PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: July 25, 2015

Auditor Information			
Auditor name: Barbara Jo Denison			
Address: 3113 Clubhouse Drive, Edinburg, TX 78542			
Email: denisobj@sbcglobal.net			
Telephone number: 956-566-2578			
Date of facility visit: July 20-21, 2015			
Facility Information			
Facility name: Salt Lake City Center			
Facility physical address: 1585 West 2100 South, Salt Lake City, UT 84119			
Facility mailing address: *(if different from above)*			
Facility telephone number: 801-973-3800			
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: Leslie Flowers, Facility Director			
Number of staff assigned to the facility in the last 12 months: 25			
Designed facility capacity: 115			
Current population of facility: 91 in house and 11 home detention			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 21-75			
Name of PREA Compliance Manager: Kris Jordan		**Title:** Social Services Coordinator/PREA Compliance Manager	
Email address: kjordan@geogroup.com		**Telephone number:** 801-973-3800, ext. 2	
Agency Information			
Name of agency: The GEO Group, Inc.			
Governing authority or parent agency: *(if applicable)*			
Physical address: One Park Place, Sute 700, 621 Northwest 53rd St., Boca Raton, Florida 33487			
Mailing address: *(if different from above)*			
Telephone number: 561-999-5827			
Agency Chief Executive Officer			
Name: George C. Zoley		**Title:** Chairman of the Board, CEO and Founder	
Email address: gzoley@geogroup.com		**Telephone number:** 561-893-0101	
Agency-Wide PREA Coordinator			
Name: Phebia L. Moreland		**Title:** Director, Contract Compliance, PREA Coordinator	
Email address: pmoreland@geogroup.com		**Telephone number:** 561-999-5827	

AUDIT FINDINGS

NARRATIVE

The initial PREA audit of the Salt Lake City Center was conducted on July 20-21, 2015 by this Certified PREA Auditor, Barbara Jo Denison. Prior to the audit, the facility provided the auditor with agency and facility policies and supporting documentation related to each standard for review. Also provided was a list of staff sorted by title and shift, a list of residents sorted by housing unit, a list of residents identified through the PREA screening process to be at risk for victimization and abusiveness, and a list of residents who self disclosed being gay. From the lists provided, residents and staff to be interviewed were selected. On the first day of the audit, an entrance meeting was held with Leslie Flowers, Facility Director, Kris Jordan, Social Services Coordinator/PREA Compliance Manager, Rex Macey, Chief of Security and Jonathon Dressler, Program Fidelity Manager, Reentry Services PREA Divisional Coordinator present, followed by a tour of the facility. All housing units and all areas that residents are allowed access to were toured. While touring, 10 residents were informally interviewed and asked about their knowledge of PREA. Throughout the facility PREA posters in both English and Spanish were prominently displayed in nurmerous locations. The facility was found to be a safe environment for the residents with no areas noted where physical barriers or blind spots would compromise the safety of residents. In the past 12 months, there were no allegations of sexual abuse or sexual harassment reported.

The population of the Salt Lake City Center on the first day of the audit was 91 residents in house and 11 on home detention. Three residents from each housing unit were selected to interview for a total of 15 formal resident interviews. Included in that number were four residents who self disclosed being gay through intial screening and three residents who were identified at risk for victimization and one identified at risk for abusiveness. At the time of the audit, there were no residents with visual, hearing or cognitive impairments and no transgender or intersex residents. All residents interviewed were knowledgeable of the agency's zero-tolerance policy and the methods of reporting available to them.

A total of 13 staff members and one volunteer (by telephone) were interviewed. Of the number of staff interviewed, seven were specialized staff and six were security staff. The Facility Director's interview included questions not only for the Director, but also the investigator and incident review team questions, as she fills those roles as well. The Social Services Coordinator/PREA Compliance Manager also fills multiple roles and she was questioned as the investigator, incident review team member and the retaliation monitor, as well as the PREA Compliance Manager. Security staff interviewed included two Security Monitors from each shift. They were well versed in their responsibilities in reporting sexual abuse and suspected sexual abuse and sexual harassment. When questioned about evidence preservation, staff responses reflected agency policies and standard requirements. The PREA Coordinator and the Agency Head were not in attendance at the audit, but were interviewed on an earlier date.

At the conclusion of the on-site visit, an exit meeting was held. The auditor explained the process that follows the on-site audit. There were no standards found to require corrective action. The final report will be made available to the public on the GEO website. The auditor acknowledged the hard work and the accomplishments of the team for compliance of the PREA standards.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Salt Lake City Center (SLCC) is a residential, community release program that contracts with the Federal Bureau of Prisons and the United States Probation Office to assist offenders as they reenter the community. SLCC has served residents for the Federal Bureau of Prisons since 1995. Is is the only GEO Group, Inc. residential reentry center in Utah for federal residents. The main building was acquired in 1995 and was originally a satellite nursing school. The entire program was housed in this building until the annex, which was formerly a printing company, was acquired in 2009. This building allowed for additional beds as well as administrative and program space.

SLCC's program focuses on developing a broad base of community providers to connect residents with prior to leaving the Center. The objective is to help each resident develop skills necessary for returning to a less restrictive environment and connecting them with providers to support their return to the community. It provides transitional housing and services for residents referred by the United States Probation Office for supervision and prison wardens for institutional referrals. Residents, for the purpose of determining placement within a level system, are classified into one of three program components – community corrections, pre-release or home confinement.

The physical plant consists of two buildings located in a commercial area of Salt Lake City minutes from the downtown section. The main/reception building is a two story building located at 1585 West 2100 South. The first floor houses the security/reception area, a kitchen and dining area, dayroom, a women's dorm, three men's dormitories, a laundry area and bathroom and shower facilities. The second floor includes a dayroom/library, workout room, two large classrooms and separate storage areas for chemicals, bedding and archived records. An annex building located across the yard behind the main building houses a fourth men's dormitory with restrooms, laundry and dayroom, administrative offices, counselors' offices, staff lounge, lobby, conference room and storage.

The facility is staffed twenty-four hours a day, seven days a week by security staff referred to as Security Monitors. The security office is in the front of the facility and is staffed around the clock. These staff members directly observe movement in and out of the facility. There is a contract with the county jail for food services. The facility does not have any medical or mental health staff. These services are available to all residents through contracts with local providers.

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

The Salt Lake City Center's Mission Statement is: "The mission of the Salt Lake City Center is to provide transitional services in a supervised environment in order to enhance public safety and assist offenders in becoming employed, law abiding citizens and to (re) establish family and/or community ties in their respective communities".

SUMMARY OF AUDIT FINDINGS

The following is the summary of the audit findings:

Number of standards exceeded: 5

Number of standards met: 36

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

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

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.213 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 2014-1, pages 3 & 4, section B-1, the agency has developed, documented and made its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents against sexual abuse. A "PREA Annual Facility Assessment" is completed by the Social Services Coordinator/PREA Compliance Manager and the Facility Director which is forwarded to the agency's PREA Coordinator and the Corporate Divisional Vice President for review and approval. The last annual assessment was completed on 10/22/14. That assessment noted that there were no deviations from the staffing plan during the past year and there were no recommendations for any changes to the established staffing plan. The assessment did note some recommendations for the installation of four additional cameras for increased visibility and security. In the past 12 months, there have been no deviations to the established staffing plan as confirmed by interview with the Facility Director.

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

Standard 115.215 Limits to cross-gender viewing and searches

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

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

GEO policy 5.1.2-A, pages 15 & 16, section I, 1-10 and facility policy 2014-4, pages 2 & 3, section VI, address resident pat searches, strip searches, body cavity searches and the limits to cross-gender viewing and searches. All staff receive training in pre-service and in annual in-service training on how to conduct searches including searches of transgender and intersex residents. This information is also reviewed at monthly staff meetings. The facility staff do not conduct cross gender pat down searches, strip searches or visual body cavity searches. A staff member of the same gender conduct pat searches and these searches are documented on a pat search log.

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

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

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

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

The agency takes appropriate steps to ensure that residents with disabilities and residents that are limited English proficient have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and harassment. GEO policy 5.1.2-A, page 10, section E and facility policy 2014-2, pages 1 & 2, section V, were used to verify compliance to this standard. The "PREA Education Manual for Residents" is available in both English and Spanish and is also available in large print in both languages for residents with visual impairments. PREA posters, a GEO PREA brochure, a PREA video and all PREA educational materials are provided in both English and Spanish. A Language Line Service is available for the translation of any other languages. A TTY is available for hearing impaired residents. The agency does not use residents as interpreters, readers or other types of resident assistants. At the time of the audit, there were no limited English proficient residents and none that had visual, hearing or cognitive impairments.

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)

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 policy 5.1.2-A, pages 7 & 8, section C-2, and page 15, section H-4, the facility is prohibited from hiring or promoting anyone who may have contact with residents who has engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in a confinement setting or the community. Criminal background checks are conducted for all potential employees through a contract with Accurate Background, Inc, as well as BOP clearance for all staff both through NCIC and the Civilian Application System. Applicants that answer on their application that they have worked in a confinement setting previously receive a PREA Verification through Accurate Background, Inc. The Salt Lake City Center does not have contractors. Volunteers do not require criminal background checks per BOP directive as volunteers are under constant supervision by facility staff. For consideration for transfers and promotions, employees complete a "PREA Disclosure and Authorization Form Promotions – PREA Related Positions" and another background check by Accurate Background Inc. is completed. At the time of annual performance evaluations, all employees complete a "PREA Disclosure and Authorization Form Annual Performance Evaluation" form. Any omissions regarding misconduct or providing any false information are grounds for termination All employees get a five-year background check by BOP during the contract revewal process. All employees hired prior to 2011 received a background check in 2011. Drivers license checks are completed annually.

In interview with the Office Support Specialist, who is responsible for HR duties, criminal background checks are completed on all applicants. If an applicant answers that he/she has worked in a confinement facility previously, the prior institution is contacted to obtain information on substantiated allegations of sexual abuse and sexual harassment. Review of 14 staff records, which included one new hire this year and two staff promoted, showed excellent adherence to the agency policy and compliance to this standard.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 8, section C, 3 and facility policy 2014-1, page 4, section B, 3, state that the facility takes into consideration the effect that any new design, acquisition, expansion or modifications of the physical plant or monitoring technology might have on the facility's ability to protect residents from sexual abuse. The facility has not made any substantial expansions or modifications to the existing facililty and has not acquired any new facilities in the past 12 months. Four new cameras were installed after a recommendation for additional cameras was made on the most recent "PREA Annual Facility Assessment" conducted on 10/22/14. Additionally, three more cameras were installed bringing the total number of cameras to 35.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-E, pages 6–10, section D-J, and facility policy 2014-6, page 7, section C-3 and section 5–f & h, the facility follows a uniform evidence protocol for the collection and preservation of evidence for administrative and criminal investigations of sexual abuse. It is the responsibility of the Salt Lake City Police Department to conduct all criminal investigations and to ensure that all evidence is collected and preserved according to evidence protocols established by the Department of Justice. Forensic examinations are not performed at this facility. Victims of sexual abuse are referred to the University of Utah Medical Center located in Salt Lake City, UT for SANE examinations at no cost to the victim. The facility has attempted to secure MOU's with the Summit County Victim Assistance Program in Park City, UT, the Safe Harbor Program in Salt Lake City, UT and the Center for Women and Children in Crisis Program in Salt Lake City , UT to provide victims with a victim advocate from a rape crisis center, but those attempts have not been successful. The facility continues to reach out to other community agencies who may be willing to provide residents with advocacy services.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, page 4, section III, A and facility policy 2014-6, page 7, section C, 2 & 3, outline the agency's policy and procedure for investigating and documenting incidents of sexual abuse. The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment including inmate-on-inmate sexual abuse or staff sexual misconduct. All allegations of staff sexual abuse are referred to the agency's Office of Professional Responsibility (OPR) and inmate-on-inmate allegations are referred to BOP. The PREA Coordinator and the Program Fidelity Manager, Reentry Services Divisional Coordinator and BOP are informed of all allegations of sexual abuse and sexual harassment. The Salt Lake City Police Department is responsible for conducting criminal investigations. The agency's policy regarding referral of allegations for sexual abuse and sexual harassment for criminal investigations is available on the GEO website. In the past 12 months, there were no allegations of sexual abuse or sexual harassment.

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 the agency's zero tolerance policy for sexual abuse and sexual harassment at pre-service and annually at in-service training. Employees sign an "PREA Basic Training Acknowledgement" form acknowledging that they have received and understood the training they received. GEO policy 5.1.2-A, pages 11 & 12, section F, 1, addresses the agency's training requirements. The PREA training program was reviewed and found to be very comprehensive and meets all the elements of this standard. Random review of ten staff training records confirmed that staff acknowledge receipt and understanding of this training and this documentation is maintained in training binders. Additionally, PREA discussions are held and ongoing training occurs during monthly staff meetings as well. In review of 14 employee training files, annual PREA training is being completed and documentation is being maintained as required. The Social Services Coordinator/PREA Compliance Manager does an excellent job of maintaining all training records in an orderly and easily accessible manner. In interview with staff, they were able to confirm receiving this training and knew their responsibilities for preventing, detecting and responding to allegations of sexual abuse.

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, page 13, section G and page 14, section H, outline the training requirements for volunteers and contractors. The objective of the training ensures that volunteers and contractors are notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and are informed of how to report such incidents. The PowerPoint training material used for volunteer training was reviewed by this auditor. The facility does not have contractors. There are 11 volunteers who received PREA training on 4/23/15 and signed a "PREA Basic Training Acknowledgement" form stating they received and understood the training. This acknowledgement form is maintained by the Social Services Coordinator/PREA Compliance Manager. When interviewed by telephone, a volunteer confirmed he received this training and understood his responsibilities under the agency's sexual abuse and sexual harassment policy.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 11, section E-2 and facility policy 2014-2, page 4, were used to verify compliance to this standard. Incoming residents during the intake process are provided with educational information explaining the zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents of sexual abuse and sexual harassment. They receive a "PREA Education Manual for Residents", a GEO PREA brochure and view a PREA video when they meet with their Case Manager within 24 hours of arrival to the facility. Residents sign an acknowledgement of receiving the manual and other required training. All information is provided in both English and Spanish. Random review of residents' files showed this documentation is maintained by the Social Services Coordinator/PREA Compliance Manager. Monthly Town Hall meetings for residents are held where PREA topics are discussed. When interviewed, residents acknowledged receiving the PREA training information and were knowledgeable of the agency's zero-tolerance policy and how to report incidents of sexual abuse and sexual harassment. The Social Services Coordinator/PREA Compliance Manager does an excellent job of maintaining documentation of PREA training to residents and ensures all training is timely.

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, the facility's investigators receive specialized training in addition to the general education provided to all staff. The agency's PREA Coordinator provides a four-hour specialized investigator training. In review of the training curriculm, it was found to be very comprehensive and included all requirements of 115.234 (b) of that standard. There are 30 Reentry Services Specialized Investigators throughout the division. At the Salt Lake City Center there are two trained investigators, they are the Facility Director and the Social Services Coordinator/PREA Compliance Manager who received a four-hour webinar training by the GEO PREA Coordinator on 10/21/14 with documentation of this training maintained by the facility. Upon interview of the Social Services Coordinator/PREA Compliance Manager and the Facility Director they confirmed receiving this training and 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)

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

Standard 115.241 Screening for risk of victimization and abusiveness

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, pages 8 & 9, section D-1 and pages 2 & 3, section VI, B-1, the agency requires that residents be screened upon admission for risk of sexual abuse victimation or sexual abusiveness toward other residents. A "PREA Risk Assessment" form is used to screen residents upon admission was found to contain all requirements of 115.241 (b) of this standard. Residents may not be disciplined for refusing to answer any questions or for not disclosing complete information. In addition to the screening form, a thorough review of any available records which can assist in determining risk assessment is required. Within 30 days of arrival, a "PREA Vulnerablity Reassessment Questionnaire" is completed to reassess the risk of victimization or abusiveness of all residents and reassessments are warranted due to a referral, request, incident of sexual abuse or receipt of additional information. The initial screenings are completed within 24 hours of arrival to the facility by the resident's assigned Case Manager. The Social Services Coordinator/PREA Compliance Manager tracks 30-Day Reassessment dates and forwards this information to the appropriate Case Manager. Reassessments are also done after six months if the resident is still at the facility at that time and every six months thereafter. Review of ten random resident files confirmed that screening upon intake and reassessments within 30 days are being completed as per policy. The Social Services Coordinator/PREA Compliance Manager maintains all assessments in binders that are stored in her office to ensure confidentiality of this information.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency uses the information from the risk screening form to make housing, bed, work and program assignments wih the goal of separating residents at high risk of being sexually victimized from residents at high risk of being sexually abusive. On interview with the Facility Director and the Social Services Coordinator/PREA Compliance Manager, they explained how the facility utilizes the information from the "PREA Risk Assessment". Residents who are identified from screening to need referrals for mental health evaluations or substance abuse treatment meet with the Social Services Coordinator/PREA Compliance Manager who determines if a referral is warranted and sends the referral to BOP for approval. If referral is approved by BOP, residents are referred to DeNovo for mental health evaluations and substance abuse treatment and to Pioneer for mandatory sex offender treatment. Residents screened at risk for victimization or abusiveness are house in Dorms A, B, or C in the bunks closests to the entry door for better visibility and supervision.

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

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 17, section K-1 and facility policy 2014-2, page 4, last paragraph and page 5, section VI, outline the procedure for resident reporting methods. The agency provides multiple ways for residents to privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse and sexual harassment. Residents are made aware that they can inform a staff member immediately, contact the facility PREA Compliance Manager, put their allegation in writing, or call the RAINN National Hotline Network at 1-800-656-4673, or the Rape Recovery Center at 1-801-467-4273. They can also call the BOP Residential Reentry Management Branch at 1-801-524-4212. Calling any of those toll-free numbers allows the residents to remain anonymous upon request. These crisis hotline numbers are posted throughout the facility at various locations. The "PREA Educational Manual for Residents", that each resident receives upon arrival, provides the residents with methods of reporting available to them. Staff have access to private reporting by calling the Employee Hotline at 866-568-5425 or the Corporate PREA Director at 561-999-5827. Information for resident as well as staff reporting is available on the GEO website and posted throughout the facility at numerous locations. Staff are all provided with a First Responder Card which they carry with them at all times. The agency's policy mandates that staff accept all reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Resident and staff interviewed were well versed in the methods of reporting available to them.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As stated in GEO policy 5.1.2-A, page 23, section N-8 and facility policy 2014-6, page 11, section H-6, residents are provided with access to outside victim advocates for emotional support. Multiple attempts have been made and are ongoing by the agency and the facility to secure MOU's with agencies willing to provide advocacy services to the facility's residents. At this time the Rape Recovery Center provides residents with confidential advocacy support services. Instructions on how to access these agencies are provided to residents in the "PREA Education Manual for Residents" and on numerous posters displayed throughout the facility. When interviewed, residents were knowledgeable about the outside advocacy services available to them.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to GEO policy 5.1.2-A, page 22, section L-5 and facility policy 2014-6, pages 9 & 10, section F, there are procedures in place if an allegation is received that a resident was sexually abused while confined at another facility. The facility is to document the allegation and the Facility Director is required to notify the Director of the facility where the abuse is alleged to have occurred as soon as possible, but no later than 72 hours. This information is required to be shared with the PREA Compliance Manager and the PREA Coordinator who ensure that the allegation is investigated in accordance with the PREA standards. The Facility Director reported during interview that in the past 12 months there have not been any allegations received that a resident was sexually abused while confined at another facility and have not received any notifications from other confinement facilities of abuse occurring while a resident was confined at the Salt Lake City Center.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In accordance with GEO policy 5.1.2-A, page 22, section L-5 and facility policy 2014-6, pages 9 & 10, section F, upon learning that a resident was sexually abused, the first security staff member to respond to the report is required to separate the alleged victim and abuser, preserve the crime scene and preserve the evidence. If the first staff responder is not a security staff member, the responder is required to request the alleged victim not take any actions that could destroy the evidence and notify security staff. All staff carry with them First Responder Cards reminding them of their duties in response to an allegation of sexual abuse. Security and non-security staff interviewed were knowledgeabnle of the policy and the practice to follow. They reported that they knew that the alleged victim and abuser must be separated and how to preserve the crime scene and the evidence. The Salt Lake City Center has not received any allegations of sexual abuse during the past 12 months.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 5, section A-3 and facility policy 2014-6, page 6, section C-1-a, were used to verify compliance to this standard. In all cases of abuse by staff, contractors or volunteers the abuser will be subject to disciplinary sanctions for violating GEO policies on sexual abuse and sexual harassment. The Salt Lake City Center does not have a collective bargaining unit. GEO would not enter into any collective bargaining agreement at any of its facilities that would limit a facility's ability to remove an alleged sexual abuser from contact with residents pending the outcome of an investigation. There have been no incidents in the past 12 months that required staff to be separated from residents.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section M-2 and facility policy 2014-6, page 11, section 9, state that residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations will be protected from retaliation from other residents and staff. Housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents who fear retaliation will be protection measures used as per policy. The Social Services Coordinator/PREA Compliance Manager is responsible for weekly monitoring for retaliation. When interviewed, the Social Services Coordinator/PREA Compliance Manager knew the responsibilities of this process per policy. These meetings will be recorded on the "Protection from Retaliation Log". Monitoring will continue for at least 90 days and longer if needed. In the past 12 months, there have been no allegations of sexual abuse or sexual harassment reported, therefore no monitoring for retaliation was required.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

According to GEO policy 5.1.2-E, page 6, section B, 2-d, the facility shall impose no standard higher than the preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated. When the Facility Director and the Social Services Coordinator/PREA Compliance Manager responsible for investigations was interviewed and asked what standard of evidence was used in determing 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.

As stated in GEO policy 5.1.2-E, pages 10 & 11, section III, K and facility policy 2014-6, pages 11 & 12, section J, indicate that proper notification be given to residents as to the outcome of an investigation of sexual abuse and sexual harassment if the outcome of the investigation proved to be substantiated, unsubstantiated or unfounded. Attachment D of policy 5.1.2-E, available in English and Spanish would be presented to the alleged victim at the conclusion of the investigation. This form is signed by the resident and retained in the investigative file. In the past 12 months, there were no allegations of sexual abuse. Based on interview with the Facility Director and the Social Services Coordinator/PREA Compliance Manager, this process is in place and notifications would be made as required by policy.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 12, section 3 states that any contractor or volunteer who engages in sexual abuse or sexual harassment shall be prohibited from contact with residents and shall be reported to law enforcement agencies. In interview with the Facility Director, there have been no incidences of sexual abuse by volunteers. The facility does not have contractors. If violations were to occur by volunteers, appropriate remedial actions would be taken.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As per GEO policy 5.1.2-E, page 12, section 2 and facility policy 2014-6, page 13, section M-2, residents found guilty of engaging in sexual abuse involving other residents shall be subject to formal disciplinary sanctions. Disciplining residents for engaging in sexual activity with an employee is prohibited unless the employee did not consent to the contact. The agency prohibits all sexual activity between residents and may disciplince residents for such behaviors. The Resident Handbook provided to all residents upon admission pages 12, sections 205 & 206 and page 20 section 409, clearly state offenses of sexual misconduct that residents will be disciplined for. In the past 12 months there have been no violations by residents that required formal disciplinary santions imposed.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 23, section 7, and facility policy 2014-6, page 7, section 5-f and page 8, section 5-h. Salt Lake City Center does not have medical or mental health staff on site; therefore referrals are made to off site providers for all medical and mental health services. The University of Utah Health Care provides medical services, including SANE services as well as mental health services. Planned Parenhood located at the West Valley Health Care in West Valley, UT provides birth control, emergency contraception, pregnancy testing and STD testing and treatment. These services are provided to every victim without financial cost to them. In the past 12 months, there have been allegations of sexual abuse, therefore there were no off site referrals for emergency medical or mental health services.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Per GEO policy 5.1.2-A, pages 25, section 3 and facility policy 2014-6, page 12, section K, facilities are required to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation in which the allegation has been determined to be substantiated or unsubstantiated. The Facility Director and the Social Services Coordinator/PREA Compliance Manager make up the Incident Review Team at the Salt Lake City Center. A "PREA After Action Review Report" is completed for each review and forwarded to the PREA Coordinator. The facility will implement recommendations for improvement or document reasons why these improvements were not done. The Social Services Coordinator/PREA Compliance Manager will maintain copies of all completed review forms in the corresponding investigative

file. There were no allegations of sexual abuse or sexual harassment in the past 12 months.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

AUDITOR CERTIFICATION

I certify that:

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

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

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

Barbara Jo Denison _____ July 25, 2015

Auditor Signature Date