PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: February 5, 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: February 1 -2, 2017			
Facility Information			
Facility name: Reality House			
Facility physical address: 5965 N. Expressway 77/83, Brownsville, TX 78520			
Facility mailing address: N/A			
Facility telephone number: 956-350-3070			
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: Maria Mancha, Facility Director			
Number of staff assigned to the facility in the last 12 months: 29			
Designed facility capacity: 94			
Current population of facility: 65			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 21-69			
Name of PREA Compliance Manager: Marko Trevino		**Title:** Assistant Facility Director/PREA Compliance Manager	
Email address: mtrevino@geogroup.com		**Telephone number:** 956-350-3070	
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 Reality House was conducted February 1-2, 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 Marko Trevino, Assistant Facility Director/PREA Compliance Manager.

On the first day of the audit, a brief entrance meeting was held with Maria Mancha, Facility Director, Marko Trevino, Assistant Facility Director/PREA Compliance Manager and Jonathon Dressler, Director, Fidelity & Quality Assurance in attendance. Those in attendance of the entrance meeting and Michael Saavedra, Monitor Supervisor, accompanied me on a facility tour following the conclusion of the meeting. During the tour, the location of cameras and mirrors, dorm layout including shower/toilet areas and placement of PREA posters and information was observed. Numerous PREA posters in both English and Spanish are prominently displayed in all common areas as well as on the walls in each resident room and in all administrative offices. The facility has done an excellent job of making PREA information continuously available to residents and staff. There is also posted information about the Valley Aids Council, a local agency that comes to the facility once a month to provide STD testing, information and referrals.

The facility has entered into a Memorandum of Understanding (MOU) with the Crisis Center, Odessa, TX 6/24/16. The Executive Director of the Crisis Center was contacted prior to the on-site visit to confirm and review the MOU. The Crisis Center provides a toll free 24-hour reporting hotline for residents. Because of the distance of the Crisis Center from Reality House, the only other services the Crisis Center can provide to residents is information and referrals over the phone and written information provided through the mail. During the tour, the number for the Crisis Center was dialed on an inmate pay phone (1-866-627-4747). The number was found to be accessible.

The facility has an agreement with Friendship of Women in Brownsville, TX to provide victim advocacy services to sexual abuse victims of Reality House. The Victim and Education Manager of Friendship of Women was contacted prior to the on-site visit. She shared that when a resident victim is taken to the hospital for a SANE exam an advocate would be sent to the hospital to accompany the resident for services. Residents can request these services by calling 956-544-7412 during business hours and calling 1-800-656-HOPE (4673) after business hours. The toll free number was called during the on-site visit from a resident pay phone. This number is answered by RAINN, the national hotline and the call was directed to Friendship of Women. The numbers for Friendship of Women were not posted on reporting information posters. It was recommended that this information be added to the posters to be readily accessible to residents. Before the close of the audit visit, this information was added and posters throughout the facility were reposted.

The records of 15 residents were reviewed to evaluate compliance to screening procedures and the requirements and documentation of PREA education for residents. All records showed initial screenings being done upon arrival to the facility and 30-day screenings being completed close to 30 days of arrival. Review of resident information on PREA education was found to be complete and documentation maintained by the facility.

The personnel files of 15 staff were reviewed to determine compliance with background check procedures. All files reviewed showed that criminal background checks for pre-employment and after five years of employment are being completed as required. At the time of annual evaluations, employees complete a *PREA Disclosure and Authorization Form – Annual Performance Evaluation.*

The Assistant Facility Director/PREA Compliance Manager maintains documentation of annual PREA training for staff and volunteers. Training documentation for this audit period was reviewed and found to be well organized and complete.

A total of 20 in-house residents and one home confinement resident were interviewed. The number of in-house residents included two from each dorm. Of the number of in-house residents interviewed, one was a female screened to be at risk for victimization. At the time of the audit, there were no residents who were blind, had low vision, deaf, hard of hearing or with cognitive deficits, assessed at initial screening at risk for abusiveness and none that were limited English proficient. There were no residents who self-disclosed at initial screening of being lesbian, gay, bisexual, transgender or intersex.

All of the residents interviewed acknowledged receiving PREA training with written information during the intake process and viewing the *PREA: What You Need to Know* video. They were familiar with the agency/facility's zero-tolerance policy against sexual abuse and sexual harassment and were able to articulate during interview the methods of reporting allegations of sexual abuse and sexual harassment available to them.

A total of 20 staff members and one volunteer were interviewed during the course of the audit. Of the 20 staff members interviewed, nine were security staff and 11 were specialized staff. Staff that serve in multiple roles were asked multiple questions as they related to the responsibilities of those roles. Staff interviewed were all knowledgeable of their responsibilities of detecting, preventing and responding to sexual abuse and sexual harassment allegations. They knew their responsibilities of reporting any knowledge or suspicions of sexual abuse and sexual harassment and reporting retaliation.

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

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

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with Maria Mancha, Facility Director, Marko Trevino, Assistant Director/PREA Compliance Manager, Laura Tamayo, Senior Program Monitor, Norma Alvarado, Account Clerk, Marlen Esquivel, Program Monitor, Josue Mascorro, Social Service Coordinator and Jonathon Dressler, Director, Fidelity & Quality Assurance in attendance and Terry Garcia, Regional Manager and Phebia Moreland, Director, Contract Compliance, PREA Coordinator in attendance via telephone.

During the exit meeting, the facility was informed of the process that would follow the on-site visit and the responsibility of the agency to post the final report on the agency website. The administrative team and the facility staff have made PREA a priority and were complimented on the outstanding efforts they have made to develop and enhance a very effective PREA program at Reality House. It was evident that protecting the residents they serve from sexual abuse has been a priority.

DESCRIPTION OF FACILITY CHARACTERISTICS

Reality House is located 5965 N. Expressway 77/83, Brownsville, Texas. The facility is a one-level light brown structure built in 2011. Reality House is a halfway house owned and operated by the GEO Group, Inc. The Federal Bureau (BOP) and the United States Probation Office (USPO) contracts with the GEO Group, Inc. to provide community confinement services to their offenders. The residents all have previously served time in secure institutions.

There is a gate in the front of the property as you enter the driveway that is left open during the day and locked at night. On the left side of the property is a recreation area for residents that includes a walking trail and a basketball court and male and female canopies with tables and chairs. Behind the building, there is a fenced in covered area with weight equipment. There are specific times available for males and females to use this equipment. A large sheet metal storage building is behind the building that is used for storage.

Entering the front of the building there is a Monitor Station enclosed in a glass partition. Outside of the glass partition, pat searches and breathalyzers are performed in view of cameras. Behind and to the right of the security office, is an electronic door that secures access to the administrative offices and a staff break room along an L-shaped hall. There are secure doors on both ends of the L-shaped hall. Staff have magnetic key cards to gain access to this area and residents are not allowed entry without a staff member.

Resident housing includes 12 dormitories, 10 for male residents and two for female residents, for a total capacity of 94 residents. Two dorms, Dorms 7 and 8 were not occupied during the on-site visit. On the first day of the audit, there were 65 residents residing at Reality House and 25 on home confinement. Nineteen males and two females are In Patient residents under the supervision of the USPO and eight are BOP Public Law residents. The remaining in house residents are in BOP custody, which included 38 males and 4 females. The age range of the population was from 21-69 and the custody level of all residents is minimum.

The dorm configuration allows staff to see the entire dorm from the doorway of each room. The In Patient hallway consists of Dorm 1 that houses USPO custody females and Dorm 2 houses BOP Public Law females. Females share a restroom that is between Dorms 1 & 2 and is accessible from each Dorm. The female restroom has three shower stalls with plastic shower curtains, three toilet stalls and two sinks. A female laundry with one washer and dryer is in the hallway close to the female dorms.

On the opposite end of the In Patient hallway Dorms 3 & 4 are located separated from Dorms 1 & 2 by a secure door. Dorms 3 & 4 are male dorms that house males in USPO custody and BOP Public Law males. Dorms 1-4 have solid doors, TV's, four bunk beds, chairs and lockers. Dorms 1, 2 and 3 have pay telephones inside of the rooms. Near the entry of each door, a sign reminds staff to make opposite gender announcements.

Two In Patient Counselors provide classes in chemical dependency, nutrition, parenting, NA, AA and Life Skills. Risk Assessments, 30-Day Reassessments and PREA education is provided to these residents by the In Patient Counselors.

In another dorm hallway there are eight male dorms all open with no doors. In each dorm, there are four bunk beds, two tables with tabletop games painted on top, chairs, lockers and a TV. The male residents have access to 10 single shower stalls with plastic curtains, four toilet stalls and four urinals divided by partitions. A male laundry room has five washers and five dryers. A solid door separates this laundry area from an indigent laundry room with one washer and one dryer. In this hallway, there are eight pay resident telephones.

A large kitchen/multipurpose room has a serving area, a pantry and tables and chairs. This room is used for family orientation, visitation and group meetings. A local catering company provides two hot meals and one cold meal four days a week and the other three days of the week; they provide two cold meals and one hot meal. Two locked restrooms on the far end of the kitchen/multipurpose room are used for UA's.

The facility has one classroom, a computer lab, a counseling room and administrative office and Case Manager

offices. All doors have window cutouts for staff monitoring of these areas.

The facility has 28 cameras, 6 exterior that all rotate and zoom and 22 interior cameras. The interior cameras are located in hallways and all common areas. The system stores the surveillance video for approximately 30 days. Real time views of camera footage are monitored in the Monitor Station, in the Facility Director, Assistant Facility Director/PREA Compliance Manager and the Social Services Coordinator's offices. Mirrors are strategically placed for additional visual coverage.

Reality House's mission statement is:
"Reality House is committed to making a difference by

- Providing a safe and secure facility.
- Providing quality residential, treatment and educations services to those entrusted to our care.
- Working in partnership with contracting agencies, community leaders and families to ensure the residents successful re-entry back to their community.
- Hiring staff with proper credentials, training, education and skills to meet the needs of the offender population in our care.
- Providing staff with continued development to ensure growth and improvement of our services.

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

SUMMARY OF AUDIT FINDINGS

The following is a summary of the audit findings:

Number of standards exceeded: 8

Number of standards met: 29

Number of standards not met: 0

Number of standards 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 Reality House policy 0803-1 are written policies mandating zero tolerance towards all forms of sexual abuse and sexual harassment and outlines the agency's/facility's approach to preventing, detecting and responding to such conduct. Both policies include definitions of prohibited behaviors and sanctions for those found to participate in these prohibited behaviors. Both policies, upon review, were found to be very comprehensive and to include a thorough description of the agency /facility's approach to reduce and prevent sexual abuse and sexual harassment of residents, exceeding in the requirement of this standard.

GEO policy 5.1.2-A, pages 6 & 7, section III, B, 1-3 and facility policy 0504-1, pages 2 & 3, section VI-A, outline the responsibilities of the PREA Coordinator and the PREA Compliance Manager. The agency not only employs an agency-wide PREA Coordinator, but also employs a Director, Fidelity & Quality Assurance who provides oversight to the agency's reentry facilities; therefore, exceeding in the requirements of this section of the standard.

In interview with the agency's PREA Coordinator on 1/22/17 and the Assistant Facility Director/PREA Compliance Manager during the on-site audit, both stated that they have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards as required.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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

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

Standard 115.213 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 0504-1, page 3, section B-1, the agency has developed and documented a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents against sexual abuse. The agency took into consideration the physical layout of the facility, the composition of the population and the prevalence of substantiated incidents of sexual abuse, and the resources the facility has available to commit to ensure adequate staffing levels in the development of the facility's staffing plan. The facility's design capacity is 94 residents and the staffing plan was developed based on that number. In the past 12 months, the average daily population was 92 residents.

The facility makes its best efforts to comply with the approved PREA Staffing Plan. In circumstances where the staffing plan is not complied with, the Facility Director would document and justify all deviations from the plan. The Facility Director and the Senior Program Monitor develop the staffing schedules and review them for compliance on a daily basis. Each month shift rosters are forwarded to BOP 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 facility exceeds in the monitoring of the staffing schedules by the review of them on a daily basis by the Facility Director and the Assistant Facility Director/PREA Compliance Manager, as well as annual assessments of the established staffing plan.

The staffing plan is reviewed annually by the Facility Director and the Assistant Facility Director/PREA Compliance Manager, and documented on the *PREA Annual Facility Assessment* form. This form is then forwarded to the Regional Director, the Director, Fidelity & Quality Assurance, the Divisional Vice President and the Corporate PREA Coordinator for signature and approval of any recommendations made to the established staffing plan to include the deployment of video monitoring systems and other monitoring technologies or the allocations of additional resources to maintain compliance to the plan. In the 2015 *PREA Annual Facility Assessment* and the 2016 *PREA Annual Facility Assessment,* 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. Shift Supervisors conduct rounds during their shift and these rounds are documented on the *Post Order* form. There are three counts per shift, which are documented on the *Housing Count Roster.* Program Monitors are required to make at a minimum, four random walk-throughs per shift. Management staff are required to complete, at a minimum, unannounced PREA rounds once a shift each month. These rounds are documented on the *Unannounced PREA Rounds Log*. Employees are prohibited from alerting residents or other employees that these supervisory rounds are occurring. For increased supervision and monitoring efforts, the agency has in place a count verification procedure to monitor surveillance tapes on a weekly basis to ensure staff are conducting formal resident counts. These verifications are documented on *Resident Count Verification Checklist.* These completed forms are forwarded to the Divisional Vice President of Reentry Services and to the Regional Director each week. The facility exceeds in its monitoring efforts.

Documentation provided for review, review of *Post Order* and *Unannounced PREA Rounds* forms while on site and in interview with staff and residents, the practice of rounds by facility management staff and supervisory staff confirmed numerous rounds being conducted on all three shifts.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Based on review of GEO policy 5.1.2-A, pages 15 & 16, section I, and facility policy 0903-1, page 3, sections on *Offender/Resident "Pat" Searches*, *Offender/Resident "Strip" Searches*, *"Body Cavity" Searches*, and *Limits to Cross-Gender Viewing and Searches*, the facility prohibits cross-gender strip searches and cross-gender visual body cavity searches except in exigent circumstances or when performed by medical practitioners. Facility policy requires that all cross-gender strip searches and body cavity searches be documented. Resident strip searches and body cavity searches are prohibited at Reality House. 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 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 an area adjacent to the Security Booth in view of cameras. Searches are documented with the reason for the search, the result of the search and the signatures of the staff member conducting the search on the *Search Activity/Breathalyzer* Log. Every shift is required to complete a minimum of 10 random searches per shift. Females are not restricted access to regular available programming or outside opportunities in order to comply with this provision. At all times, there is a female and a male staff member on duty.

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

The agency has policies and procedures in place that enable residents to shower, perform bodily functions and change clothing without staff viewing their breast, buttocks or genitalia. Policy requires staff of the opposite gender to announce their presence when they enter resident housing and restroom areas. Signs are on all resident rooms reminding staff to make opposite gender announcements. 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 female staff are in their housing unit.

Based on GEO policy 5.1.2-A and facility policy 0903-1, the facility prohibits examining transgender or intersex residents for the sole purpose of determining genital status. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. In the past 12 months, there were no transgender or intersex residents housed at the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency takes appropriate steps to ensure that residents with disabilities and residents that are limited English proficient have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. GEO policy 5.1.2-A, page 10, section E and facility policy 1702-1, page 2, section V, were used to verify compliance to this standard. Residents receive a *PREA Education Manual for Residents* during the intake process that is available in English, Spanish and in large print for residents with low vision. PREA posters and a *PREA What*

You Need to Know video is provided in both English and Spanish. All staff members are proficient in the Spanish language and provide interpretation to Spanish speaking residents. A contract with Language Line Services, Inc. provides for the translation of any other languages including sign language. Two TDD's are available for residents who are deaf or hard of hearing and video remote interpretation is available through the Language Line Services, Inc.

At the time of the audit, there were no residents that were deaf, hard of hearing, blind, had low vision, with cognitive deficits or low reading skills and none that were limited English proficient.

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

Standard 115.217 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GEO policy 5.1.2-A, pages 7 & 8, section C-2 and page 15, section H-4 and facility policy 0504-1, page 4, section 2, interview with the Office Support Specialist and review of all employee files were used to verify compliance to this standard.

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

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

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

Criminal Background checks for all employees are completed every five years at the time of the contract renewal. Reality House is currently in the bidding process for a contract renewal and all staff have been submitted for an NCIC background checks. Personnel files of random staff and volunteers were reviewed and found to contain pre-employment criminal background checks and five-year background checks on staff who were employed at the time of the last contract renewal in 2012. The facility is doing an excellent job of maintaining personnel files on all staff and volunteers. Files were complete and in an excellent and consistent format.

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 0504-1, page 4, section 3, and documentation provided for review was used to verify compliance to this standard. Per agency and facility policies, Reality House 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.

Due to recommendations made on the 2015 *PREA Annual Facility Assessment,* a security camera was installed in the kitchen pantry and there are plans to install a camera in the indigent laundry room and add an additional exterior camera.

In interview with the Facility Director, she explained what the agency would consider for planning for new construction or making modifications to existing facilities and in installing or updating video monitoring systems, electronic surveillance systems or other monitoring technology for the agencies facilities.

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)

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GEO policy 5.1.2-E, pages 6-9, sections D-I and facility policy 0803-1, pages 6 & 7, section 2, outlines the agency's requirements as it applies to this standard. The Social Services Coordinator and the Lead Case Manager are trained facility investigators responsible for administrative investigations of sexual abuse and sexual harassment at Reality House. The Brownsville Police Department are responsible for conducting criminal investigations and to ensure all forensic evidence is collected and preserved in accordance with evidence protocols established by the Department of Justice (DOJ). The investigating entities follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence and fulfill all requirements of this standard.

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

Victims of sexual abuse have access to forensic medical examinations with the victims consent and without cost to the resident regardless if the victim names the abuser or cooperates with an investigation arising out of incident. Forensic exams are not performed at this facility. Victims of sexual abuse are referred to the Valley Baptist Hospital in Harlingen, TX for SANE exams at no cost to the resident. In the past 12 months, there have been no residents who have required SANE exams.

The agency/facility entered into an MOU with the Crisis Center, Odessa, TX in June 2014. The Crisis Center provides a crisis

hotline 24 hours a day to provide crisis intervention to the residents of Reality House. An agreement with Friendship of Women, Inc., Brownsville, TX provides Reality House residents victim advocacy services, counseling and referrals.

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

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, page 4, section III-A-1 and facility policy 0803-1, page 7, sections 2 & 3 outline the agency's policy and procedures for investigating and documenting incidents of sexual abuse. The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment, including resident-on-resident sexual abuse or staff sexual misconduct.

Upon receipt of an allegation of sexual abuse, the supervisor receiving the report immediately notifies the Facility Director. The Facility Director will make immediate notification to the PREA Coordinator, to the Director, Fidelity & Quality Assurance, to GEO's Office of Professional Responsibility (OPR) (if the allegation involved staff), and to the BOP Residential Reentry Manager and the GEO Reentry Services Regional Director. The facility initiates an administrative investigation and if it is determined that the allegation involved potential criminal activity, a referral is made to the Brownsville Police Department who conducts a criminal investigation. It is the responsibility of the Brownsville Police Department to ensure that all forensic evidence is collected and preserved in accordance with evidence protocols established by the Department of Justice.

The agency documents all referral of allegations of sexual abuse or sexual harassment for criminal investigation. A *Serious Incident Report* is completed for all allegations of sexual abuse. All allegations are tracked on the *PREA Monthly Incident Outcome Tracking Log.*

The agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the GEO website http://www.geogroup.com/reporting_sexual_abuse-prea. In the past 12 months, there were no allegations of sexual abuse or sexual harassment reported.

Standard 115.231 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

In the past 12 months, all Reality House staff have received this training as verified by review of employee training files. The most recent refresher was completed on 1/27/17 with 24 staff in attendance. Three staff were not in attendance and will receive this training upon their return to work. In interview with staff, they were able to confirm receiving this training and knew their responsibilities for preventing and responding to allegations of sexual abuse and sexual harassment. The facility exceeds in this standard as was evident by review of the training curriculums, review of staff training records and the overall knowledge of staff in response to interview questions.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A states that all contractors and volunteers shall receive training on the agency's policy on zero tolerance for sexual abuse and sexual harassment. Guidelines on volunteer training can be found on page 13, section G-1 & 2, and contractor training on page 14, section 1 & 2. Reality house does not utilize the services of contractors. The facility currently has 10 active volunteers, which include interns from UT-RGV, a volunteer facilitating a Parenting Class and three religious volunteers. The training curriculum *Sexually Abusive Behavior Prevention and Intervention Program (PREA Orientation and Training*) was provided for review. Volunteers are trained on their responsibilities under GEO's sexual abuse and harassment prevention, detection and response policies and procedures including their responsibility and method of reporting any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment.

Volunteers sign a *PREA Basic Acknowledgement* form acknowledging that have received and understood the training provided to them. The facility has six volunteers at this time. In review of volunteer training records, all six volunteers have completed this training and the Assistant Facility Director/PREA Compliance Manager maintains documentation of this training. In interview with Center Director of the Centro Cultural who provides an Abstinence Program once a week for the residents, she confirmed receiving volunteer training and knew her responsibilities in reporting allegations of sexual abuse and sexual harassment.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 11, section E-2 and facility policy 1702-1, page 4, *Documentation* section, all residents receive information at time of intake and if transferred from another facility about the zero-tolerance policy and how to report incidents of sexual abuse or sexual harassment, their rights to be free from retaliation for reporting such incidents and are informed of the agency policy and procedures for responding to such incidents. The Assistant Facility Director/PREA Compliance Manager provides comprehensive resident PREA education within the first week of arrival to the facility.

In the past 12 months, 401 residents admitted to the facility and one resident transferred from another community confinement facility received PREA education. Upon intake residents view a *PREA: What You Need to Know* video, which is available in both English and Spanish, and receive a *PREA Education Manual for Residents* that is available in English and Spanish. Spanish speaking staff are available for Spanish translation and Language Line Services, Inc. is used for the translation of any other languages as well as remote video interpretation for deaf or hard of hearing residents.

Residents acknowledge by their signature on a *Prison Rape Elimination Act (PREA) Resident Manual Acknowledgement Manual* form that they have received a copy of the *PREA Education Manual for Residents*. They also sign another acknowledgement form acknowledging viewing the *PREA What You Need to Know* video, receiving training on the zero-tolerance policy, their right to report and their right to free medical and mental health care. The Assistant Facility Director/PREA Compliance Manager maintains this documentation. Ongoing information is provided on numerous posters, both in English and Spanish, prominently displayed in various other locations throughout the facility, including in all resident rooms. The Assistant Facility Director/PREA Compliance Manager has developed a *Checklist of Completed Orientations* form that documents not only when PREA education was received, but also documents other required orientation requirements.

When interviewed, residents were knowledgeable of the zero-tolerance policy and the methods of reporting available to them. It was evident that the facility has done an excellent job of informing residents and makes PREA information continuously accessible at all times. The facility has a movie night every Friday evening. The Assistant Facility Director/PREA Compliance Manager has begun showing the *PREA: What You Need to Know* video on Friday evening a month. The facility exceeds in the requirements of this standard.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 13, section F-3, in addition to general education provided to all employees, GEO ensures that facility investigators receive training on conducting sexual abuse investigations in confinement settings. In review of the training curriculum, the training includes techniques for interviewing sexual abuse victims, proper use of the Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or referral for prosecution.

At Reality House, the Facility Director, the Assistant Facility Director/PREA Compliance Manager, the Social Service Coordinator and one Case Manager are trained facility investigators. The agency's PREA Coordinator provided a four-hour specialized training for investigators in 2014. The facility maintains documentation that the investigators have received this training.

Upon interview, with all three investigators, they were knowledgeable of their responsibilities in conducting sexual abuse investigations.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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

Reality House 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 1702-1, pages 2 & 3, section VI-B, all offenders placed at are assessed for their risk of being sexually abused or sexually abusive towards others within 24 hours of arrival to the facility by their Case Manager. The *PREA Risk Assessment* form is used for this purpose. The form was reviewed and found to contain all requirements of 115.241 (b) of this standard and considers prior acts of sexual abuse and prior convictions for violent offenses. Residents may not be disciplined for refusing to answer any questions or for not disclosing complete information. In addition to the screening form, a thorough review of any available records that can assist in determining risk assessment is completed.

Within a set time, not to exceed 30 days of the resident's arrival to the facility, their Case Manager using the PREA Vulnerability Reassessment Questionnaire (HWH 38) for their risk for victimization and abusiveness reassesses residents. A resident's risk level will also be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information. PREA intake screenings are tracked on the *Checklist of Completed Orientations* form The *PREA Risk Assessments* and *PREA Vulnerability Reassessment Questionnaires* are filed in a binder maintained by the Assistant Facility Director/PREA Compliance Manager. To maintain confidentiality, only the Facility Director, the Assistant Facility Director/PREA Compliance Manager and Case Managers have access to screening information.

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

Standard 115.242 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency uses the information from the risk screening form to make housing, bed, work, education and program assignments with the goal of separating residents at high risk of being sexually victimized from residents with those at high risk of being sexually abusive. Individualized determinations are made about how to ensure the safety of each resident. GEO policy 5.1.2-A, page 10, section D-3 and facility policy 1701-1, page 3, section 2, explains the use of PREA screening information. On interview with the Assistant 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 *PREA Risk Assessment Referral* form. Residents have an option of refusing these services. Those identified to be at risk are tracked on an *At Risk Log*. Male residents screened to be at risk for victimization are housed in Dorms 4, 5, or 9 and those screened for risk of abusiveness are housed in Dorms 8 or 12. Females screened to be at risk for victimization are housed in Dorms 1 or 2 and those screened at risk for abusiveness are housed in Dorm 1 or 2.

GEO does not place lesbian, gay, bisexual, transgender or intersex residents in dedicated units or wings solely based on such identification. At the time of the on-site visit, there were no residents who self-disclosed being lesbian, gay, bisexual, transgender or intersex housed at the facility.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 17, section K-1 and facility policy 1702-1, page 4, last paragraph outline the agency/facility's responsibility for providing residents methods of reporting. The agency provides multiple ways for residents to privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse and sexual harassment and any staff neglect or violation of responsibilities that may have contributed to such incidents.

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 poster and continuously through other posters and brochures displayed throughout the facility. Residents are made aware that they can verbally inform any staff member, the Facility Director or the Assistant Facility Director/PREA Compliance Manager immediately or in writing. They are informed they can call the Crisis Center at 1-866-627-4747 to report sexual assault.

Residents can also file a grievance and facility policy 0805-1, pages 4 & 5 addresses sexual abuse grievances and emergency grievance procedures.

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

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

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

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In review of GEO policy 5.1.2-A, pages 17 & 18, section K-2, and facility policy 0805-1, pages 4 & 5, there is a procedure in place for residents to submit grievances regarding sexual abuse and the agency has procedures for dealing with these grievances. Instructions on how to file grievances are provided on pages 7 & 8 of the *PREA Education Manual for Residents.* Upon arrival to the facility, residents receive a copy of the

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 Assistant 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, page 23, section N-8 and facility policy 0803-1, page 10, section H-6, addresses the agency's policy on providing residents with access to outside victim advocates for emotional support services related to sexual abuse. Residents are given the telephone numbers to the Crisis Center (1-866-627-4747), Friendship of Women (956-544-7412), or HOPE (1-800-656-4673), where advocates are available 24 hours a day, seven days a week. Representatives from Friendship of Women once a month to provide educational classes to the residents. This information is provided to residents in the *PREA Education Manual for Residents* and on *Resident Reporting Options* posters displayed throughout the facility. Residents are informed of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

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

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency's requirement on staff reporting duties can be found pages 18 & 19, section 4 of GEO policy 5.1.2-A. The facility's

requirement on staff reporting duties can be found on pages 5 & 6 of facility policy 0803-1. Staff must take all allegations of sexual abuse and sexual harassment seriously. All staff are required to report immediately to the Facility Director or to the Assistant Facility Director/PREA Compliance Manager any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment and any retaliation against residents or staff who reported such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations of sexual abuse and sexual harassment, including third party and anonymous reports, are reported to supervisors. The supervisor receiving the report immediately notifies the Facility Director. For an allegation of sexual abuse, the Facility Director will make notification to the PREA Coordinator, the Director, Fidelity & 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.

Reality House houses adult male and female residents only, none of whom according to their classified level of care are considered vulnerable adults under the State Vulnerable Persons Statue.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

In interview with the Assistant 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 22, section 5 and facility policy 0803-1, page 9, 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 and the Assistant Facility Director/PREA Compliance Manager.

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

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

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 19-22, section L-2-4 and facility policy 0803-1, pages 6 & 7, section C, outlines the procedure for first responders to follow for allegations of sexual abuse and sexual harassment whether that person is a security or non-security staff member. Per policy, upon learning of an allegation of sexual abuse, the first security staff member to respond to the report is to separate the alleged victim and abuser, immediately notify the on-duty or on-call supervisor, preserve and protect the crime scene, not let the alleged victim or abuser take any actions that could destroy physical evidence and not reveal to anyone information related to the incident to anyone other than staff involved with investigating the alleged incident.

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

Random interviews with security and non-security staff revealed that they knew the policy and practice to follow if they were the first responder to an allegation of sexual abuse or sexual harassment. They reported that they knew that the alleged victim and abuser must be separated and knew how to preserve the crime scene and preserve the physical evidence. In the past 12 months, there have been no PREA incidents that required implementing first responder duties.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 5 & 6, section III-A-4 and review of Reality Houses' *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 and the Security Manager 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 0803-1, 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.

Reality House does not have a collective bargaining unit. In interview with the Executive Vice President Continuum of Care & Reentry Services on 1/19/17, he shared that there are no collective bargaining agreements for any of the agency's reentry facilities. GEO would not enter into any collective bargaining agreement at any of its facilities that would limit the facility's ability to remove an alleged sexual abuser from contact with residents pending the outcome of an investigation.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO has as policy to protect residents who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff as outlined in policy 5.1.2-A, page 24, section 2 and in facility policy 0802-1, page 10, section H-3 and page 11, section H-7-11. The agency has multiple protection measures, such as housing changes or transfers for residents, victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. If any other individual who cooperates with an investigation expresses a fear of retaliation, appropriate measures to protect that individual against retaliation are put in place.

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

In the past 12 months, there were no incidents of retaliation that occurred. When interviewed, the Assistant 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 Reality House, including third party and anonymous reports. The Assistant Facility Director/PREA Compliance Manager, the Lead Case Manager and the Social Service Coordinator are the trained facility investigators responsible for conducting administrative investigations. The agency's policy on administrative and criminal investigations is outlined in GEO policy 5.1.2-E, pages 4-6, section III-B & C.

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

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

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

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

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

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

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, pages 10 & 11, section III-K and facility policy 0803-1, 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 Assistant Facility Director/PREA Compliance Manager is responsible to present to the resident the *Notification of Outcome of Allegation* form which the resident signs. This form is retained in the investigative file of the corresponding PREA incident.

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

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 Assistant Facility Director/PREA Compliance Manager, the process of providing notification to resident victims at the conclusion of an investigation is in place and being followed.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

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

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Reality House does not utilize the services of contractors. In the past 12 months, no volunteers have violated the agency/facility's zero-tolerance policies.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to facility policy 0803-1, page 13, section N-2, the BOP and the USPO are the supervising authorities over all residents at Reality House. If a resident is found guilty of engaging in sexual abuse involving another resident, it will be reported to the BOP Residential Reentry Manager who will determine whether to subject the offender to formal disciplinary sanctions. Residents are made aware of sexual misconduct they will be disciplined for and the sanctions that will be imposed in the *Resident Handbook,* Chapter 202.

Based on GEO policy 5.1.2-E, page 12, section 2, the disciplinary process may consider whether an individual's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The

FBOP and/or the USPO will determine if the offender will be required to participate in counseling or other interventions designed to address the reasons or motivations for the abuse. Disciplining an offender for sexual contact with an employee is prohibited unless it is found that the employee did not consent to the contact. The agency prohibits all sexual activity between residents. Facilities may not deem that sexual activity between residents is sexual abuse unless it is determined that the activity was coerced.

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

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 23, section 7 and facility policy 0803-1, pages 6 & 7, section 5-f & h. Resident victims are referred to the Valley Baptist Medical Center, Harlingen, TX for SANE exams at no cost to the resident. Counseling services would be provided by referral to the Friendship of Women, Inc., Brownsville, TX.

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 reported; therefore, emergency medical or mental health services were not required for any residents.

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 Reality House who have been victimized by sexual abuse. According to GEO policy 5.1.2-A, pages 23 & 24, section M-1 and facility policy 0803-1, pages 7 & 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 Valley Baptist Hospital for emergency and ongoing medical services.

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

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

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 25, section 3 and facility policy 0803-1, page 12, section K, the facility is required to conduct a sexual abuse incident review within 30 days of every sexual abuse investigation in which the allegation has been determined to be substantiated or unsubstantiated.

The Facility Director, the Assistant Facility Director/PREA Compliance Manager 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 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 Facility Director, the Assistant Facility Director/PREA Compliance Manager and the Social Service Coordinator knew their responsibilities as they relate to the review of sexual abuse incidents.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

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

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

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

Standard 115.288 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 26, section N-3, the agency ensures that the data collected is securely retained for at

least 10 years or longer if required by state statue.

GEO makes all aggregated sexual abuse data, from facilities under its direct control readily available to the public annually on their website at http://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 February 5, 2017

Auditor Signature Date