PREA AUDIT REPORT ☐ Interim ☒ Final
COMMUNITY CONFINEMENT FACILITIES

Date of report: November 29, 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: August 1–3, 2017			
Facility Information			
Facility name: Taylor Street Center			
Facility physical address: 111 Taylor Street, San Francisco, CA 94102			
Facility mailing address: N/A			
Facility telephone number: 415-346-9769			
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 Richard, Facility Director			
Number of staff assigned to the facility in the last 12 months: 40			
Designed facility capacity: 240			
Current population of facility: 211			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 22-80			
Name of PREA Compliance Manager: Maria Richard	**Title:** Facility Director/PREA Compliance Manager		
Email address: mnrichard@geogroup.com	**Telephone number:** 415-346-9769, ext. 77421		
Agency Information			
Name of agency: The Geo Group Inc.			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: One Park Place, Suite 700, 621 Northwest 53rd Street, Boca Raton, FL 33487			
Mailing address: *(if different from above)* N/A			
Telephone number: 561-999-5827			
Agency Chief Executive Officer			
Name: George C. Zoley	**Title:** Chairman of the Board, CEO and Founder		
Email address: gzoley@geogroup.com	**Telephone number:** 561-893-0101		
Agency-Wide PREA Coordinator			
Name: Phebia L. Moreland	**Title:** Director, Contract Compliance, PREA Coordinator		
Email address: pmoreland@geogroup.com	**Telephone number:** 561-999-5827		

AUDIT FINDINGS

NARRATIVE

The PREA on-site audit of the Taylor Street Center was conducted August 1-3, 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 Maria Richard, Facility Director, who is designated as the facility's PREA Compliance Manager.

The facility has attempted to enter into Memorandum of Understandings (MOU's) with community agencies to provide confidential support services to resident victims of sexual abuse in addition to other community resources to the residents of the Taylor Street Center.

The Community Health Worker for the Transitions Clinic was contacted prior to the on-site visit. He shared that he forwarded the draft of the MOU he received from the Facility Director to the Executive Director of the Transitions Clinic Network for review. Transitions Clinic assists men and women who are coming out of federal and state prisons navigate the available resources to make them successful upon their release. Those services include housing, programs, medical needs (primary and specialty appointments and medications), social needs and SSI benefits.

Transition Clinic services are accessed through referrals from parole officers and probation officers. The Community Health Worker shared that he has a good working relationship with the CDCR Program Manager, the CDCR Assistant Program Manager and the Facility Director at the Taylor Street Center who contact him when they feel that residents could benefit from the services that the Transitions Clinic has to offer. The Community Health Worker came to the Taylor Street Center on the first day of the audit to meet me and further discuss the wide-range of services that are available to the residents of the Taylor Street Center.

The facility has attempted to secure an MOU with the San Francisco General Hospital. The Clinical Social Worker from the Trauma and Recovery Center of the hospital was contacted prior to the on-site audit. On-call victim advocates provide support through forensic exams for victims of sexual abuse including the residents of the Taylor Street Center.

Prior to the on-site audit the Program Coordinator for the Women's Place, a subsidiary of the Community Awareness and Treatment Center, was contacted. The Women's Place provides five different housing programs in the city of San Francisco. One is a 90-day homeless shelter program, a one-week domestic violence program, a four-month inpatient substance abuse program and two 18-month housing programs. One of the 18-month programs is for women with HIV and Aids and the other is a traditional housing program for people in the city shelter system.

Residents are given the number of the Rape Crisis Center of San Francisco (415-647-7273). The facility made attempts in 2014 and 2015 to secure an MOU with the Rape Crisis Center to provide confidential emotional support services to resident victims of sexual assault. The Rape Crisis Center was contacted during the on-site visit. Services for victims of sexual abuse are encouraged to go to the San Francisco General Hospital when reporting an incident of sexual abuse. The Rape Crisis Center provides peer counseling, legal advocacy, STD and pregnancy testing to victims. There is not a toll-free number to contact the Rape Crisis Center, but they do accept collect calls. All services are free to victims and are confidential.

The Physician Assistant of the Rape Crisis Center was contacted and discussed the forensic services and other medical services that victims of sexual assault are offered, including victim advocacy services through the clinical team of the Trauma and Recovery Center of the San Francisco General Hospital. We discussed the possibility of the Center entering into an MOU with the Taylor Street Center. She was given the Facility Director's name and e-mail address.

During the facility tour, the number for the RAINN National Hotline (800-656-4673) was dialed on a resident pay phone and found to be routed to the Rape Crisis Center of San Francisco.

On the first day of the audit, an entrance meeting was held with Maria Richard, Facility Director/PREA Compliance Manager; Jennine McFarlane, Assistant Facility Director; Jason Carpenter, CDCR Program Manager; Jonathon Dressler, Director, PREA & Quality Assurance; Dragan Spiroski, Manager, Program Performance and Adam Schlager, Manager, Program Performance in attendance. Those in attendance of the entrance meeting 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.

There were areas noted during the tour that were observed to be areas that the addition of mirrors could improve staff supervision of residents in these areas. These areas were revisited on the second day of the audit and the following recommendations were made for the addition of dome mirrors:

1. In the Day Room on the first floor there were two small round tables against the wall to the right of the room – a dome mirror in the back corner near tables
2. The stairwell from the first floor to the basement – a dome mirror by the first landing
3. Stairwells on floors two and three – one dome mirror in each corner on the first landing
4. Room 305 and 435 (6-man rooms) – a dome mirror in back right-hand corner of the room

In addition, it was recommended to lower a camera in a second-floor hallway (camera 202), below a sprinkler pipe that when the camera monitors were viewed, the pipe obstructed the view of the camera. A recommendation was also made to move a camera in the Red Room so when the door of the room is left open in this room, the camera would give a view of the stairway that leads to the basement. On the second day of the audit, the camera was moved as recommended. The facility was asked that when the recommended cameras are installed and camera 202 is moved, that photos be taken and forwarded to me for my review.

While touring the outdoor smoking/bicycle storage area, a narrow area at the end of the smoking area appeared to have a blind spot behind a brick extension in that area. The Facility Director stated that residents were not supposed to be in that area, but it was clear that they are accessing this area. A recommendation was made to install a gate to block residents' access to this area. When the gate is installed, the facility was asked to take a photo and forward it to me for my review.

During the corrective action period, the facility provided photos of the recommended dome mirrors that were installed in the Day Room, the stairwells and in rooms 305 and 435. They also provided a photo of the gate that was installed in the outdoor smoking/bicycle storage area. In review of the photos, visibility was improved in all areas with the installation of mirrors. The installation of the gate in the smoking/bicycle storage area will help to keep residents from accessing this area.

Sexual Assault Awareness and *Resident Reporting Options* posters are prominently displayed in all common areas of the facility as well as on the walls in each resident room. Information for visitors and staff reporting are posted in the front entryway of the facility, in staff offices and in the staff breakroom. The facility has done an excellent job of ensuring PREA information is readily accessible to both residents, staff and visitors.

The records of 40 residents were reviewed to evaluate compliance to screening procedures. The record review revealed that required timeframes for initial assessments and 30-day reassessments were not consistently adhered to. Due to the resident record review, the facility was found to be non-compliant with the requirements of standard 115.241 and standard 115.242. (See narrative of those standards for details)

The PREA training records of 22 residents were reviewed for compliance to PREA education requirements for residents. Documentation for receipt of the *PREA Education Manual for Residents* and acknowledgement of viewing the *PREA: What You Need to Know* video were found in all files.

The personnel files of 21 staff and one volunteer were reviewed to determine compliance with criminal 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, as well as criminal background checks for staff who are considered for a promotion or who transfer from another facility.

Documentation of annual PREA training for staff is filed alphabetically in binders, with BOP and CDCR filed in separate binders. The Facility Director/PREA Compliance Manager maintains these binders, with the assistance of the Social Service Coordinator. The training records of 21 staff and one volunteer was reviewed for compliance to training requirements since the last PREA audit. Initially, training acknowledgement forms for six staff members for 2017 training was not found in the binders. The Facility Director/PREA Compliance Manager was able to locate three of those acknowledgement forms and was able to locate sign-in sheets and completed quizzes for the other three staff who completed the training, but did not sign the acknowledgement form. The Facility Director/PREA Compliance Manager will ensure those staff sign the acknowledge forms and forward a copy of the signed acknowledgement forms to me for my review. It was suggested that tracking this information more carefully will ensure that all training is completed and that the required documentation is signed and filed upon completion of the training.

The population on the first day of the audit was 211. This included 114 BOP residents, 3 Public Law residents, 87 CDCR residents and 7 residents on home confinement. Thirty-five of the in-house residents were randomly selected to be interviewed, of the number of residents interviewed, two residents self-disclosed at initial screening to be gay, one self-disclosed being lesbian, five were screened at risk for victimization and three were screened at risk for abusiveness. At the time of the audit, there were no residents who were blind, had low vision, deaf, hard of hearing or with cognitive or reading deficits. There was one resident identified as limited English proficient (Vietnamese), but when interviewed he was able to understand and answer questions in English. There were no residents who self-disclosed at initial screening of being bisexual, transgender or intersex.

The residents interviewed acknowledged receiving PREA training with written information during the intake process. They were familiar with the agency/facility's zero-tolerance policy against sexual abuse and sexual harassment and were able to articulate during interview the methods of reporting allegations of sexual abuse and sexual harassment available to them. They shared that they feel they have privacy when showering, toileting and changing clothing when staff of the opposite gender are in their housing area.

Twenty-five staff members were interviewed during the course of the audit. Of the 25 staff members interviewed, 10 were security staff selected from each of the three security shifts and the remaining 15 were specialized staff. The part-time Psychologist and the volunteer were interviewed by telephone. The Facility Director/PREA Compliance Manager, the Assistant Facility Director and the CDCR Program Manager have multiple roles and were asked questions as they relate to the responsibilities of those roles. Staff interviewed were all knowledgeable of the zero-tolerance policy and of their responsibilities of detecting, preventing and responding to allegations of sexual abuse and sexual harassment.

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 was one allegation of staff-on-inmate sexual abuse that is pending investigation. In 2016 there was one allegation of staff-on-inmate sexual abuse that was determined to be substantiated and one allegation of inmate-on-inmate sexual harassment that was determined to be unsubstantiated. In 2015, there was one allegation of inmate-on-inmate sexual harassment and one allegation of inmate-on-inmate sexual abuse; both were determined to be unsubstantiated. Investigative files were reviewed with the CDCR Program Manager who is the facility's trained investigator. Allegations that appear to be criminal are referred to the San Francisco Police Department.

At the conclusion of the onsite audit, an exit meeting was held to discuss the audit findings with Maria Richard, Facility Director/PREA Compliance Manager; Jennine McFarlane, Assistant Facility Director; Jason Carpenter, CDCR Program Manager; Dejuan Lewis, CDCR Assistant Program Manager; Shelley Mays, Social Services Coordinator; Jonathon Dressler, Director, PREA & Quality Assurance; Dragan Spiroski, Manager, Program Performance and Adam Schlager, Manager, Program Performance, with Steve Farugie, Senior Area Manager in attendance via telephone. The facility was informed of the process that would follow the on-site visit including recommended corrective measures for achieving compliance to standard 115.241 and 115.242. These standards were reviewed with the team along with recommendations for bringing those standards into compliance. The facility will be working closely with the PREA Coordinator and the Divisional PREA Director to accomplish this. The team was complimented for their cooperation prior to the audit and during the on-site visit and for the PREA program they have developed and continue to improve.

Following the on-site audit visit, the facility entered into a 60-day corrective action period to bring standards 115.241 and 115.242 into compliance. The corrective action period was extended an additional 30 days for a total of 90 days due to the training date of staff responsible for PREA screenings delayed until all staff were available to attend. The following is the corrective action taken by the facility during this period:

Corrective Action Taken:

On 8/14/17, the PREA Coordinator forwarded me a tracking spreadsheet that was implemented to assist staff in tracking and adhering to required screening timeframes. The form is sorted by arrival date and documents initial and reassessment screening dates and notes if residents were screened to be at risk for victimization or abusiveness and documents receipt of the PREA video and the PREA Education Manual. The form also documents if a resident self discloses being transgender or intersex and if so, if the *Pat Search Preference Form* was completed. This spreadsheet is being maintained for both the BOP and CDCR programs and shared access given to the Divisional PREA Director for oversight monitoring.

On August 23, 2017, the facility provided BOP and CDCR staff responsible for PREA screenings with training on the procedures for completing *PREA Risk Assessments* and *PREA Vulnerability Reassessment Questionnaires,* as well as the tracking process for information obtained from these screenings. A training roster showing staff attendance of this training was provided for my review.

The facility implemented an *At-Risk Log* to be used to track residents who screen to be at risk for victimization or abusiveness. The log is to be updated to be kept current at all times. The *At-Risk Log* was provided for my review. The facility also provided for review a *Taylor Street Center Resident Referral Verification* form to be completed for all residents who are screened at risk for victimization or abusiveness or who become victims of an allegation of sexual abuse for referral to medical or mental health services. Residents have an option of declining the referral.

Beginning 7/18/17 thru 11/3/17 the facility provided for review 93 initial *PREA Risk Assessments* completed on new arrivals to the facility during that timeframe. Sixty-nine *PREA Vulnerability Reassessment Questionnaires* of those residents who remained at the facility within 30 days of their arrival to the facility were also provided for review. A *PREA Intake Tracking* form and a *PREA 30-Day Reassessment Tracking* form were also provided for review. The *PREA Intake Tracking* form documents the resident's arrival date, their risk assessment date and whether a referral was required, with a referral date if applicable. The *PREA 30-Day Reassessment Tracking* form documents the resident's arrival date, the date of their reassessment and indicates whether a referral was required due to new information obtained from the *PREA 30-Day Reassessment Tracking* form.

During the corrective action period, the facility worked closely with Divisional PREA Director providing him with documentation for his review of PREA screenings and tracking logs along with the newly implemented spreadsheet. This information was also forwarded to the PREA Coordinator for a final review before being forwarded to me. In review of the documentation provided, all *PREA Risk Assessments* of arrivals of residents to the Taylor Street Center were completed within 24 hours of arrival and *PREA Vulnerability Reassessment Questionnaires* were completed within the 30-day required time period. Those screened to be at risk for victimization or abusiveness were offered a referral for mental health treatment and were tracked on the *At-Risk Log* to ensure they were housed appropriately for their safety. A *Pat Search Preference Form* was completed for one resident who self-disclosed at intake screening of being transgender.

In review of all information provided for review, the facility was found to meet all of the requirements of standards 115.241 and 115.242.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Taylor Street Center is located at 111, Taylor Street, San Francisco, California, in San Francisco's Tenderloin District. The facility is a converted hotel built in 1907 and purchased by Cornell Companies in 1991. In August 20, 2010, GEO Group, Inc. merged with Cornell and assumed management of the facility. The rated capacity of the facility is 240. The facility currently has 40 employees with four vacancies and one volunteer.

The Taylor Street Center through a performance-based contract for over 20 years, receives pre-release male and female offenders from the Federal Bureau of Prisons (FBOP) and from the California Department of Corrections and Rehabilitation (CDCR), as well as public law commitments through the United States Probation Services (USPS). The facility has had a contract with BOP for a Mothers and Infants Nurturing Together (MINT) program since 1996. Female residents are allowed to have their babies reside with them from birth to 3-months of age. At the time of the audit, there were no females from the MINT program residing at Taylor Street Center. The Facility Director reported that since the facility has sex offenders residing at Taylor Street Center, modifications need to be made to secure the area on the second floor hallway where the MINT program was housed to allow the program to resume.

The Taylor Street Center consists of four floors and a basement. The first floor of the facility houses the Monitor Station, a Control Station, a dining room, kitchen, day room, BOP laundry room, a phone/resource room with five pay telephones, administrative, case manager and job developer offices, plus a fitness room. An outside exit near the fitness room allows entrance to a smoking area and a bicycle storage area. Smoking is not allowed in the facility.

When entering the main facility entrance, the Monitor Station is located on the left-hand side. The entrance doors are kept locked and visitors and residents are buzzed into the facility into a foyer area. There are two windows outside of the Monitor Station, one for visitors to sign in and one for residents to sign in. All residents are pat searched and breathalyzed when returning to the facility. UA's are performed in a UA restroom once each week for high-risk residents and once a month for low risk. Pat-searches are conducted in the foyer area in view of a camera. Camera monitors are in a Control Center that is located adjacent to the Monitor Station.

The second and third floors of the facility houses BOP residents. The second floor houses female BOP residents in rooms to the left of the elevator. At the time of the audit, there were 10 BOP female residents housed at the facility. The fourth floor houses CDCR residents, along with offices for the CDCR Program Manager and the CDCR Assistant Program Manager, a laundry and a day room. At the time of the audit, there were 87 male CDCR residents and no females. Each resident room on the second, third and fourth floors has two, four or six residents in each room, depending on the size of the room, with a restroom with a solid door within each room. Each of these floors has two rooms that are ADA accessible. Each resident has a bed, table, chair, locker and storage area within their room. PREA signage is posted in all resident rooms as well as in common areas. The facility has an elevator for use of physically disabled residents, staff and MINT program women only. Male and female residents are not allowed to ride the elevator together.

The basement is a large storage area and a maintenance/tool area. Residents are not allowed access to the basement area.

The hallways of each floor are covered by cameras. There are 42 cameras located throughout the facility, which are monitored by security staff in the Control Station and in the Facility Director/PREA Compliance Manager and the CDCR Program Manager offices. Two DVR's maintain surveillance data for up to 30 days.

Security of the Taylor Street Center is by direct staff supervision. Security staff perform nine counts is a 24-hour period and frequent security rounds throughout are made each shift.

Taylor Street Mission Statement:

> "The mission of the Taylor Street Center RRC is to provide temporary co-ed housing, monitoring, and transitional services in a supervised environment in an effort to enhance public safety while assisting offenders in becoming law-abiding and employable citizens able to (re)establish family and/or community ties in their respective communities in a positive way."

GEO's Mission Statement:

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

SUMMARY OF AUDIT FINDINGS

The following is a summary of the audit findings:

Number of standards exceeded: 4

Number of standards met: 33

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

GEO policy 5.1.2-A, pages 6 & 7, section III-B, and facility policy 2014-1, pages 2 & 3, section VI-A, outline the responsibilities of the PREA Coordinator and the PREA Compliance Manager. The agency not only employs an agency-wide PREA Coordinator, but also employs a Director, PREA & Quality Assurance who provides oversight to the agency's reentry facilities; therefore, exceeding in the requirements of this section of the standard. The PREA Coordinator and the Director, PREA & Quality Assurance are extremely knowledgeable and continue to provide facilities with support and assistance for the implementation and enhancement of the agency's PREA program.

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

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

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

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

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 7, section C-1 and facility policy 2014-1, pages 3 & 4, section B-1, the agency has developed and documented a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents against sexual abuse. The agency took into consideration the physical layout of the facility, the composition of the population and the prevalence of substantiated incidents of sexual abuse, and the resources the facility has available to commit to ensure adequate staffing levels in the development of the facility's staffing plan. The facility's design capacity is 240 residents and the staffing plan was developed based on that number. The BOP contract renewed in April 2016 added one Lead Monitor II position to each of the three security shifts. Renewal of the CDCR contract added seven CDCR Security Monitor positions to the staffing plan.

The facility makes its best efforts to comply with the approved PREA Staffing Plan. At all times, there must be a male and a female staff person on duty. In circumstances where the staffing plan is not complied with, the Facility Director would document and justify all deviations from the plan. The Facility Director/PREA Compliance Manager and the CDCR Program Manager together develop the weekly staffing schedule in the absence of a Security Manager, due to that position being vacant. In review of documentation provided by the facility and upon interview with the Facility Director/PREA Compliance Manager, in this audit period there were no times that there were deviations to the staffing plan. Staff vacancies are filled by the use of staff overtime and Case Managers are scheduled from 5:30 a.m. – 9:30 p.m. Monday – Friday and Sunday afternoon and evening and are available to assist with filling vacant positions to ensure adherence to the staffing plan.

The staffing plan is reviewed annually by the Facility Director/PREA Compliance Manager along with other administrative team members, and documented on the *PREA Annual Facility Assessment* form. This form is then forwarded to the Regional Director, Director, PREA & Quality Assurance, Divisional Vice President and the Corporate PREA Coordinator for signature and approval of any recommendations made to the established staffing plan to include the deployment of video monitoring systems and other monitoring technologies or the allocations of additional resources to maintain compliance to the plan. Based on the *PREA Annual Facility Assessments* completed since the last PREA audit, no recommendations were made for changes to the established staffing plan.

Per policy, facility management staff and mid-level supervisors conduct unannounced rounds within their respective areas to identify and deter employee sexual abuse and sexual harassment. These unannounced rounds are documented on the *Manager/Supervisor Facility Walkthrough* form and in a log book. 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. In the absence of a Security Manager, the Facility Director/PREA Compliance Manager, the Assistant Facility Director and the CDCR Program Manager performs these verifications and document them on the *Resident Count Verification Checklist,* which are forwarded to the Divisional Vice President of Reentry Services and to the Regional Director.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on review of GEO policy 5.1.2-A, pages 16 & 17, section I-J, and facility policy 2014-4, pages 2 & 3, sections on *Offender/Resident "Pat" Searches*, *Offender/Resident "Strip" Searches and "Body Cavity" Searches*, and *Limits to Cross-Gender Viewing and Searche*s, the facility prohibits cross-gender strip searches and cross-gender visual body cavity searches except in exigent circumstances or when performed by medical practitioners. Facility policy requires that all cross-gender strip searches and body cavity searches be documented. Resident strip searches and body cavity searches are prohibited at the Taylor Street Center. If at any time there is cause to strip search a resident, the Facility Director or designee will contact the nearest correctional institution to arrange and have the search conducted at the local institution. In the past 12 months, there were no cross-gender strip or cross-gender visual body cavity searches performed.

Pat searches are conducted in the front entrance foyer in view of cameras. 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, staff receive training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents which is included in the DOJ 2017 In-Service training curriculum that was provided for review. The curriculum was found to instruct staff on how to effectively and professionally conduct cross gender searches of all residents. Staff sign a *Cross Gender Pat Searches & Searches of Transgender & Intersex* acknowledgement form upon completion of this training and a *Training Meeting Employee Sign-In Sheet*. Receipt of this training was verified through interviews with staff and in review of staff training records.

The agency has policies and procedures in place that enable residents to shower, perform bodily functions and change clothing without staff viewing their breast, buttocks or genitalia. Policy requires staff of the opposite gender to announce their presence when they enter resident housing and restroom areas. This practice was observed while on-site and residents and staff interviewed confirmed that this practice is being followed. Signs on all floors remind residents that both male and female staff will be on duty. Residents shared that they feel they have privacy to shower, toilet and change clothing when staff of the opposite sex are in their housing unit. Each resident room has a restroom with a solid door.

Based on GEO policy 5.1.2-A and facility policy 2014-4, the facility prohibits examining transgender or intersex residents for the sole purpose of determining genital status. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. At the time of the on-site audit, there were no transgender or intersex residents housed at the Taylor Street Center.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The agency takes appropriate steps to ensure that residents with disabilities and residents that are limited English proficient have an opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. GEO policy 5.1.2-A, pages 11 & 12, section E-1 and facility policy 2014-2, pages 1 & 2, section V, were used to verify compliance to this standard. Residents receive a *PREA Education Manual for Residents* during the intake process which is available in English, Spanish and in large print for residents with low vision. PREA posters and a *PREA: What You Need to Know* video is available in both English and Spanish. Staff members proficient in the Spanish language provides interpretation to Spanish speaking residents. A contract with Language Line Services, Inc. provides for the translation of any other languages. A TTY is available for residents who are deaf or hard of hearing. At the time of the on-site visit, there were no residents who were deaf, hard of hearing, blind, had low vision or who had cognitive or reading deficits. One resident was identified as limited English proficient, but when interviewed he reported he could read the English language and was able to understand interview questions and respond appropriately.

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)

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 7 & 8, section C-2 and page 16, section 4 and facility policy 2014-1, page 4, section 2, and review of random employee files were used to verify compliance to this standard. Per policy the agency/facility prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who have engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings or in the community. GEO considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The agency requires that all applicants and employees who may have contact with residents have a criminal background check and every five years thereafter. Criminal background checks for all potential employees are completed through a contract with Aurico, as well NCIC clearance for all applicants. If an applicant answers that they have previously worked at a confinement facility, a Custom Employment Report is ordered from Aurico for PREA verification. Aurico performs driver's license checks on applicants, and those considered for promotions or who transfer from another facility and every five years thereafter. In the past 12 months, 12 criminal background checks were completed on applicants. The agency also requires that all contractors and volunteers who have contact with residents have criminal background checks. Page 16, section 4 of the agency policy addresses the requirements of criminal background checks for contractors. The facility does not utilize the services of contractors. Volunteers have a criminal background check before being allowed access to the facility and every five years thereafter.

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

Criminal Background checks by Aurico and NCIC for all employees are completed every five years for BOP and CDCR staff. Personnel files of random employees and the one volunteer were reviewed and found to contain pre-employment criminal background checks and five-year background checks as required by this standard and agency policy.

The Office Support Specialist who is responsible for HR duties was not on duty during the on-site audit, but she does an excellent job of maintaining HR records and ensuring that criminal background checks and all documentation required is maintained, exceeding in the requirements of 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 3, and documentation provided for review was used to verify compliance to this standard. Per agency and facility policies, the Taylor Street Center shall consider the effect any new design, acquisition, expansion or modification of physical plant or monitoring technology might have on the facility's ability to protect residents from sexual abuse. Since the last PREA audit, there were no new facilities and no substantial expansions or modifications were made to the existing facility. Since the last PREA audit, there have been camera replacements and new cameras and monitors installed to enhance supervision of residents.

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

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-E, pages 6-10, sections D-I outlines the agency's requirements as it applies to this standard. The CDCR Program Manager is Taylor Street Center's trained investigator responsible for conducting administrative investigations of allegations of sexual abuse and sexual harassment. It is the responsibility of the San Francisco Police Department or FBOP to conduct all criminal investigations and to ensure all forensic evidence is collected and preserved in accordance with evidence protocols established by the Department of Justice (DOJ). The investigating entities follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence and fulfill all requirements of this standard.

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

Victims of sexual abuse have access to forensic medical examinations. Forensic exams are not performed at this facility. Victims of sexual abuse are referred to the San Francisco General Hospital for SANE exams at no cost to the resident. In the past 12 months, there have been no residents who have required SANE exams. A 24-hour hotline, counseling, individual therapy, groups for victims and court advocacy are services available to resident victims through the Rape Crisis Center of San Francisco.

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 *Resident Reporting Options* posters displayed throughout the facility. When interviewed, residents were aware of the confidential emotional support services available to them and how to access them.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Upon receipt of an allegation of sexual abuse, the supervisor receiving the report immediately notifies the Facility Director. The Facility Director will make immediate notification to the PREA Coordinator, to the Director, PREA & Quality Assurance and to GEO's Office of Professional Responsibility (OPR) (if the allegation involved staff), the BOP Residential Reentry Manager and the GEO Reentry Services Senior Area Manager. If the resident is in CDCR custody, the Oversight Specialist and the Parole Officer are notified. The facility initiates an administrative investigation and if it is determined that the allegation involved potential criminal activity, a referral is made to the San Francisco Police Department who conduct a criminal investigation.

The agency documents all referral of allegations of sexual abuse or sexual harassment for criminal investigation. A *Serious Incident Report* is completed for all allegations of sexual abuse. All allegations are tracked on the *PREA Monthly Incident Outcome Tracking Log.* In the past 12 months, there were three allegations of sexual abuse/sexual harassment reported. Two were investigated administratively and one was referred for criminal investigation. In 2015 there were two allegations reported that were determined to be unsubstantiated.

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

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO employees receive training on GEO's zero-tolerance policy (5.1.2-A) for sexual abuse and sexual harassment at pre-service and annually at in-service. The agency's requirement of this training is found on pages 12 & 13, section F-1. Between trainings, the facility has monthly staff meetings where PREA is reviewed and discussed. The pre-service and in-service training curriculums were reviewed and found to address all elements of 115.231 (a) as required by this standard. The CDRC Program Manager provides PREA training to new hires and the Facility Director/PREA Compliance Manager provides annual staff PREA in-service training. Employees sign an *In-service Training Roster* acknowledging reading and understanding the agency's sexual abuse and sexual harassment policy and staff first responder duties. They also sign a *PREA Basic Acknowledgement* form that they have received and understood the training they received. Staff also receive the *Guidance in Cross-Gender and Transgender Pat Searches* training and sign a *Cross Gender & Pat Searches & Searches of Transgender and Intersex* form upon completion of this training. Documentation of annual PREA training for employees is maintained in employee personnel files and copies filed in a binder that is maintained by the Facility Director/PREA Compliance Manager. During monthly staff meetings, PREA is reviewed and discussed.

Since the last audit, all Taylor Street Center's staff has received annual PREA training. 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.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The Taylor Street Center does not utilize the services of contractors. The facility has one volunteer who completed the *Sexually Abusive Behavior Prevention and Intervention Program Orientation and Training* 4/13/16 and signed a *Volunteer Orientation Acknowledgement/Policy Agreement* form.

In interview with the volunteer by telephone, he confirmed receiving the training annually and he was knowledgeable of the agency/facility's zero-tolerance policy and his PREA-related responsibilities.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 12, section E-2 and facility policy 2014-2, pages 6 & 7, *Documentation* section, all residents receive information at time of intake and if transferred from another facility about the zero-tolerance policy and how to report incidents of sexual abuse or sexual harassment, their rights to be free from retaliation for reporting such incidents and are informed of the agency policy and procedures for responding to such incidents. Resident education is provided by the upon arrival to the facility in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired or otherwise disabled.

In the past 12 months, 724 residents admitted to the facility and three residents who transferred from another community confinement facility received written PREA educational material upon arrival to the facility. Upon arrival to the Taylor Street Center, residents are provided with a *PREA Education Manual for Residents, sign an Acknowledgement of Receipt of PREA Educational Manual form, and are shown the PREA: What You Need to know* video. Ongoing information is provided on posters, both in English and Spanish, prominently displayed in all resident rooms and in numerous other locations throughout the facility. Town Hall Meetings are held with residents on a regular basis where PREA information is discussed.

Per agency/facility procedures, Case Manager Orientation is provided to residents within 72 hours of arrival to the facility where PREA information is reviewed with residents. Residents are required to sign another acknowledgement form acknowledging viewing the *PREA: What You Need to Know* video, receiving training on the zero-tolerance policy, their right to report and their right to free medical and mental health care.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, page 14, section F-3, in addition to general education provided to all employees, GEO ensures that facility investigators receive training on conducting sexual abuse investigations in confinement settings. In review of the training curriculum, the training includes techniques for interviewing sexual abuse victims, proper use of the Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or referral for prosecution. The agency has 85 trained investigators agency-wide. At the Taylor Street Center, the CDCR Program Manager is the trained facility investigator. He completed *Specialized Training: Investigating Sexual Abuse* facilitated by GEO's PREA Coordinator on 10/21/14. The facility maintains documentation that this training was completed.

Upon interview, the CDCR Program Manager was knowledgeable of his responsibilities in conducting sexual abuse investigations.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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 13 & 14, section 2 , states that each facility will train all full-time and part-time medical and mental health staff to detect signs of sexual abuse and sexual harassment, preserving physical evidence and responding effectively and professionally to victims of sexual abuse and sexual harassment.

All medical and mental health staff receives specialized training in addition to general PREA training provided to all staff. The facility does not employ medical staff. Mental Health Staff consists of one part-time Psychologist who is scheduled evenings for 10 hours per week to address residents' mental health needs and supervise the AA volunteer. The Psychologist who received GEO's *Medical & Mental Health Specialized PREA* web-based training on 8/16/16 and received a certificate of completion.

The Psychologist when interviewed by telephone verified receiving this training and knew his responsibilities in responding to victims of sexual abuse, proper reporting and how to preserve the physical evidence and the crime scene.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

The records of 40 residents were reviewed to evaluate compliance to screening procedures. Records of four resident files reviewed showed initial risk assessments were completed past 24 hours after arrival to the facility; with one being completed 9 days after date of arrival, two completed 7 days after arrival date and one 46 days after arrival date. In review of 30-day reassessments, 10 records revealed *PREA Vulnerability Questionnaires* not completed within 30 days of arrival, with two of them as late as three months past the 30-day due date.

Due to the results of the resident record review, the facility was found non-compliant with the requirements of this standard and entered into a corrective action period for 60 days beginning on 8/7/17 and ending on 10/5/17. The recommended corrective action was as follows:

<u>Recommended Corrective Action:</u>
To bring this standard into compliance, the corrective action plan recommended was for the facility to identify staff who will conduct the risk screenings and the reassessments for both the BOP and the CDCR programs. Once identified, the identified staff will need to be trained on the procedures for completing the *PREA Risk Assessment* and the *PREA Vulnerability Reassessment Questionnaires* timely ensuring compliance to screening requirements. Staff receiving this training will be required to sign a training roster acknowledging receiving this training and the

PREA Risk Assessment and *PREA Vulnerability Reassessment Questionnaires* completed in the 60-day corrective action period will need to be forwarded to the Director, PREA & Quality Assurance for his review. At the end of the 60-day period, the arrival rosters and the tracking spreadsheet will need to be forwarded to me for my review and approval.

The facility was found to meet all the requirements of this standard during the corrective action period. See pages 6 & 7 under the Narrative Section of this report for details of the corrective action taken.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Residents who score at risk of victimization or abusiveness are referred for further evaluation using the *Resident Referral Verification* form. Residents have an option of refusing these services. Those identified to be at risk are tracked on a *PREA Risk Assessment Roster* . Female residents screened to be at risk for victimization or abusiveness are housed in one of the female rooms and those screened to be at risk for abusiveness housed in another female room away from the potential victim. Male BOP residents screened to be at risk for victimization or abusiveness are housed on separate floors (floors 2 or 3). CDCR residents screened to be at risk for victimization are housed in rooms in opposite hallways.

GEO does not place lesbian, gay, bisexual, transgender or intersex residents in dedicated units or wings solely based on such identification. On interview with one resident who self-disclosed being lesbian and two residents who self-disclosed being gay, they reported that they were not placed in any special housing area because of their sexual orientation.

Due to the record review to assess compliance to screening procedures, it was felt that assessments of residents that may be at risk of victimization or abusiveness could not always be determined upon arrival or after 30 days because the assessments were not consistently being completed within the required timeframes. This delay in screening residents could result in residents not being housed properly and putting them at risk of victimization or abusiveness. The facility was found non-compliant with the requirements of this standard and entered into a corrective action period for 60 days beginning on 8/7/17 and ending on 10/5/17. The recommended corrective action was as follows:

<u>Recommended Corrective Action:</u>

To bring this standard into compliance the corrective action plan would be the same as recommended for standard 115.241. The spreadsheet the facility will be implementing, in addition to tracking dates of initial and reassessment screenings, tracks those residents that are screened at risk for victimization or abusiveness and those residents who self-disclose being transgender or intersex. It also is noted on the spreadsheet a reminder for staff that residents who scored at risk be added to the "At Risk" Log and for staff ensure that a Referral Verification form for referral for counseling be completed. This tracking of information will assist the facility to ensure not only timely completion of initial and reassessment screenings, but assist them in making accurate determinations of housing to keep residents safe.

The facility was found to meet all the requirements of this standard during the corrective action period. See pages 6 & 7 under the Narrative Section of this report for details of the corrective action taken.

Standard 115.251 Resident reporting

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 18, section L-1 and facility policy 2014-2, page 4, last paragraph outline the agency's options for resident reporting methods. The agency provides multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and any staff neglect or violation of responsibilities that may have contributed to such incidents.

Residents are made aware of methods of reporting available to them through the *PREA Education Manual for Residents* (page 9) provided to them upon intake, on the *Resident Reporting Options* posters posted in all resident rooms and in common areas throughout the facility. Residents are made aware that they can verbally inform any staff member, the Facility Director or the PREA Compliance Manager immediately or in writing. They are informed they can call the RAINN National Hotline Network (1-800-656-4673), the Rape Crisis Center of San Francisco (415-647-7273), the CDCR Parole – Northern Region (916-255-2758), the US Probation Supervisor (415-436-7540, the Bureau of Prisons Residential Reentry Office (916-930-2010) and they are given their address or call the GEO Corporate PREA Coordinator (561-999-5827). Residents are informed of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Residents are also informed that a third party can make a report for them.

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

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

Staff have access to private reporting by calling the Employee Hotline (866-568-5425) or the Corporate PREA Coordinator (561-999-5827). Information for resident and staff reporting can be found on the GEO website (https://www.geogroup.com//PREA (Social Responsibility-PREA Certification Section). Page 4, section I of the

Employee Handbook informs employees of their responsibility of reporting sexual abuse and sexual harassment. Staff carry with them a Sexual Abuse First Responder Card, which has the employee hotline number and the website address for anonymous reporting.

Residents and staff interviewed were well versed in the methods of reporting available to them. The facility provides many reporting options for residents and was found to exceed in the requirements of this standard.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In review of GEO policy 5.1.2-A, pages 19 & 20, section K-2, and facility policy 2014-5, pages 4 & 5, there is a procedure in place for residents to submit grievances regarding sexual abuse and the agency has procedures for dealing with these grievances. Instructions on how to file grievances are provided on page 8 of the *PREA Education Manual for Residents.*

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

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

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

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, pages 24 & 25, section N-8 and facility policy 2014-6, page 11, section H-6, addresses the agency's policy on providing residents with access to outside victim advocates for emotional support services related to sexual abuse. Residents are given the telephone number to the Rape Crisis Center of San Francisco in the *PREA Education Manual for Residents* and on the *Resident Reporting Options* posters displayed throughout the facility. Residents are informed of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

The facility has reached out to several community agencies attempting to secure an MOU for confidential support services to resident victims of sexual abuse. Those agencies are the Community United Against Violence, the Community Awareness and Treatment Services, Inc. and the Transitions Clinic. To date those efforts have been unsuccessful.

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

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency's requirement on staff reporting duties can be found on page 20, section N-4 of GEO policy 5.1.2-A. The facility's requirement on staff reporting duties can be found on pages 5 & 6, section VII-B of facility policy 2014-6. Staff must take all allegations of sexual abuse and sexual harassment seriously. All staff are required to report immediately to the Facility Director/PREA Compliance Manager any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment and any retaliation against residents or staff who reported such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, are reported to supervisors. The supervisor receiving the report immediately notifies the Facility Director. For an allegation of sexual abuse, the Facility Director will make notification to the PREA Coordinator, the Director, PREA & Quality Assurance, the BOP Residential Reentry Manager and the CDRC Oversight Specialist. If the allegation involves staff, notification is also made to GEO's OPR.

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

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

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident according to GEO policy 5.1.2-A, pages 20 & 21, section M-1. All allegations of sexual abuse are to be handled in a confidential manner.

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

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 24, section 5 and facility policy 2014-6, pages 9 & 10, section F were used to verify compliance to this standard. Upon receiving an allegation that a resident was sexually abused while confined at another facility, the allegation will be documented and the Facility Director or his designee shall notify the head of the facility where the sexual abuse was alleged to have occurred and document that notification was provided. This notification is to occur as soon as possible, but no later than 72 hours of receiving the allegation and should include all actions taken regarding the incident. Copies of this documentation will be forwarded to the PREA Coordinator.

In interview with the Facility Director/PREA Compliance Manager and in review of documentation provided, in the past 12 months, there were no residents of the Taylor Street Center that alleged that sexual abuse occurred while confined to another facility.

If a report is received from another facility regarding alleged sexual abuse occurring at the Taylor Street Center, the allegation will be reported and investigated according to PREA standards. In interview with the Facility Director, in the past 12 months, there were no allegations of sexual abuse received from other facilities. Documentation provided for review showed one allegation was received in 2015 alleging sexual abuse while a resident was assigned to Taylor Street Center and was handled according to agency policy and investigated in accordance with the PREA standards.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO policy 5.1.2-A, page 21, section L-2, outlines the procedure for first responders to follow for allegations of sexual abuse and sexual harassment whether that person is a security or non-security staff member. Per policy, upon learning of an allegation of sexual abuse, the first security staff member to respond to the report is to separate the alleged victim and abuser, immediately notify the on-duty or on-call supervisor, preserve and protect the crime scene, not let the alleged victim or abuser take any actions that could destroy physical evidence and not reveal to anyone information related to the incident to anyone other than staff involved with investigating the alleged incident.

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

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 reported 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, page 6, section A-4 and review of the Taylor Street Center's *PREA Coordinated Response Plan* were used to verify that there is a plan in place to coordinate actions to be taken in response to an incident of sexual abuse. The plan provides written guidance to staff and administration regarding actions to take and notifications to be made. A *PREA After-Action Checklist for Incidents of Sexual Abuse and Harassment* is completed to ensure that all steps of the plan and proper notifications are made. This checklist is filed with the completed investigative packet. The Facility Director/PREA Compliance Manager, the Assistant Facility Director and the Social Service Coordinator are responsible to ensure compliance to the plan. Staff interviewed confirmed that they are knowledgeable of the plan and the necessary actions to be taken in response to an allegation of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The Taylor Street Center does not have a collective bargaining unit. GEO would not enter into any collective bargaining agreement at any of its facilities that would limit the facility's ability to remove an alleged sexual abuser from contact with residents pending the outcome of an investigation.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

GEO has as policy to protect residents who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff as outlined in policy 5.1.2-A, pages 25 & 26, section N-2 and in facility policy 2014-6, pages 10 & 11, section H. The agency has multiple protection measures, such as housing changes or transfers for residents, victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. If any other individual who cooperates with an investigation expresses a fear of retaliation, appropriate measures to protect that individual against retaliation are put in place.

The Facility Director/PREA Compliance Manager is responsible for weekly monitoring of residents and staff who reported sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations for retaliation for at least 90 days and longer if there is a continuing need. Monitoring is documented on the *Protection from Retaliation Log.* Completed logs are filed in the investigative file.

In the past 12 months, there was no incidents of retaliation that occurred. When interviewed, the Facility Director/PREA Compliance Manager knew her responsibilities for monitoring for retaliation per policy.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The supervisor receiving the report of an allegation of sexual abuse or sexual harassment immediately notifies the Facility Director who notifies the PREA Coordinator and the Director, PREA & Quality Assurance and the BOP Residential Reentry Manager if the resident is in BOP custody and the Oversight Specialist and parole officer if the resident is in CDCR custody. If the allegation involves a staff member, notification is made to GEO's OPR.

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

When the quality of evidence appears to support criminal prosecution, the allegation is referred to the San Francisco 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.

Since the last audit, there were no allegations that appeared to be criminal that were referred for prosecution.

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 investigator was asked what standard of evidence was used in determining if an allegation is substantiated, he confirmed the agency policy.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

In the past 12 months, there were no notifications of the outcome of an investigation required. Based on interview with the Facility Director/PREA Compliance Manager, the process of providing notification to resident victims at the conclusion of an investigation is in place.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse policy as outlined in policy GEO policy 5.1.2-E, page 11, section L-1 and facility policy 2014-6, page 13, section M-1. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. All terminations for violations of the agency's policies on sexual abuse and sexual harassment, or resignations, shall be reported to law enforcement and licensing agencies unless the activity was clearly not criminal. In the *GEO Employee Handbook,* provided to all staff, pages 16 & 17 explain the zero-tolerance policy for employees and the sanctions that would be imposed for violations of that policy.

In the past 12 months, one staff member violated the agency/facility's sexual abuse and sexual harassment policies. The staff member was immediately placed on administrative leave and resigned prior to the conclusion of the investigation.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on review of GEO policy 5.1.2-E, page 12, section L-3, any volunteer or contractor who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies and licensing boards, unless the activity was clearly not criminal.

The Taylor Street Center does not utilize the services of contractors. In interview with the Facility Director/PREA Compliance Manager, in the past 12 months the volunteer has not violated the agency's sexual abuse policy.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

According to facility policy 2014-6, pages 13, section M-2, the Federal Bureau of Prisons and the United States Probation Office are the supervising authorities over all residents at the Taylor Street Center. If a resident is found guilty of engaging in sexual abuse involving another resident, it will be reported to the BOP Residential Reentry Manager and/or the USPO supervisor who will determine whether to subject the resident to formal disciplinary sanctions. Residents are made aware of sexual misconduct they will be disciplined for and the sanctions that will be imposed in the *Resident Program Handbook.*

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

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

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as stated in GEO policy 5.1.2-A, page 24, section 7 and facility policy 2014-6, page 7, section 5-f and page 8, section 5-h. Resident victims are referred to the San Francisco General Hospital for SANE exams and emergency medical treatment. Counseling services would be provided by referral to the Psychologist or to the Rape Crisis Center or other outside community providers.

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

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

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility will offer ongoing medical and mental health care to all the residents of the Taylor Street Center who have been victimized by sexual abuse. According to GEO policy 5.1.2-A, pages 25, section N-1 and facility policy 2014-6, page 8, section 5-h, the evaluation and treatment will include follow-up services, treatment plans and referrals for continued care upon transfer or release consistent with the community level of care. Victims will also be offered tests for sexually transmitted infections. Female victims of sexually abusive vaginal penetration, shall be offered pregnancy tests. If pregnancy results shall receive timely and comprehensive information about access to all lawful pregnancy-related medical services. All services will be provided without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Referrals are made to the San Francisco General 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. Counseling support, individual and group therapy for victims and abusers are provided by the facility's Psychologist or through outside community providers.

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

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

According to GEO policy 5.1.2-A, pages 26 & 27, section N-3 and facility policy 2014-6, page 12, section K, the facility is required to conduct a sexual abuse incident review within 30 days of every sexual abuse investigation in which the allegation has been determined to be substantiated or unsubstantiated.

The Facility Director/PREA Compliance Manager, the Assistant Facility Director, the CDCR Program Manager, the CDCR Assistant Program 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 Facility Director/PREA Compliance Manager maintains copies of all completed *PREA After Action Review Reports* and a copy is retained in the corresponding investigative file.

In review of investigative files of all allegations received in this audit period, an after action review was completed on investigations that were completed and determined to be substantiated and unsubstantiated. *PREA After Action Review Reports* were filed in the investigative files. When interviewed, the members of the Incident Review Team knew their responsibilities as they relate to the review of sexual abuse incidents.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

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

Standard 115.288 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based on GEO policy 5.1.2-A, pages 27 & 28, sections O-2 & 3, and on interview with the PREA Coordinator, the agency reviews all of the data collected from all of its facilities and aggregates that data annually to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. The PREA Coordinator prepares an annual report that provides the problem areas and corrective actions for each facility and the agency as a whole. The report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The Annual PREA Report provides an excellent overview of the agency's efforts in the prevention of sexual abuse and sexual harassment in its facilities and therefore, exceeds in the requirements of this standard.

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

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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

AUDITOR CERTIFICATION

I certify that:

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

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

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

Barbara Jo Denison ______________________________ November 29, 2017 ____________

Auditor Signature Date