PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: August 14, 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: July 31 – August 1, 2017			
Facility Information			
Facility name: Oakland Center			
Facility physical address: 205 MacArthur Blvd., Oakland, CA 94610			
Facility mailing address: N/A			
Facility telephone number: 510-839-9051			
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: Matthew Lange, Facility Director			
Number of staff assigned to the facility in the last 12 months: 21			
Designed facility capacity: 69			
Current population of facility: 79			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 26-71			
Name of PREA Compliance Manager: Matthew Lange		**Title:** Facility Director/PREA Compliance Manager	
Email address: mlange@geogroup.com		**Telephone number:** 510-839-9051, ext. 77310	
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 Oakland Center was conducted July 31 – August 1, 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 Matthew Lange, Facility Director who is designated as the facility's PREA Compliance Manager.

On the first day of the audit, an entrance meeting was held with Matthew Lange, Facility Director/PREA Compliance Manager; Jonathon Dressler, Director, PREA & Quality Assurance; Dragan Spiroski, Manager, Program Performance and Adam Schlager, Manager, Program Performance in attendance. Those in attendance of the entrance meeting and Shaina Wells, Social Service Coordinator accompanied me on a facility tour following the conclusion of the entrance 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. Resident PREA reporting option information and other PREA information was posted in all resident rooms and in all common areas of the facility. Staff reporting information is posted in all administrative offices and the staff break room.

During the tour, the number for the RAINN National Hotline Network (1-800-656-4673) was dialed on a resident pay phone. The number was found accessible and calls to this number are forwarded to the Sexual Assault Response Team of the Highland Hospital. Calls to this number are confidential and toll free.

The Oakland Center entered into a Memorandum of Understanding (MOU) with the Bay Area Women Against Rape on 1/26/17. The Executive Director of that agency was contacted prior to the on-site visit to confirm and review the MOU. The terms of the MOU provide a 24-hour confidential hotline, victim advocacy, court advocacy and counseling support, in the form of individual and group therapy, for victims of sexual abuse. Victim advocates who are on-call for the Bay area respond within 30 minutes to the Highland Hospital when a victim is transported to the hospital for SANE exam. All services provided by the Bay Area Women Against Rape are at no cost to the victim and are confidential.

The Oakland Center has attempted to enter into an MOU with the Highland Hospital Sexual Assault Response Team (SART), but those efforts have been unsuccessful. Although the facility does not have an MOU with the Sexual Assault Response Team at the Highland Hospital, the SART is available 24-hours a day to assist resident victims of sexual abuse. Efforts to enter into an MOU with the Alameda County Crisis Support Services were also unsuccessful.

The records of 20 residents were reviewed to evaluate compliance to screening procedures. The PREA training records of the same 20 residents were reviewed and documentation of receipt of the *PREA Education Manual for Residents* upon intake and acknowledgement of viewing the *PREA: What You Need to Know* video was found in all records reviewed.

The personnel files of all Oakland Center staff were reviewed to determine compliance with

background check procedures. Review of files showed that criminal background checks for pre-employment and after five years of employment are being completed as required.

Documentation of annual PREA training for staff is filed in a binder maintained by the Facility Director/PREA Compliance Manager. Training documentation for all staff since the last PREA audit was reviewed and found to be complete.

On the first day of the audit, the population of the Oakland Center totaled 79 with 68 residents in-house and 11 on home confinement. A total of 18 in-house residents were interviewed. The number of in-house residents included two residents that were screened to be at risk of victimization and one resident who was hard of hearing. At the time of the audit, there were no residents who were blind, had low vision, deaf, with cognitive deficits, low reading skills, 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 lesbian, bisexual, transgender or intersex. There was one resident who self-disclosed at initial screening to be gay, but he was unable to be interviewed due to his long hours away from the facility working.

All of the residents interviewed acknowledged receiving PREA training with written information during the intake process and viewing the PREA video. They were familiar with the agency/facility's zero-tolerance policy against sexual abuse and sexual harassment and were able to articulate during interview the methods of reporting allegations of sexual abuse and sexual harassment available to them. Residents shared that staff of the opposite gender consistently knock and announce their presence when they enter their housing area and they feel that they have privacy when showering, toileting and changing clothing. Signs posted on the doors of resident rooms informs residents that both male and female staff will be on duty.

Twelve staff members were interviewed during the course of the audit and two religious volunteers were interviewed by telephone. Of the 12 staff members interviewed, four were security staff and the remaining were specialized staff. Security staff interviewed were from the second and third shifts. Security staff scheduled to work the first shift were unavailable to be interviewed due to illness. 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 Facility Director/PREA Compliance Manager is the facility's trained investigator responsible for conducting administrative investigations. Criminal investigations are referred to the Oakland Police Department. In the past 12 months, there have been no allegations of sexual abuse or sexual harassment reported. Since the last audit there were three allegations received and investigated administratively. One staff-on-inmate sexual abuse received in 2016 was determined to be unfounded. In 2015 one allegation of staff-on-inmate sexual abuse was determined to be unfounded and one allegation of staff-on-inmate sexual harassment was determined to be unsubstantiated. In review of investigative files, all allegations were investigated in accordance with the PREA standards.

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with Matthew Lange, Facility Director/PREA Compliance Manager; Jonathon Dressler Director, PREA & Quality Assurance; Dragan Spiroski, Manager, Program Performance and Adam Schlager, Manager, Program Performance in attendance. During the exit meeting, the Facility Director/PREA Compliance Manager was informed of the process that would follow the on-site visit including the agency's responsibility of posting the final report on the agency's website. The Facility Director/PREA Compliance Manager was thanked for his cooperation prior to the audit and during the on-site visit and complimented on the excellent PREA program the Oakland Center has developed and enhanced.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Oakland Center is located at 205 MacArthur Boulevard, Oakland, California. The Oakland Center is owned and operated by the GEO Group, Inc. and contracted to house male and female offenders transferred from the Federal Bureau of Prisons (FBOP). The conrtact with FBOP began in 1981 and is a performance-based contract with renewal each year based on performance for up to 10 years. The design capacity of the facility is 69 and the population on the first day of the audit was 79 with 68 in-house residents and 11 on home confinement. There was one pre-trial resident, 10 public law residents and the remaining in-house residents were in BOP custody. Residents are minimum security custody level with an average length of stay of 3-6 months.

Oakland Center is a large, dark brown wood Victorian-style home built in 1904, which has been converted into the present facility. The building has four floors with a large front porch. The entrance from the front porch opens into a wide-open foyer with a large staircase. To the right of the foyer there is a multipurpose room with chairs, sofas, books, bulletin board and staff boxes for resident communications. *Third Party Reporting Options* posters and *Resident Reporting Options* posters were posted. The multipurpose room is used for programming, visitation, watching television from 4-11 p.m. and just relaxing. The Facility Director's office is located behind the television room with a staircase opposite the Facility Director's office.

To the left of the entryway there is a Monitor Station. Residents and visitors check in and out from the Monitor Station. Residents sign in and out on a paper log and this information is entered electronically in GEO Track. Residents enter into the front door, wait in the foyer, and are allowed to enter the Monitor Station one at a time. There residents are breathalyzed and random urinalysis are performed in a UA restroom. The Monitor Station is staffed 24 hours a day where they monitor surveillance cameras. Cameras can also be monitored from the Facility Director and the Assistant Director's offices and on the Facility Director's phone. Security staff conduct pat-down searches in view of a camera. A cubicle in the Monitor Station provides office space for the Office Support Specialist.

Behind the Monitor Station there is an office for the Security Manager, Social Service Coordinator, Case Managers and the Job Developer, with an office behind that office for the Assistant Facility Director. There is one resident room on the first floor with four beds with an adjoining restroom with a toilet, sink and a shower with a curtain. This room is used to house resident with mobility problems or for male residents who are screened to be at risk for victimization. There is one pay phone on the main floor with PREA reporting information posted by the telephone.

A stairwell from the main floor leads to a basement floor which contains two male rooms (1 & 2); one with 8 beds and one with 6 beds. There is a restroom with a sink, toilet and two showers with frosted glass doors on the showers. Another restroom in the basement has two sinks and one toilet with no shower. A laundry with five stackable washer/dryers, a kitchen area and dining hall are also in the basement. In close proximity to the laundry area is the kitchen that has food catered in and kept under lock and key. There is a small closet next to the bathroom downstairs that has no shower. The closet is used to store mops and mop buckets which is kept locked at all times. The staff breakroom is down in the basement area as well as a chemical room. All areas are under lock and key and cameras capture movement in and out of those areas. An exit door from this level provides access to the backyard. Doors and the backyard area are monitored by cameras and a wooden fence behind the property is locked and alarmed. On the left side of the

building, there is a small staff parking area and a large maintenance/storage shed which was the old carriage house.

There is a large landing between the first and second floor with two pay telephones with PREA *Resident Reporting Options* information posted by each phone. There are eight resident rooms on the second floor of the building; six male rooms and two female rooms. Three rooms have their own restroom and a common restroom on this floor has a shower with a shower curtain, a toilet and a sink. The two female rooms (25 & 26) have a restroom with a tub/shower with curtain, a toilet and a sink. A single room (26A) is a small room adjacent to room 26.

On the third floor, there is large room with four bunks in an open area. Around the larger room, there are four smaller rooms with two beds in each, for a total of five resident rooms on the third floor.

Security Monitors conduct four counts per shift and a minimum of four walkthroughs each shift. The Oakland Center has 27 cameras with a DVR with the ability to store data for up to 30 days.

The facility has 21 staff with vacancies for two part-time Security Monitors. Two volunteers provide religious services to residents. The Oakland Center does not utilize the services of contractors.

SUMMARY OF AUDIT FINDINGS

The following is a summary of the audit findings:

Number of standards exceeded: 5

Number of standards met: 32

Number of standards not met: 0

Number of standard not applicable: 2

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

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

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

GEO policy 5.1.2-A and Oakland 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 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, PREA & Quality Assurance who provides oversight to the agency's reentry facilities; therefore, exceeding in the requirements of this section of the standard. The PREA Coordinator and the Director, PREA & Quality Assurance are extremely knowledgeable and continue to provide facilities with support and assistance for the implementation and enhancement of the agency's PREA program requirements.

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

Standard 115.212 Contracting with other entities for the confinement of residents

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

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

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

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 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 69 residents and the staffing plan was developed based on that number with 18.5 allocated positions. There are two security staff on duty at all times, one male and one female. Case Management personnel are staffed at a 1:30 ratio.

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. Staffing rosters are forwarded to BOP monthly for their review. In review of documentation provided by the facility and upon interview with the Facility Director, in this audit period there were no times that there were deviations to the staffing plan. Staff vacancies are filled by the use of staff overtime to ensure the correct staff ratio.

The staffing plan is reviewed annually by the Facility Director/PREA Compliance Manager along with other administrative team members, and documented on the *PREA Annual Facility Assessment* form. This form is then forwarded to the Regional Director, Director, PREA & 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 *PREA Annual Facility Assessments* completed each year since the last PREA audit*,* no recommendations were made for changes to the established staffing plan.

Per policy, facility management staff and mid-level supervisors conduct unannounced rounds within their respective areas to identify and deter employee sexual abuse and sexual harassment. These unannounced rounds are documented on the *Manager/Supervisor Facility Walkthrough* 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 Security Manager performs these verifications and documents them on the *Resident Count Verification Checklist.* He completes three verifications for each shift weekly and forwards the completed forms to the Divisional Vice President of Reentry Services and to the Regional Director.

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-J, and facility policy 2014-4, pages 2 & 3, sections on *Offender/Resident "Pat" Searches*, *Offender/Resident "Strip" Searches*, *"Body Cavity" Searches*, and *Limits to Cross-Gender Viewing and Searche*s, 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 Oakland 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 Monitor Station in view of cameras and documented on the *Pat Down (PD)/Breathalyzer (BA) Record*. 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 floors remind residents that both male and female staff are on duty. Opposite gender staff knock on all resident doors and announce themselves before entering resident 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.

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, pages 11 & 12, section E-1 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. A TTY is available for residents who are deaf or hard of hearing At the time of the on-site visit, there were no residents who were limited English proficient and none that were deaf, blind, had low vision or who had cognitive deficits. One resident interviewed that was hard of hearing reported that he had no problems hearing or understanding the PREA information presented to him and his responses to interview questions were appropriate.

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

Standard 115.217 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, pages 7 & 8, section C-2 and page 16, section 4 and facility policy 2014-4, page 4, section 2, interview with the Facility Director/PREA Compliance Manager in the absence of the Office Support Specialist and review of random employee files were used to verify compliance to this standard.

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

The agency requires that all applicants and employees who may have contact with residents have a criminal background check and every five years thereafter. Criminal background checks for all potential employees are completed through a contract with Aurico, as well BOP NCIC clearance for all applicants. If an applicant answers that they have previously worked at a confinement facility, a Custom Employment Report is ordered from Aurico for PREA verification. Aurico performs driver's license checks. In the past 12 months, 12 criminal background checks were completed on applicants. The agency also requires that all contractors and volunteers who have contact with residents have criminal background checks. Page 16, section 4 of the agency policy addresses the

requirements of criminal background checks for contractors. The facility does not utilize the services of contractors.

For consideration for promotions or transfers, employees complete a *PREA Disclosure and Authorization Form Promotions – PREA Related Positions* and another background check by Aurico is completed which includes PREA verification through a Custom Employment Report. At the time of annual performance evaluations, employees complete a *PREA Disclosure and Authorization Form – Annual Performance Evaluation.* GEO policy mandates that material omissions regarding sexual misconduct and the provision of materially giving false information are grounds for termination as required by this standard. Employees have a continuing affirmative duty to disclose any sexual misconduct and/or misconduct to the Facility Director. Unless prohibited by law, GEO Corporate Reentry Services Human Resources Department will provide information on substantiated allegations of Sexual Abuse or Sexual Harassment involving a former employee upon receiving a request from an institutional employer for whom the individual has applied for work.

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

The facility is doing an excellent job of ensuring that all agency and standard requirements are adhered to and that all records of required criminal background checks are maintained.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, page 8, section C-3 and facility policy 2014-1, page 4, section 3, and documentation provided for review was used to verify compliance to this standard. Per agency and facility policies, the Oakland Center shall consider the effect any new design, acquisition, expansion or modification of physical plant or monitoring technology might have on the facility's ability to protect residents from sexual abuse. Since the last PREA audit, there were no new facilities and no substantial expansions or modifications were made to the existing facility. Since the last PREA audit, there have been camera upgrades with more upgrades pending.

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 6-10, 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 is the facility's trained investigators responsible for conducting administrative investigations of allegations of sexual abuse and sexual harassment. It is the responsibility of the Oakland 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 Highland Hospital for SANE exams at no cost to the resident. The Oakland Center entered into an MOU with the Bay Area Women Against Rape 1/26/17. The Bay Area Women Against Rape will ensure an on-call victim advocate is present during the SANE exam. In the past 12 months, there have been no residents who have required SANE exams. A 24-hour hotline, counseling, individual therapy, groups for victims and court advocacy are services available to resident victims through the Bay Area Women Against Rape.

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, PREA &

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 Senior Area Manager. The facility initiates an administrative investigation and if it is determined that the allegation involved potential criminal activity, a referral is made to the Oakland 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 the past 12 months, there were no allegations of sexual abuse or sexual harassment reported. Since the last PREA audit there were three allegations received and investigated.

The agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the GEO website https://www.geogroup.com/PREA (Documents and Resource Section).

Standard 115.231 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO employees receive training on GEO's zero-tolerance policy (5.1.2-A) for sexual abuse and sexual harassment at pre-service and annually at in-service. The agency's requirement of this training is found on pages 12 & 13, section F-1. Between trainings, 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/PREA Compliance Manager provide staff PREA training and there are many staff training opportunities throughout the year. Employees sign a *Staff Meeting Record* and a *PREA Basic Acknowledgement* form that they have received and understood the training they received. Staff also receive the *Guidance in Cross-Gender and Transgender Pat Searches* training and sign a *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 Facility Director/PREA Compliance Manager.

Since the last audit, all Oakland Center's staff has 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)

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

All volunteers and contractors who have contact with detainees are trained and have annual refreshers on their responsibilities regarding sexual abuse/harassment prevention, detection and response as outlined in GEO policy 5.1.2-A, page 14, section G-1 for volunteers and page 15, section H-1, for contractors.

The Oakland Center does not utilize the services of contractors. The facility has two active religious volunteers. Upon completion of PREA training, volunteers sign a *PREA Basic Training Acknowledgement* form.

In interview with both volunteers by telephone, they confirmed receiving the training and were knowledgeable of the agency/facility's zero-tolerance policy and their PREA-related responsibilities.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 12, section E-2 and facility policy 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 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, 200 residents admitted to the facility received written PREA educational material upon arrival to the facility. Security Monitors provide residents with a *PREA Education Manual for Residents and* residents sign a *Prison Rape Elimination Act (PREA) Notice* upon arrival to the Oakland Center. Residents receive a copy of the *PREA Education Manual for Residents* and sign an *Acknowledgement of Receipt of PREA Educational Manual* form. 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 agency/facility procedures, Case Manager Orientation is provided to residents within 72 hours of arrival to the facility where PREA information is reviewed with residents. 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.

In review of resident files, documentation showed that the Oakland Center is doing an excellent job of providing residents with PREA information upon intake and continuously by making information readily available at all times exceeding in the requirements of this standard.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 14, section F-3, in addition to general education provided to all employees, GEO ensures that facility investigators receive training on conducting sexual abuse investigations in confinement settings. In review of the training curriculum, the training includes techniques for interviewing sexual abuse victims, proper use of the Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or referral for prosecution. At the Oakland Center, the Facility Director/PREA Compliance Manager is the trained facility investigator. He completed specialized training for investigators on 7/18/13 and on 10/21/14. The facility maintains documentation that this training was completed.

Upon interview, the Facility Director/PREA Compliance Manager was knowledgeable of his 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 Oakland 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, all residents placed at the Oakland 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 Facility Director, Assistant Director, Security Manager or the Social Service Coordinator, who make up the Management Team. 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 a member of the Management Team 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 filed in a binder maintained by the Facility Director/PREA Compliance Manager. To maintain confidentiality, only the members of the Management Team have access to screening information.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency uses the information from the risk screening form to make housing, bed, work, education and program assignments with the goal of separating residents at high risk of being sexually victimized from residents with those at high risk of being sexually abusive. Individualized determinations are made about how to ensure the safety of each resident. GEO policy 5.1.2-A, pages 10 & 11, section D-3 and facility policy 2014-3, page 3, section 2, explains the use of PREA screening information. On interview with the Facility Director/PREA Compliance Manager, he explained how the facility utilizes screening information from the *PREA Risk Assessment* form for this purpose.

Residents who score at risk of victimization or abusiveness are referred for further evaluation using the *Resident Referral Verification* form and forwarded to the BOP Residential Reentry Manager for approval. 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 a single room. Male residents screened to be at risk for victimization are housed in room 10 on the first floor which is close to staff offices and those screened at risk of abusiveness are housed in any room on the second floor.

GEO does not place lesbian, gay, bisexual, transgender or intersex residents in dedicated units or wings solely based on such identification.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 18, section L-1 and facility policy 2014-2, page 4, 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. Residents are made aware that they can verbally inform any staff member or the Facility Director/PREA Compliance Manager immediately or in writing. They are informed they can call the RAINN National Hotline Network (1-800-656-4673), the Bay Area Women Against Rape (510-845-7273), the Bureau of Prisons Residential Reentry Office (916-930-2010) and given their address or call the GEO Corporate PREA Coordinator (561-999-5827). 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 are also informed that a third party can make a report for them.

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

The agency's policy mandates that staff accept all reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Information concerning the identity of resident victim's report of sexual abuse or sexual harassment is limited to those who need to know only.

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 (https://www.geogroup.com//PREA (Social Responsibility-PREA Certification Section). Page 4, section I of the *Employee Handbook* informs 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 19 & 20, 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 8 of the *PREA Education Manual for Residents.*

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

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

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

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 24 & 25, section N-8 and facility policy 2014-6, 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 number to the Bay Area Women Against Rape. An MOU with this agency provides residents with a crisis hot line reporting, counseling, court advocacy, individual therapy and group therapy for victims of sexual abuse. Information about the confidential support services offered by the Bay Area Women Against Rape is provided to residents in the *PREA Education Manual for Residents* and on the *Resident Reporting Options* posters displayed throughout the facility. Residents are informed of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

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

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency's requirement on staff reporting duties can be found on page 20, section N-4 of GEO policy 5.1.2-A. The facility's requirement on staff reporting duties can be found on pages 5 & 6, section VII-B 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 Facility Director/PREA Compliance Manager any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment and any retaliation against residents or staff who reported such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, are reported to supervisors. The supervisor receiving the report immediately notifies the Facility Director. For an allegation of sexual abuse, the Facility Director will make notification to the PREA Coordinator, the Director, PREA & Quality 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 Oakland 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 California State Vulnerable Persons Statue.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident according to GEO policy 5.1.2-A, pages 20 & 21, section M-1 and facility policy 2014-6, section V1.

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

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section 5 and facility policy 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.

In interview with the Facility Director/PREA Compliance Manager and in review of documentation provided, in the past 12 months, one resident of Oakland Center alleged that sexual abuse occurred while he was confined to another facility. Documentation was provided to show that the Facility Director/PREA Compliance Manager notified the Warden of the other facility. The resident requested to talk to someone about the incident and the resident was offered a mental health referral, which he refused. The resident's request to talk to someone was for legal assistance, which was denied.

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

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 21, section L-2 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.

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 the physical evidence. In the past 12 months, there have been no PREA incidents reported.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 6, section A-4 and review of the Oakland Center's *PREA Coordinated Response Plan* were used to verify that there is a plan in place to coordinate actions to be taken in response to an incident of sexual abuse. The plan provides written guidance to staff and administration regarding actions to take and notifications to be made. A *PREA After-Action Checklist for Incidents of Sexual Abuse and Harassment* is completed to ensure that all steps of the plan and proper notifications are made. This checklist is filed with the completed investigative packet. The Facility Director/PREA Compliance Manager, the Assistant Facility Director, the Security Manager, the Social Service Coordinator, the Case Managers and the Security Monitors 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 Oakland 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 5.1.2-A, pages 25 & 26, section N-2 and in facility policy 2014-6, pages 10 & 11, section H. The agency has multiple protection measures, such as housing changes or transfers for residents, victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. If any other individual who cooperates with an investigation expresses a fear of retaliation, appropriate measures to protect that individual against retaliation are put in place.

The Facility Director/PREA Compliance Manager is responsible for weekly monitoring for retaliation for at least 90 days and longer if there is a continuing need. Retaliation 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 allegations reported; therefore, no retaliation monitoring was required. In review of investigative files of allegations received since the last PREA audit, this process is in place. When interviewed, the Facility Director/PREA Compliance Manager knew his responsibilities for monitoring for retaliation per policy.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment at the Oakland Center, including third party and anonymous reports. The Facility Director/PREA Compliance Manager is the trained facility investigator responsible for conducting administrative investigations. The agency's policy on administrative and criminal investigations is outlined in GEO policy 5.1.2-E, pages 4-8, section III-B-F.

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, PREA & Quality 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 Oakland 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. Since the last PREA audit there were three allegations received and administratively investigated. There were no allegations referred for criminal investigation in this audit period.

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 Director/PREA Compliance Manager asked what standard of evidence was used in determining if an allegation is substantiated, he 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 11 & 12, section J were used to verify compliance to this standard. The policies indicate that following an investigation of sexual abuse of a resident, the resident shall be informed as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded. The Facility Director/PREA Compliance Manager is responsible to present to the resident the *Notification of Outcome of Allegation* form which the resident signs. This form is retained in the investigative file of the corresponding PREA incident.

If the facility did not conduct the investigation, the facility shall request the relevant information from the investigative agency in order to inform the resident. The policy further states that following a resident's allegation that an employee has committed sexual abuse against the resident, the facility is required to inform the resident of the outcome of the investigation, unless the facility has determined that the allegation was unfounded. Following a resident's allegation that 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 Facility Director/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-1 and facility policy 2014-6, page 13, section M-1. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. All terminations for violations of the agency's policies on sexual abuse and sexual harassment, or resignations, shall be reported to law enforcement and licensing agencies unless the activity was clearly not criminal. In the *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, there has been no staff that violated agency/facility sexual abuse and sexual harassment policies.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on review of GEO policy 5.1.2.E, page 12, section 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 Oakland Center does not utilize the services of contractors. In interview with the Facility Director/PREA Compliance Manager, in the past 12 months there were no volunteers who violated the agency's sexual abuse policy.

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 2014-6, page 13, section M-2, the Federal Bureau of Prisons and the United States Probation Office are the supervising authorities over all residents at the Oakland Center. If a resident is found guilty of engaging in sexual abuse involving another resident, it will be reported to the BOP Residential Reentry Manager and/or the USPO supervisor who will determine whether to subject the resident to formal disciplinary sanctions. Residents are made aware of sexual misconduct they will be disciplined for and the sanctions that will be imposed in the *Resident 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 resident will be required to participate in counseling or other interventions designed to address the reasons or motivations for the abuse. Disciplining a resident for sexual contact with an employee is prohibited unless it is found that the employee did not consent to the contact. The agency prohibits all sexual activity between residents. Facilities may not deem that sexual activity between residents is sexual abuse unless it is determined that the activity was coerced.

In the past 12 months, two residents had disciplinary sanctions imposed related to sexual misconduct.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 24, section 7 and facility policy 2014-6, page 7, section 5-f and page 8, section 5-h. Resident victims are referred to the Highland Hospital or the Alta Bates Summit Medical Center for SANE exams and emergency medical treatment. Counseling services would be provided by referral to the Bay Area Women Against Rape.

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 Oakland Center who have been victimized by sexual abuse. According to GEO policy 5.1.2-A, pages 25, section N-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 Highland Hospital or to the Alta Bates Summit Medical Center for emergency and ongoing medical services. Referrals are made to Planned Parenthood for HIV testing, men's and women's health care, pregnancy testing and services and STD testing and treatment.

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. Counseling support, individual and group therapy for victims and abusers are provided by referral to the Bay Area Women Against Rape.

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

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, pages 26 & 27, section N-3 and facility policy 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/PREA Compliance Manager, the Assistant Facility Director, the Chief of Security and the Social Service Coordinator make up the facility's Incident Review Team. The team meets and the PREA Coordinator may attend via telephone or in person. The team considers whether the incident was motivated by race, ethnicity, gender identity, perceived status or gang affiliation. The team examines the area where the incident was alleged to have occurred and assesses whether physical barriers in the area may have contributed to the abuse, whether monitoring technology should be deployed or augmented and whether the staffing levels at the time of the incident were adequate.

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

In the past 12 months, there were no 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. Investigative files of allegations received in 2015 and 2016 revealed that this process is in place.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Information on data collection is found on page 27, section O-1 of GEO policy 5.1.2-A. GEO collects uniform data for every allegation of sexual abuse at all facilities under their control. The data collected, will be at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Bureau of Justice Statistics (BJS).

The Facility Director/PREA Compliance Manager ensures that the data is compiled and forwarded to the PREA Coordinator on a monthly basis on the *Monthly PREA Incident Tracking Log* (attachment D of policy 5.1.2-A). In addition to submitting the *Monthly PREA Incident Tracking Log,* PREA Compliance Managers are to ensure that a PREA Survey is created, updated and submitted for review and approval in the PREA Portal for every allegation of sexual abuse, sexual harassment and sexual activity. At least annually, the PREA Coordinator aggregates this data. Upon request, or no later than June 30th, the agency provides aggregated data information for the previous calendar year to DOJ.

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

Standard 115.288 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, pages 27 & 28, section O-2 & 3, 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 Senior Vice President of GEO Care for signature and approval. The report is then made public on the GEO website at https://www.geogroup.com/PREA. Before making aggregated sexual abuse data public, all personal identifiers are redacted.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

AUDITOR CERTIFICATION

I certify that:

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

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

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

Barbara Jo Denison — August 14, 2017

Auditor Signature — Date