Center does not utilize the services of contractors or volunteers; 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.

Based on GEO policy 5.1.2-A, page 11, section E-2 and facility policy 2014-2, pages 6 & 7, *Documentation* section, all residents receive information at time of intake and if transferred from another facility about the zero-tolerance policy and how to report incidents of sexual abuse or sexual harassment, their rights to be free from retaliation for reporting such incidents and are informed of the agency policy and procedures for responding to such incidents. Resident education is provided by the Acting Social Service Coordinator/Acting PREA Compliance Manager upon arrival to the facility in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired or otherwise disabled.

In the past 12 months, 298 residents admitted to the facility and 5 residents transferred from other community confinement facilities received written PREA educational material upon arrival to the facility. Residents acknowledge

by their signature on a *Prison Rape Elimination Act (PREA) Resident Manual Acknowledgement Manual* form that they have received a copy of the *PREA Education Manual for Residents*. Ongoing information is provided on posters, both in English and Spanish, prominently displayed in all resident rooms and in numerous other locations throughout the facility. Town Hall Meetings are held with residents on a regular basis where PREA information is discussed.

Per facility procedures, Case Manager Orientation is provided to residents within 72 hours of arrival to the facility. Comprehensive PREA education is required to be given to residents during Case Manager Orientation. Residents are required to sign another acknowledgement form acknowledging viewing the *PREA What You Need to Know* video, receiving training on the zero-tolerance policy, their right to report and their right to free medical and mental health care. The week before the audit, the PREA Compliance Manager showed the *PREA: What You Need to Know* video to all residents and had them sign an acknowledgement form. In review of resident records, the facility was not providing comprehensive PREA education to residents within 72 hours of arrival. Limited information was being reviewed during Case Manager Orientation, but the video was not being shown. Prior to Acting Social Service Coordinator assuming the role as the Acting PREA Compliance Manager, some records of sign in sheets considered training rosters showed some residents viewed the video, but in most instances a length of time after their arrival. It was found that the facility did not meet the requirements of this standard. The following is the recommended Corrective Action Plan to bring the facility into compliance to this standard:

Recommended Corrective Action Plan:
The corrective action to bring this standard into compliance is to develop a procedure to make it a requirement that all residents watch the *PREA: What You Need to Know Video* and be provided the accompanying facilitator's narrative interpretation of the video during Case Manager Orientation within 72 hours or arrival to the facility. Upon completion of this training, residents are to individually sign the required acknowledgement form. Case Management staff will need to be trained on the new procedure and sign a training roster acknowledging receiving training on the new procedure. For the months of February and March, copies of acknowledgement forms upon completion of this training for residents are to be forwarded to me for review with information on the date of arrival of the resident.

Corrective Action Taken:
During the corrective action period, a procedural change was made to the process of providing comprehensive PREA education to all incoming residents, which, includes viewing the *PREA: What You Need to Know* video with facilitator guidance. Once developed, the facility provided training to the case management staff. Documentation of the new procedure as well as the training roster showing those in attendance of training session held on 1/25/17. After viewing the video, residents are required to sign the *PREA Video Acknowledgement* form. Beginning on 1/23/17 and continuing thru 3/31/17, the facility provided a printout showing residents' dates of arrival as well as their signed *PREA Video Acknowledgement* form, in addition to their *PREA Resident Manual Acknowledgement* form that is signed when residents receive a copy of the *PREA Education Manual for Residents* at intake.

Based on the review of all documentation provided to me at the conclusion of the corrective action period, it was determined that the facility has achieved compliance with all elements of this standard.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 13, section F-3, in addition to general education provided to all employees, GEO ensures that facility investigators receive training on conducting sexual abuse investigations in confinement settings. In review of the training curriculum, the training includes techniques for interviewing sexual abuse victims, proper use of the Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or referral for prosecution. At the Marvin Gardens Center, the Facility Director and the Acting Social Service Coordinator/Acting PREA Compliance Manager are trained facility investigators. The agency's PREA Coordinator provided a four-hour specialized training for investigators on 10/22/15. The facility maintains documentation that the investigators have received this training.

Upon interview, the facility's investigators were knowledgeable of their 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)

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

Standard 115.241 Screening for risk of victimization and abusiveness

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, pages 8 & 9, section D-1 and facility policy 2014-3, pages 2 & 3, section VI-B-1, all offenders placed at the Marvin Gardens Center are assessed for their risk of being sexually abused or sexually abusive towards others within 24 hours of arrival to the facility by the Case Managers. The *PREA Risk Assessment* form is used for this purpose. The form was reviewed and found to contain all requirements of 115.241 (b) of this standard and considers prior acts of sexual abuse and prior convictions for violent offenses. Residents may not be disciplined for refusing to answer any questions or for not disclosing complete information. In addition to the screening form, a thorough review of any available records that can assist in determining risk assessment is

completed.

Within a set time period, not to exceed 30 days of the resident's arrival to the facility, residents are reassessed by their Case Manager using the *PREA Vulnerability Reassessment Questionnaire* (HWH 38) for their risk for victimization and abusiveness. A resident's risk level will also be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information. When completed, the *PREA Risk Assessment* forms and the *PREA Vulnerability Reassessment Questionnaires* are given to the Acting Social Service Coordinator/Acting PREA Compliance Manager for her review and to be filed in a binder kept in her office. To maintain confidentiality, only the Facility Director, the Acting Social Service Coordinator/Acting PREA Compliance Manager and Case Managers have access to screening information.

In interview with the Case Managers and the Acting Social Service Coordinator/Acting PREA Compliance Manager and in review of random residents' records, this process is in place and the facility is doing an excellent job in screening residents for risk of victimization and abusiveness exceeding in the requirements of this standard.

Standard 115.242 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency uses the information from the risk screening form to make housing, bed, work, education and program assignments with the goal of separating residents at high risk of being sexually victimized from residents with those at high risk of being sexually abusive. Individualized determinations are made about how to ensure the safety of each resident. GEO policy 5.1.2-A, page 10, section D-3 and facility policy 2014-3, page 4, section 2, explains the use of PREA screening information. On interview with the Acting Social Services Coordinator/Acting PREA Compliance Manager, she explained how the facility utilizes screening information from the PREA Risk Assessment form for this purpose.

Residents who score at risk of victimization or abusiveness are referred for further evaluation using the *Resident Referral Verification* form. Residents have an option of refusing these services. Those identified to be at risk are tracked on an *At-Risk Log*. Female residents screened to be at risk for victimization or abusiveness are housed in one of the female rooms (8 or 9). Male residents screened to be at risk for victimization are housed in Room 6 and if screened for risk of abusiveness are housed in Room 1.

GEO does not place lesbian, gay, bisexual, transgender or intersex residents in dedicated units or wings solely on the basis of such identification. On interview with one female resident who self-disclosed being bisexual, reported that she was not placed in any special room because she was bisexual.

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 7, last paragraph outline the agency's options for resident reporting methods. The agency provides multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and any staff neglect or violation of responsibilities that may have contributed to such incidents.

Residents are made aware of methods of reporting available to them through the *PREA Education Manual for Residents* (page 9) provided to them upon intake, on the Resident Reporting Options posters and continuously through other posters and brochures displayed throughout the facility. Residents are made aware that they can verbally inform any staff member, the Facility Director or the Acting Social Service Coordinator/Acting PREA Compliance Manager immediately or in writing or contact the agency PREA Coordinator. They are informed they can call the YWCA Sexual Crisis Division or the Santa Monica-UCLA Medical Center-Rape Treatment Center. They are also given the address to write to the Residential Reentry Office located in San Pedro, CA. Residents are informed of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Residents can also file a grievance and facility policy 2014-5, pages 4 & 5 addresses sexual abuse grievances and emergency grievance procedures.

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

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

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

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In review of GEO policy 5.1.2-A, pages 17 & 18, section K-2, and facility policy 2014-5, pages 4 & 5, there is a procedure in place for residents to submit grievances regarding sexual abuse and the agency has procedures for

dealing with these grievances. Instructions on how to file grievances are provided on page 7 of the *PREA Education Manual for Residents.*

There is no time limit when a resident can submit a grievance regarding sexual abuse. Residents are not required to use any informal grievance process or attempt to resolve this type of grievance prior to submission. Residents have a right to submit grievances alleging sexual abuse to someone other than the staff member who is the subject of the complaint. If a third party files a grievance on a resident's behalf, the alleged victim must agree to have the grievance filed on his behalf.

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

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

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 23, section N-8 and facility policy 2015-6, page 11, section H-6, addresses the agency's policy on providing residents with access to outside victim advocates for emotional support services related to sexual abuse. Residents are given the telephone numbers to the Santa Monica-UCLA Medical Center-Rape Treatment Center at 424-259-7208 and to the YWCA Sexual Crisis Division at 877-943-5778. Both agencies provide hot line reporting, counseling, psychotherapy and victim advocacy services. This information is provided to residents in the *PREA Education Manual for Residents* and on *Resident Reporting Options* posters displayed throughout the facility. Residents are informed of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

The facility has attempted to enter into an MOU with the Santa Monica-UCLA Medical Center-Rape Treatment Center and the YWCA Sexual Crisis Division with no avail. They continue to pursue these MOU's. Both agencies have given verbal confirmation that they will provide advocacy and counseling services to the residents of the Marvin Gardens Center upon referral. Other community resources available for emotional support services include the LAC & USC Medical Center, the Augustus Hawkins and the Exodus Recovery.

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

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 18, section 3, the agency has a method to receive third-party reports of sexual abuse and sexual harassment on behalf of individuals in a GEO facility or program. Information on third-party reporting is found on facility postings and is made available on the GEO website at http://www.geogroup.com/reporting_sexual_abuse_prea. Third-party reports can be made in person, in writing, anonymously or by contacting the agency's PREA Coordinator. Residents interviewed were aware of this method of reporting.

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

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency's requirement on staff reporting duties can be found pages 18 & 19, section 4 of GEO policy 5.1.2-A. The facility's requirement on staff reporting duties can be found on pages 5 & 6 of facility policy 2014-6. Staff must take all allegations of sexual abuse and sexual harassment seriously. All staff are required to report immediately to the Acting Social Service Coordinator/Acting PREA Compliance Manager any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment and any retaliation against residents or staff who reported such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, are reported to supervisors. The supervisor receiving the report immediately notifies the Facility Director. For an allegation of sexual abuse, the Facility Director will make notification to the PREA Coordinator, the Director, Fidelity & Assurance and the BOP Residential Reentry Manager. If the allegation involves staff, notification is also made to GEO's OPR.

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

The Marvin Gardens Center houses adult male and female residents only, all of whom according to their classified level of care are not considered to be vulnerable adults under the State Vulnerable Persons Statue.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident according to GEO policy 5.1.2-A, page 19, section L-1 and facility policy 2014-6, section V1.

In interview with the Acting Social Services Coordinator/Acting PREA Compliance Manager and documentation provided, there were no times during the past 12 months that it was necessary for the agency to take immediate action in regards to a resident being in substantial risk of sexual abuse. Staff interviewed were aware of their responsibilities if they felt a resident was at risk for sexual abuse.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 22, section 5 and facility policy 2014-6, pages 9 & 10, section F were used to verify compliance to this standard. Upon receiving an allegation that a resident was sexually abused while confined at another facility, the allegation will be documented and the Facility Director or his designee shall notify the head of the facility where the sexual abuse was alleged to have occurred and document that notification was provided. This notification is to occur as soon as possible, but no later than 72 hours of receiving the allegation and should include all actions taken regarding the incident. Copies of this documentation will be forwarded to the PREA Coordinator a Social Services Coordinator/Acting PREA Compliance Manager.

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

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

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 19-22, section L-2-4 and facility policy 2015-6, pages 6 & 7, section C, outlines the procedure for first responders to follow for allegations of sexual abuse and sexual harassment whether that person is a security or non-security staff member. Per policy, upon learning of an allegation of sexual abuse, the first security staff member to respond to the report is to separate the alleged victim and abuser, immediately notify the on-duty or on-call supervisor, preserve and protect the crime scene, not let the alleged victim or abuser take any actions that could destroy physical evidence and not reveal to anyone information related to the incident to anyone other than staff involved with investigating the alleged incident.

If the first responder is not a security staff member, the responder is to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff. All staff carry with them a Sexual Abuse First Responder Card affixed to their badges reminding them of the steps to take if they are the first responders to an allegation of sexual abuse or sexual harassment.

Random interviews with security and non-security staff revealed that they knew the policy and practice to follow if they were the first responder to an allegation of sexual abuse or sexual harassment. They reported that they knew that the alleged victim and abuser must be separated and knew how to preserve the crime scene and preserve the physical evidence. In the past 12 months, there have been no PREA incidents 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 III-A-4 and review of the Marvin Gardens Center's *PREA Coordinated Response Plan* were used to verify that there is a plan in place to coordinate actions to be taken in response to an incident of sexual abuse. The plan provides written guidance to staff and administration regarding actions to take and notifications to be made. A *PREA After-Action Checklist for Incidents of Sexual Abuse and Harassment* is completed to ensure that all steps of the plan and proper notifications are made. This checklist is filed with the completed investigative packet. The Facility Director, the Acting Social Service Coordinator and the Chief of Security are responsible to ensure compliance to the plan. Staff interviewed confirmed that they are knowledgeable of the plan and the necessary actions to be taken in response to an allegation of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, page 4, section III-A-2 was used to verify compliance to this standard. In all cases where the alleged abuser is an employee, contractor or a volunteer, there will be no contact between the alleged abuser and the alleged victim pending the outcome of an investigation. Facility policy 2014-6, page 9, section 5-e, states that if the suspect is a staff member, the staff member shall be reassigned to a post with no resident contact or placed on administrative leave pending the outcome of an investigation. In all cases, the abuser would be subject to disciplinary sanctions for violating GEO policies on sexual abuse and sexual harassment.

The Marvin Gardens 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 the facility's ability to remove an alleged sexual abuser from contact with residents pending the outcome of an investigation.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO has as policy to protect residents who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff as outlined in policy 5.1.1-A, page 24, section 2 and in facility policy 2014-6, pages 11, section H-7-11. The agency has multiple protection measures, such as housing changes or transfers for residents, victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. If any other individual who cooperates with an investigation expresses a fear of retaliation, appropriate measures to protect that individual against retaliation are put in place.

The Facility Director and/or the Acting Social Services Coordinator/Acting PREA Compliance Manager is responsible for weekly monitoring for retaliation for at least 90 days and longer if there is a continuing need. Monitoring is documented on the *Protection from Retaliation Log.* Completed logs are filed in the investigative file.

In the past 12 months, there were no incidents of retaliation that occurred; therefore no retaliation monitoring was required. When interviewed, the Acting Social Service Coordinator/Acting PREA Compliance Manager knew her responsibilities for monitoring for retaliation per policy.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment at the Marvin Gardens Center, including third party and anonymous reports. The Acting Social Service Coordinator/Acting PREA Compliance Manager are the trained facility investigators responsible for conducting administrative investigations. The agency's policy on administrative and criminal investigations is outlined in GEO policy 5.1.2-E, pages 4-6, section III-B & C.

The supervisor receiving the report of an allegation of sexual abuse or sexual harassment immediately notifies the Facility Director who notifies the PREA Coordinator and the Director, Fidelity & Assurance and the BOP Residential Reentry Manager. If the allegation involves a staff member, notification is made to GEO's OPR.

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

When the quality of evidence appears to support criminal prosecution, the allegation is referred to the Los Angeles Police Department who conduct criminal investigations pursuant to the requirements of this standard. Since the initial PREA audit, there were no substantiated allegations of sexual abuse that were referred for criminal investigation.

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

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

In the past 12 months, there were no allegations of sexual abuse or sexual harassment reported.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2,-E, page 6, section B-2-d, the agency/facility shall impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. When the facility investigators were asked what standard of evidence was used in determining if an allegation is substantiated, they 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.

GEO policy 5.1.2-E, pages 10 & 11, section III-K and facility policy 2014-6, pages 12 & 13, section J were used to verify compliance to this standard. The policies indicate that following an investigation of sexual abuse of a resident, the resident shall be informed as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded. The Acting Social Service Coordinator/Acting PREA Compliance Manager is responsible to present to the resident the *Notification of Outcome of Allegation* form which the resident signs. This form is retained in the investigative file of the corresponding PREA incident.

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

In the past 12 months, there were no allegations reported; therefore, no notification of the outcome of an investigation were required. Based on interview with the Acting Social Service Coordinator/Acting PREA Compliance Manager, the process of providing notification to resident victims at the conclusion of an investigation is in place.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse policy as outlined in policy GEO policy 5.1.2-E, page 11, section L and facility policy 2014-6, page 13, section M. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. All terminations for violations of the agency's policies on sexual abuse and sexual harassment, or resignations, shall be reported to law enforcement and licensing agencies unless the activity was clearly not criminal. In the *GEO Employee Handbook,* provided to all staff, pages 16 & 17 explain the zero-tolerance policy for employees and the sanctions that would be imposed for violations of that policy.

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

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ 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.

Based on review of GEO policy 5.1.2.A, page 14, section G-3 and page 15, section H-3, any volunteer or contractor who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies and licensing boards, unless the activity was clearly not criminal.

The Marvin Gardens Center does not utilize the services of contractors or volunteers; therefore, this standard is not applicable to this facility.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to facility policy 2015-6, pages 13 & 14, section M-2, the FBOP and the USPO are the supervising

authorities over all residents at the Marvin Gardens Center. If a resident is found guilty of engaging in sexual abuse involving another resident, it will be reported to the appropriate DOC staff or Residential Reentry Manager who will determine whether to subject the offender to formal disciplinary sanctions. Residents are made aware of sexual misconduct they will be disciplined for and the sanctions that will be imposed in attachment E of the *Resident Program Handbook.*

Based on GEO policy 5.1.2-E, page 12, section 2, the disciplinary process may consider whether an individual's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The FBOP and/or the USPO will determine if the offender will be required to participate in counseling or other interventions designed to address the reasons or motivations for the abuse. Disciplining an offender for sexual contact with an employee is prohibited unless it is found that the employee did not consent to the contact. The agency prohibits all sexual activity between residents. Facilities may not deem that sexual activity between residents is sexual abuse unless it is determined that the activity was coerced.

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

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 23, section 7 and facility policy 2014-6, page 7, section 5-f and page 8, section 5-f. Resident victims are referred the Santa Monica-UCLA Medical Center-Rape Crisis Center for SANE exams at no cost to the resident. Counseling services would be provided by the Santa Monica-UCLA Medical Center-Rape Crisis Center or by referral to the YWCA Sexual Crisis Division.

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

In the past 12 months, there have been no sexual abuse cases requiring emergency medical or mental health services.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The facility will offer ongoing medical and mental health care to all the residents of the Marvin Gardens Center who have been victimized by sexual abuse. According to GEO policy 5.1.2-A, pages 23 & 24, section M-1 and facility policy 2014-6, page 8, section 5-h, the evaluation and treatment will include follow-up services, treatment plans and referrals for continued care upon transfer or release consistent with the community level of care. Victims will also be offered tests for sexually transmitted infections. Female victims of sexually abusive vaginal penetration, shall be offered pregnancy tests. If pregnancy results shall receive timely and comprehensive information about access to all lawful pregnancy-related medical services. All services will be provided without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Referrals are made to the Santa Monica-UCLA Medical Center-Rape Treatment Center for emergency and ongoing medical services.

The facility attempts to conduct a mental health evaluation of all known abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate. Mental health services are provided by referral to the YWCA Sexual Crisis Division.

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

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 25, section 3 and facility policy 2014-6, page 12, section K, the facility is required to conduct a sexual abuse incident review within 30 days of every sexual abuse investigation in which the allegation has been determined to be substantiated or unsubstantiated.

The Facility Director, the Chief of Security and the Acting Social Service Coordinator/Acting PREA Compliance Manager make up the facility's Incident Review Team. The team meets and the PREA Coordinator may attend via telephone or in person. The team considers whether the incident was motivated by race, ethnicity, gender identity, perceived status or gang affiliation. The team examines the area where the incident was alleged to have occurred and assesses whether physical barriers in the area may have contributed to the abuse, whether monitoring technology should be deployed or augmented and whether the staffing levels at the time of the incident were adequate.

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

In the past 12 months, there were no allegations of sexual abuse or sexual harassment reported. When interviewed, the members of the Incident Review Team knew their responsibilities as they relate to the review of sexual abuse incidents.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Information on data collection is found on page 25, section N-1 of GEO policy 5.1.2-A. GEO collects uniform data for every allegation of sexual abuse at all facilities under their control. The data collected, will be at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Bureau of Justice Statistics (BJS).

The Acting Social Service Coordinator/Acting PREA Compliance Manager ensures that the data is compiled and forwarded to the PREA Coordinator on a monthly basis on the *Monthly PREA Incident Tracking Log* (attachment D of policy 5.1.2-A). At least annually, the PREA Coordinator aggregates this data. Upon request, or no later than June 30th, the agency provides aggregated data information for the previous calendar year to DOJ.

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

Standard 115.288 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 26, section N-3, the agency ensures that the data collected is securely retained for at least 10 years or longer if required by state statue.

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

AUDITOR CERTIFICATION

I certify that:

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

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

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

Barbara Jo Denison April 17, 2017

Auditor Signature Date