

## Prison Rape Elimination Act (PREA) Audit Report Community Confinement Facilities

Interim       Final

Date of Report    September 20, 2019

### Auditor Information

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Company Name: B.A.K Correctional Consulting	
Mailing Address: 1145 Eastland Ave	City, State, Zip: Akron, Ohio 44305
Telephone: 330-618-7456	Date of Facility Visit: June 19-21, 2019

### Agency Information

Name of Agency: <b>The GEO Group, Inc.</b>		Governing Authority or Parent Agency (If Applicable): Click or tap here to enter text.	
Physical Address: 4955 Technology Way		City, State, Zip: Boca Raton, Florida 33487	
Mailing Address: Click or tap here to enter text.		City, State, Zip: Click or tap here to enter text.	
Telephone: 561-999-5827		Is Agency accredited by any organization? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
The Agency Is:	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Agency mission: GEO's mission is to develop innovative public-private partnerships with government agencies around the globe that deliver high quality, cost-efficient correctional, detention, community reentry, and electronic monitoring services while providing industry leading rehabilitation and community reintegration programs to the men and women entrusted to GEO's care.			
Agency Website with PREA Information: www.geogroup.com    Social Responsibility Section			

### Agency Chief Executive Officer

Name: George C. Zoley	Title: Chairman of the Board, CEO and Founder
Email: gzoley@geogroup.com	Telephone: 561-893-0101

### Agency-Wide PREA Coordinator

<b>Name:</b> Ryan Seuradge	<b>Title:</b> Director, Contract Compliance, PREA Coordinator
<b>Email:</b> rwallings@geogroup.com	<b>Telephone:</b> 561-999-5875
<b>PREA Coordinator Reports to:</b> Daniel Ragsdale, Executive Vice President, Contract Compliance	<b>Number of Compliance Managers who report to the PREA Coordinator</b> 108: 56 US Corrections; 41 Reentry Services; 8 Youth Services; and 3 Lockups

### Facility Information

<b>Name of Facility:</b> Southeast Texas Transitional Center
<b>Physical Address:</b> 10950 Beaumont Highway, Houston, Texas 77703
<b>Mailing Address (if different than above):</b> Click or tap here to enter text.
<b>Telephone Number:</b> 713-675-4426

<b>The Facility Is:</b>	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
<b>Facility Type:</b>	<input type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Halfway house	<input type="checkbox"/> Restitution center
	<input type="checkbox"/> Mental health facility	<input type="checkbox"/> Alcohol or drug rehabilitation center	
	<input type="checkbox"/> Other community correctional facility		

**Facility Mission:** It is the mission of GEO Reentry Services – Southeast Texas Transitional Center to provide an integrated delivery of individual transitional needs to the resident population. To facilitate this mission, the facility shall provide the following opportunities, programs, and/or services: Transitional Programs -To include but not limited to life skills, employment related assistance and residency development. These programs will be provided in accordance with contractual and licensing requirements and be presented in a manner that encourages residents to obtain and employ the necessary skills for the useful transition into the community. Case Management Services: To include but not limited to appropriate case management and referral services that assist the residents in identifying risk factors for successful transition, developing formal written plans of action to pursue in their transition process and the periodic evaluation of progress made towards the goals and objectives identified within these plans.

**Facility Website with PREA Information:** www.geogroup.com Social Responsibility Section

**Have there been any internal or external audits of and/or accreditations by any other organization?**  Yes  No

### Director

<b>Name:</b> Milton David Johnson	<b>Title:</b> Facility Director
<b>Email:</b> mdjohnson@geogroup.com	<b>Telephone:</b> 281-638-6126

**Facility PREA Compliance Manager**

<b>Name:</b> Danielle Lias	<b>Title:</b> Program Fidelity Specialist / PREA Compliance Manager
<b>Email:</b> dlias@geogroup.com	<b>Telephone:</b> 713-351-1504

**Facility Health Service Administrator**

<b>Name:</b> N/A	<b>Title:</b> Click or tap here to enter text.
<b>Email:</b> Click or tap here to enter text.	<b>Telephone:</b> Click or tap here to enter text.

**Facility Characteristics**

<b>Designated Facility Capacity:</b> 500	<b>Current Population of Facility:</b> 483 (the day of the audit)
<b>Number of residents admitted to facility during the past 12 months</b>	3,141
<b>Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:</b>	0
<b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:</b>	1,355
<b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:</b>	2,767
<b>Number of residents on date of audit who were admitted to facility prior to August 20, 2012:</b>	0
<b>Age Range of Population:</b>	<input checked="" type="checkbox"/> Adults <input type="checkbox"/> Juveniles <input type="checkbox"/> Youthful residents 21-72 Adult facility only Adult facility only
<b>Average length of stay or time under supervision:</b>	55 days
<b>Facility Security Level:</b>	Minimum
<b>Resident Custody Levels:</b>	Minimum
<b>Number of staff currently employed by the facility who may have contact with residents:</b>	86
<b>Number of staff hired by the facility during the past 12 months who may have contact with residents:</b>	48
<b>Number of contracts in the past 12 months for services with contractors who may have contact with residents:</b>	0

**Physical Plant**

<b>Number of Buildings:</b> 8	<b>Number of Single Cell Housing Units:</b> 0
<b>Number of Multiple Occupancy Cell Housing Units:</b>	0
<b>Number of Open Bay/Dorm Housing Units:</b>	5

**Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):**

The facility utilizes a video surveillance system with sixty-seven (67) cameras for twenty-four monitoring of housing areas, the interior of the kitchen, the dining room, the administration building (including the control

room, parole office, classrooms), the grounds, and the maintenance shop. The surveillance system stores the surveillance video for thirty days, allowing supervisory staff the ability to obtain evidence in the event of an allegation. The surveillance system provides supervisors and monitoring staff with real time views of the camera footage, enabling the staff to respond to any unusual activities. Two of the cameras located in central control and the parole office have audio capability. A camera project that includes updating eight monitors, installing 18 dome cameras, installing two hard drives, and a 16 channel DVR is in progress.

**Medical**

<b>Type of Medical Facility:</b>	N/A. The facility utilizes local hospitals and community facilities/services for medical and mental health services.
<b>Forensic sexual assault medical exams are conducted at:</b>	Local hospitals: Harris Health Center and Ben Taub Hospital

**Other**

<b>Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:</b>	0
<b>Number of investigators the agency currently employs to investigate allegations of sexual abuse:</b>	111 agency-wide 4 facility

# Audit Findings

## Audit Narrative

The Prison Rape Elimination Act (PREA) Audit of the Southeast Texas Transitional Center (STTC) in Houston, Texas, a facility under the operation of the GEO Group, Inc. was conducted on June 19-21, 2019 by Department of Justice certified PREA Auditor Barbara King. The audit process began with communication between the agency's Director of Contract Compliance/PREA Coordinator and the Auditor in February 21, 2019. The Auditor explained the audit process detailing that compliance is assessed through written policies and procedures, observed practices, and interviews with residents and staff. The audit period is June 1, 2018 through May 31, 2019.

The Audit Posting was sent to the facility by the Auditor on May 16, 2019. The facility acknowledged receiving the audit posting and the postings were placed throughout the facility on May 20, 2019. The photos of the audit postings for verification was provided on May 23, 2019. The Auditor observed the postings during the tour of the facility.

On March 23, 2019, the Auditor received the PREA Pre-Audit Questionnaire and supporting documents on a thumb drive provided by the agency. The thumb drive contained five files: a master folder of supporting documentation for the PREA standards, STTC's average daily population report, corporate resources, floor plan with camera locations, and the GEO mission statement. The master folder contained relevant policies and procedures, the Pre-Audit Questionnaire, and supporting documentation to demonstrate compliance. On June 5, 2019, after the review of the Pre-Audit Questionnaire and documentation, the Auditor emailed the agency and facility requesting further documentation for clarification and review on various standards. Some of this information was provided electronically prior to the audit and the remaining documentation was provided during the on-site audit visit. Prior to the on-site visit, contact was made with the agency's PREA Contract Compliance Manager and the Facility Director to discuss the audit process and set a tentative time schedule for the on-site audit.

The policies utilized for the policy and procedure review and documentation were:

Agency Policies:

- 5.1.2-A Sexually Abusive Behavior Prevention and Intervention Program (PREA) for Adult Prisons and Jail and Community Confinement Facilities
- 5.1.2-E Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection

Facility Policies:

- 0803-1 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
- 0903-1 Searches, Urinalysis, Viewing, and Contraband (PREA)
- 0805-1 Grievances Process
- 1702-1 Intake and Processing
- 0504-1 PREA Staffing and Facility Requirements
- 0503-1 Staff, Volunteer, and Contractor Training
- 1701-1 Resident Orientation and PREA Screening
- 1702-2 Resident Intake and Orientation

TDCJ Policies– the facility abides by:

- TDCJ Safe Prison/PREA Plan
- TDCJ policy PD-29 Sexual Misconduct with Offenders

The Auditor reviewed the PREA Annual Reports for 2015, 2016, 2017, and 2018 plus the PREA information on the GEO Group, Inc. website under the Social Responsibility Section - PREA ([www.geogroup.com](http://www.geogroup.com)) prior to the audit. The agency's website has a page dedicated to PREA. The PREA page provides general information on PREA, the zero-tolerance statement and policy, how to report allegations, employee reporting options, investigation process, investigation policy, PREA policy, Department of Justice PREA Final Standards, GEO's facility certification information, and GEO's Annual Report. The reporting options provided on the website includes calling the Facility Director, the GEO Corporate PREA Coordinator, and email to [www.reportline.com/geogroup](http://www.reportline.com/geogroup). It stated reports can be made by phone, in person, writing, and anonymously.

Also on June 4th, the auditor requested the following information be provided the first day of the audit: daily population report (use June 18th), staff roster to include all departments (include title, shift, and off days), resident roster by housing unit and alpha listing, list of staff who perform risk assessments, list of contractors and volunteers (include times available during audit), list of residents with a PREA classification (who have screened for risk or abusiveness), list of lesbian/gay/bisexual/transgender/intersex (LGBTI) residents, list of PREA allegations in the past 12 months (type of case, victim name, investigation outcome), list of residents that reported sexual abuse, list of disabled and limited English proficient residents, list of the first responders from the reported allegations, and list of how the allegations were reported (i.e. verbal to staff, hotline, grievance). This information would be utilized to establish interviews schedules. The facility provided the requested information the night prior to the on-site audit. This information was utilized for the random selection of residents and staff to be interviewed for random and specialized interviews.

Before the start of the audit, the Auditor met with agency and facility staff. The agency's Contract Compliance Manager opened the entry briefing on the first day of the on-site visit. In attendance were:

- Milton D. Johnson            Facility Director
- Santina Anderson            Assistant Facility Director- Programs
- Danielle Lias                Program Fidelity Specialist
- Verschell Lincoln            Human Resource Manager
- Jennifer Sheahan            GEO Contract Compliance Manager

Brief introductions were made and the detailed schedule for the audit was discussed. The Auditor provided an overview of the on-site audit process and methodology used to demonstrate PREA compliance. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures, but also to ascertain whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour and while on-site, additional onsite documentation provided for review, and conducting both staff and resident interviews. It was established that the Auditor would meet with the Facility Director, Assistant Facility Director, PREA Compliance Manager, the agency's Contract Compliance Manager and any identified staff at the close of each day to review the day's activities and prepare for the next audit day. Key facility staff during the audit included the Facility Director, Assistance Facility Director, PREA Compliance Manager, and GEO's Contract Compliance Manager.

The Auditor utilized the Auditor Compliance Tool, Instructions for the PREA Audit Tour, the Interview Protocols, Process Map, Auditors Summary Report, and the PREA Auditor Handbook for guidance during the audit process. These documents were available through the National PREA Resource Center.

A facility tour was completed after the opening meeting with the key staff. The housing units, detainee sleeping rooms and dorms, bathrooms, program areas, and service areas were toured by the Auditor. All areas of the facility where residents are afforded the opportunity to go or provided services was observed by the Auditor. During the tour, the Auditor made visual observations of the program, service, and housing areas including bathrooms, staff sight lines, and camera locations. The audit notice postings were printed on colored paper and readily available to all residents through the posting in each housing unit, dayrooms, and shared spaces. The Auditor spoke to random staff and residents regarding PREA education and facility practices during the tour. Review of the housing unit logbooks was conducted to verify staff rounds for security staff and supervisors. All facility staff were very cooperative and informative during the audit process.

During the tour, the Auditor identified blind spots in the facility. These areas were the left front corner of classroom 112, left front corner of classroom 110, space behind the records room in maintenance, area behind the supply room/indigent supply in maintenance, building 5 dayroom and bunk area from monitor's desk area, front left and right corners in building 6 laundry room, the left front corner of the prep room in the kitchen. The Auditor recommended that mirrors be added to the areas to enhance visual monitoring of the areas. While on-site the facility corrected the left front corner of classroom 112 by installing a mirror. The space behind the records room and the

area behind the supply room/indigent supply in maintenance was corrected with the installation of fence barriers. The facility ordered seven heavy duty convex security mirrors to install in the other areas.

The residents have accessibility to phones through their own personal cell phones and phones available in the courtyard pavilion. There are four phones for the detainees use. On the phone are stickers providing phone numbers for reporting agencies and emotional support services. The numbers include RAINN National Hotline Network, Houston Police Department Sexual Assault Information Line, Texas Department of Criminal Justice (TDCJ) PREA Ombudsman Office, and TDCJ Agency toll free number. The Auditor tested the phone. The Auditor was able to reach RAINN. The number for the TDCJ agency toll-free number did not work. The phone connection was repaired by the last day of the audit. The Auditor recommended that a staff member be responsible for checking the phones periodic to ensure they are working properly.

All required facility staff and resident interviews were conducted on-site during the three-day audit. The staff and resident interviews were held in the administrative conference room that afforded privacy for the interviews. The Auditor utilized the PREA Auditor Handbook table for resident interviews for determination of interviews to be held at the facility. Resident interviews were based on the resident population size of 251-500 residents; a requirement of at least 26 resident interviews with at least 13 from the target groups and 13 random interviews. Forty (40) formal resident interviews were conducted and eighteen (18) residents were informally interviewed during the facility tours, (12% of the 483-resident population). Residents were selected randomly by the Auditor from each housing unit and from the lists provided for the specialized interviews. Random resident interviews from different housing units (25), Disabled and Limited English Proficient (LEP) (5), LGBTI (6), and Resident Who Reported Sexual Abuse (4). Interviews were not conducted for youthful offenders and Residents Who Disclosed Sexual Victimization. The facility does not house youthful offenders and the facility had no resident currently housed who disclosed sexual victimization during intake. The residents interviewed acknowledged they had been screened during the intake process, education was provided which began at intake, and they knew how to report. Residents also acknowledged the zero tolerance of sexual abuse and sexual harassment, and their right to be free from retaliation for reporting. There were mixed answers from the random residents interviewed regarding feeling safe at the facility. Fourteen of the forty residents interviewed stated they did not feel safe at the facility. Of those fourteen residents, there was no trend to the housing unit or area. It was unclear if these concerns were directly related to sexual safety, the concerns were attributed to facility disruptions caused by residents who may appear under the influence of unknown substances which may be contraband. The residents shared when residents are acting out, they do not know what could happen to them. In those instances, they do not feel safe at the facility. Sixteen of the forty residents interviewed shared that staff are not responsive when incidents occur of any kind. They feel they may be retaliated against for reporting incidents; however, it was unclear if they were concerned about retaliation from staff, residents, or both. This information was shared with the administrative staff, TDCJ Contract Monitor, and GEO's Regional Director.

A total of twenty-nine (29) formal staff interviews were conducted and additional six (6) informal staff interviews were also conducted during the facility tours (43% of the 86 staff who may have contact with residents). Several staff have multiple roles within the facility for PREA functions and these staff members were interviewed for multiple specialized interviews. Staff were randomly selected from the three shifts: security staff (11) and non-security facility staff (3). Additionally, specialized staff interviews conducted were the Facility Director (1), PREA Compliance Manager (1), Administrative/Human Resources (1), Volunteer (1), Contractor (1), Investigator (1), Staff Who Perform Risk Screening (1), Intake staff (1), Incident Review Team (2), Staff Charged with Monitoring Retaliation (1), and First Responder (2). Written interviews of the Agency Director and PREA Coordinator were provided from the agency. An interview was not conducted for the Contract Administrator. The facility does not contract for housing of their residents. Medical and mental health services are provided by outside local community agencies. The staff interviewed acknowledged they have received training and understood the PREA policies and procedures. Most of the staff were knowledgeable in their responsibilities to prevent, detect, report, and response to sexual abuse and sexual harassment. They understood their roles in reporting and responding to all allegations. Six staff members interviewed indicated they would not take a report or report the allegation. The same six staff members that noted they would not report an incident and three random staff during informal interviews attitudes were the residents are just sex offenders, as they stated. The Auditor conducted a telephone interview with a representative from Ben

Taub Hospital after the on-site audit regarding medical treatment including forensic exams conducted by SANE staff.

There were 30 allegations reported of sexual abuse and sexual harassment during the audit period (June 1, 2018 through May 31, 2019). Of the 30 reported allegations; 17 were resident on resident and 13 staff on resident allegations. Eight of the cases were still open at the corporate level at the time of the audit. Of the closed cases, there were 9 staff on resident and 13 resident on resident. The resident on resident allegations were 8 sexual harassment and 5 sexual abuse. The administrative findings of the 5 resident on resident allegations of sexual abuse were 2 unsubstantiated and 3 unfounded. The administrative findings of the resident on resident allegations of sexual harassment were 6 unsubstantiated and 2 unfounded. The staff on resident allegations were 2 sexual harassment and 7 sexual abuse. The administrative findings of the 7 staff on resident allegations of sexual abuse were 3 unsubstantiated and 4 unfounded. The administrative findings of the staff on resident allegations of sexual harassment were 2 unfounded. When an investigation is completed at the local level, the facility must submit to the corporate office for review and a final outcome determination. Of those eight open cases, the facility had completed the administrative investigation and was waiting on the corporate review to close. There were no cases referred for criminal investigation nor referred for prosecution. A review of ten cases was conducted by the Auditor.

The Auditor also reviewed staff personnel records, staff training records, and resident files. The Auditor observed five resident intakes, risk screenings, and classification.

An exit briefing was conducted by the Auditor at the completion of the on-site audit. The following employees were in attendance:

- Milton D. Johnson            Facility Director
- Santina Anderson            Assistant Facility Director- Programs
- Danielle Lias                Program Fidelity Specialist/PREA Compliance Manager
- Verschell Lincoln            Human Resource Manager
- Jennifer Sheahan            GEO Contract Compliance Manager
- Sherrine Deshotel            TDCJ Contract Monitor
- Terry Garcia                 GEO Regional Director

While the Auditor could not give the facility a final finding per standard, the Auditor did provide a preliminary status of the findings. There were six outstanding standards at the end of the site visit; standards 115.217, 115.232, 115.242, 115.251, 115.262, and 115.264.

- 115.217 Hiring and Promotion Decisions: The contractor interviewed on-site was not cleared by TDCJ or the facility by a background check. All contractors and volunteers need to have background checks.
- 115.232 Volunteer and Contractor Training: The contractor interviewed onsite did not have training. Volunteers and contractors need to have training prior to assignment.
- 115.242 Use of Screening Information: Although risk screening is occurring on residents, and the information is being utilized to make appropriate housing placements. The goal of the screening is to keep separate the residents at high risk of being sexually victimized from those at risk of being sexually abusive. This is not occurring at the facility. The common shared areas of the recreation areas and laundry, the residents can mingle without supervision. The facility needs to develop a policy and procedure to keep separate the residents at high risk of being sexually victimized from those at risk of being sexually abusive.
- 115.251(b) Resident Reporting Staff and Agency Reporting Duties: Staff were not aware that third party and anonymous reports are to be accepted. Staff are not accepting reports from the residents. The staff need refresher training on reporting methods and their responsible to accept reports from residents and handle properly.
- 115.262 Agency Protection Duties: Staff were not able to answer how a resident would be protected if at imminent risk. They stated they would interview the resident or just monitor the resident. The staff needs refresher training on their responsibilities when a resident is at imminent risk for sexual abuse.

- 115.264 Staff First Responder: Staff were not able to explain the first responder duties. The staff needs refresher training on the first responder role.

The Auditor made recommendations to the facility administration. The recommendations made were:

- 115.213 Supervision and Monitoring: Unannounced rounds need to be documented consistency by the supervisors in the housing unit logbooks to ensure rounds are being conducted on each shift per policy.
- 115.221 Evidence Protocol and Forensic Medical Examinations: The facility should work to obtain an MOU with Harris Health System.
- 115.271 Criminal and Administrative Agency Investigations: Written investigation reports are not timely being completed after investigation is closed. Written investigation reports need to be promptly finished. The facility should attempt an MOU with Beaumont City Police Department if this agency is to conduct sexual abuse investigations.
- Enhanced visual monitoring – The facility should place mirrors in the kitchen dishwasher area and Dorm E dayroom to provide further visibility for staff.
- The facility should develop a plan for monitoring the shower in building 2, where the shower stall is a L design that does not allow staff supervision or viewing of the back shower. Residents and staff acknowledged that sexual activities occur in this area.
- The video monitors in control are located in an area that does not encourage constant monitoring. If the control center is responsible for monitoring residents, the video monitors should be in an area that is visible for monitoring.

The Auditor suggests the facility continue to expand their written operating procedures. The facility should review the local policies and expand to include detailed procedural direction for staff of the practices outlined and demonstrated throughout the audit. The local policies mirror the corporate policy and standard languages and provides little procedural direction for staff. This will provide staff direction on how to properly handle a situation and provide consistency in staff actions.

The Auditor shared with those in attendance the appreciation of the hospitality received by the facility staff. The Auditor shared with the Facility Director and the agency's administration feedback from the resident population; the residents stated they did not feel safe at the facility, that staff do not take reports from the residents, they felt staff would not be responsive if an allegation was made, and they felt they would be retaliated against by staff for reporting an incident. Also, the Auditor shared the comments made by some selected staff that residents are just sex offenders. With this sentiment of some selected staff, it reinforces the residents' concerns for their safety. The Auditor also shared there was staff that were knowledgeable in their duties and demonstrated professionalism during the audit. The Auditor thanked the Facility Director, Assistant Facility Director, the PREA Compliance Manager, and the staff of Southeast Texas Transitional Center for their work and commitment to the Prison Rape Elimination Act.

The facility provided documentation on July 31, 2019 for compliance review. The information is noted with each standard below:

- For 115.217 Hiring and Promotion Decisions, the facility provided an email chain regarding the background checks for volunteers and contractors on the process from TDCJ. Examples of background checks were provided for compliance review. The facility also provided an updated list of volunteers and contractors with five individuals not cleared for entry; they are waiting on verifications. After a careful review of all documentation and the information received from the facility, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.
- For 115.232 Volunteer and Contractor Training, the facility provided sixteen volunteer and contractor's training records documenting PREA training completed in July 2019. The Prison Rape Elimination Act Basic Training Acknowledgement Forms for the volunteers and contractors was provided for compliance review. After a careful review of all documentation and the information received from the facility, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

- For 115.242 Use of Screening Information, the facility provided an amended shift schedule for first and second shifts to assign a security monitor to a grounds rover post to supervise the common areas. After a careful review of all documentation and the information received from the facility, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.
- For 115.251(b) Resident Reporting Staff and Agency Reporting Duties, 115.262 Agency Protection Duties, and 115.264 Staff First Responder, the facility provided staff training records for compliance review. Training was conducted on resident reporting; staff and agency reporting duties; agency protection duties; and staff first responders. Training occurred during the end of June and the beginning of July. It was documented through the PREA Refresher Training Form containing staff signatures of all staff, with the date and time of training. After a careful review of all documentation and the information received from the facility, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

No further action was necessary for compliance. The agency met compliance; a corrective action period was not initiated or warranted.

The auditor based the decision of standard compliance on: data gathering; review of documentation; observations during the tour of the facility; interviews with staff and residents; file reviews of investigations, staff personnel and training files, and resident files; and the facility's policy and practices.

The initial forty-five days from the day of the onsite audit for the final report was extended upon mutual agreement between the agency and the Auditor, based on the Auditors request. The Auditor had unforeseen circumstances during this time period.

## Facility Characteristics

The Southeast Texas Transitional Center is located in Houston, Texas. It is a residential, community treatment and release program that contracts with the Texas Department of Corrections (TDCJ) to house male residents released on parole or mandatory supervision and provide services to assist residents as transitioning from confinement to a parole approved home plan. The facility's primary focus is the transition of the resident from an institutional setting to an independent living in the community. The majority of the resident population is sex offenders, noted by the facility about 80% of the population and also noted, there is a high percentage residents with mental illness. The TDCJ Reentry Division conducts classes and assists with reentry leads. The residents are of minimum custody. The average length of the residential stay is 55 days. The design capacity is 500. The first day of the on-site audit, the population was 483.

The facility is a campus style facility with buildings scattered on the grounds around the open courtyard including two recreation areas. The facility consists of eight buildings to include five resident housing units, an administrative building, a storage building, and the maintenance shop/warehouse building. The administrative building contains central control, classrooms, parole office, medication room, and administrative offices. Three of the housing units are open dorms and the other two contain multiple occupancy rooms

Each housing unit is an individual unit that operates independently, allowing security monitors to interact directly and with smaller groups of residents. Each of the housing units have cameras and mirrors for enhanced monitoring. There is a sign at the entrance of each housing unit that states, "Female staff must announce their presence upon entering." Each of the housing unit has at least one staff, and when possible, two staff for supervision. There is a bulletin board in each unit that contains the PREA Reporting Options poster, Sexual Assault and Awareness pamphlet, No Means No poster, grievance procedures for sexual abuse and emergency grievances, the Audit Notice, and a notice that the payphones are not monitored. There is a grievance box available for the submittal of grievances. All residents are required to change their clothes in the bathrooms. The bathrooms provide privacy for changing clothes, showering, and bodily functions. There are shower curtains and doors that provide privacy.

Building 2 is a two-story building that contains program area, case management offices, the kitchen, and dining room. This dorm houses residents not on an at-risk log and work in the kitchen area. On the first level is the kitchen and dining room; other than dining, this area is also utilized for programming. On the second floor is the case management offices, located by a staircase from the dining room. At the other end of the second floor is a dorm. The dorm and case management offices are not connected. Residents enter the housing unit through an outside stairway. The housing unit has a bathroom area that provides privacy for showering, bodily functions, and changing clothes. The bathroom area has a L design shower with a blind area in the back-shower area. The Auditor made a recommendation the facility should develop a plan for monitoring the back shower that does not allow staff supervision or viewing of the back shower. Residents and staff acknowledged that sexual activities occur in this area. The dorm is monitored through in-direct supervision. A security monitor, that is shared with building 4, makes rounds into the dorm hourly.

Building 5 is a two-story building with a dorm and bathroom area located on each floor. This housing unit houses residents that identified both at risk for being victimized and at risk of being an abuser. A laundry room is located on the first floor. The bathroom area has a partial door into the bathroom. The showers have individual stalls with shower curtains, as well as, the toilets. The staff monitoring station is located on the first floor and staff is required to make rounds hourly through the building. The housing unit also contains case managers offices. The dayroom is a blind area from the monitor's station. The auditor suggested a mirror placed on the wall between the dorm and the dayroom to eliminate the blind spot and allow visibility into each area.

Building 3 is a two-story housing unit with a linear design. The unit houses the at risk of being abuser residents. The building has a hallway the length of the building with two-person occupancy rooms on each floor and a bathroom area. There is a dayroom on the first floor next to the monitoring station. The bathroom contains three sinks, three toilets, and one shower area. The toilets are within stalls and the multiply occupancy shower with three 3 shower heads has a curtain. Building monitors are required to make rounds hourly through the building.

Building 4 is a two-story building with 7 dorms and a bathroom area on both floors. The unit houses honor residents. The bathroom area contains three sinks, three toilets, and one shower area. The toilets are within stalls and the multiply occupancy shower with three 3 shower heads has a curtain. Building monitors are required to make rounds hourly through the building.

Building 6 is a large dorm with bathroom areas on each end of the building and a dayroom. The unit houses the at risk of victimization residents. The dorm has partial walls throughout the dorm providing a sense of smaller separate housing areas for residents. A raised staff monitoring station is located in the center of the dorm and near the entrance. The monitors are required to make rounds hourly through the building. The bathroom areas are located on each end of the unit. There are three separate areas; one area with sinks, one area with toilets, and the third area has showers. Each area has doors or privacy. The shower areas are a multi-occupancy shower with ten shower heads. The laundry room is connected to the building which has an observation window into the laundry room but no entrance. Entrance to the laundry room is an exterior door from the courtyard. The housing unit always contains case management offices.

The storage building was the record storage area. The records have been moved to a climate control section within the maintenance building. The storage building is used for general storage and not accessible to the residents. The maintenance building is only accessible to residents under staff supervision. There were two blind areas identified in the maintenance area; a space behind the records room in maintenance and the area behind the supply room/indigent supply area. The space behind the records room and the area behind the supply room/indigent supply in maintenance was corrected with the installation of fence barriers.

The kitchen operates on three shifts with 2-3 staff per shift. The kitchen was an open design with no blind area. The prep room had a blind spot in the left corner. The Auditor suggested a mirror to eliminate the blind spot. The dining room is an open area. There is a restroom off the dining room that is locked. The residents working in the area are under direct supervision.

The Central Control monitors and coordinates the security, life safety, and communications for the facility. It is staffed 24 hours a day, 7 days a week. The area is staffed with a Captain or Lieutenant, a front gate monitor, and a utility monitor. This is the entry and exit post for the residents. The residents must go through a metal detector and a pat down each time upon entering the facility. The control center has two monitors with one having sixteen screen views and the other nine screen views. The facility cameras are monitored in the control center. The video monitors are located in an area that does not encourage constant monitoring. If the control center is responsible for monitoring residents, the Auditor suggested that the video monitors should be in an area that is visible for monitoring.

The facility operates with three eight-hour shifts: 6:00 am to 2:00 pm, 2:00 pm to 10:00 pm, and 10:00 pm to 6:00 am. Each shift has a minimum of a shift supervisor and a resident monitor assigned to each housing unit. The resident monitors are the primary security staff members. There is always a male staff resident monitor on shift. The facility has a required staff ratio by contract with the TDCJ. The ratio is 1 staff to 60 residents from 6:00 am to 10:00 pm. From 10:00 pm to 6:00 am, the ratio is 1 to 100. The resident monitors make hourly rounds in each housing unit. The security department is also supported through an Assistant Director of Operations/Security, Shift Supervisors, and Assistant Shift Supervisors.

The facility does not have medical or mental health services on site. Several staff members are trained to do health screenings which are conducted upon arrival to the facility. All staff are trained in CPR, first aid, and AED usage. Residents in need of medical treatment can make appointments with local doctors and utilize the hospital's emergency room. If there is a medical emergency, 911 would be called. The resident would be transported by the EMS with staff escort. This was witnessed by the Auditor during the audit. Non-emergency incidents may be transferred by facility staff. The primary hospital is Harris Health Center. The facility has attempted to obtain a cooperative agreement with hospital on various occasions as documented through emails. The facility has a MOU with Montrose Center. The MOU states the Montrose Center will provide trained specialist to help identify and prioritize the needs of the victim, and connect them with helpful resources; provide information informing the victim of their rights under the law, and referrals for legal consultation and representation when ready; provide the victim with a support advocate to accompany them during medical exams, legal and or court appointments; and provide confidential emotional support services related to sexual abuse consistent with those that are provided to the community. The MOU was executed November 2018. The residents may also be referred to an outside local agency for services through a Victim Advocate Referral Form.

The facility utilizes a video surveillance system with sixty-seven (67) cameras for twenty-four monitoring of housing areas, the interior of the kitchen, the dining room, the administration building (including the control room, parole office, classrooms), the grounds, and the maintenance shop. The surveillance system stores the surveillance video for thirty days, allowing supervisory staff the ability to obtain evidence in the event of an allegation. The surveillance system provides supervisors and monitoring staff with real time views of the camera footage, enabling the staff to respond to any unusual activities. The operations managers are to conduct daily reviews of the surveillance video, at random shift and times, in order to identify any problems with staff and/or residents conduct and to maintain the integrity of the security rounds/counts. Two of the cameras located in central control and the parole office have audio capability. A camera project that includes updating eight monitors, installing 18 dome cameras, installing two hard drives, and a 16 channel DVR is in progress. The Auditor reviewed the camera monitors in the control center; there were no cross-gender viewing through the facility cameras.

All residents are expected to work that are not in programming. Case Managers provide employment services and assist residents in finding employment.

## Summary of Audit Findings

The PREA Audit of the Southeast Texas Transitional Center found forty-one (41) standards in compliance with six (6) of those standards exceeding the requirement of the standard. These standards are: 115.211 Zero Tolerance of Sexual Abuse and Sexual Harassment; PREA Coordinator; 115.217 Hiring and Promotion Decisions, 115.231 Employee Training; 115.233 Resident Training; 115.267 Agency Protection Against Retaliation, and 115.273 Reporting to Residents. An explanation of the findings related to each standard showing policies, practice, observations, and interviews are provided under each standard in this report.

**Number of Exceeds Standards: 6**

115.211 Zero Tolerance of Sexual Abuse and Sexual Harassment; PREA Coordinator  
115.217 Hiring and Promotion Decisions  
115.231 Employee Training  
115.233 Resident Training  
115.267 Agency Protection Against Retaliation  
115.273 Reporting to Residents

**Number of Standards Met: 35**

115.212 Contracting with other Entities for the Confinement of Inmates  
115.213 Supervision and Monitoring  
115.215 Limits to Cross-Gender Viewing and Searches  
115.216 Residents with Disabilities and Inmates Who Are Limited English Proficient  
115.218 Upgrades to Facilities and Technologies  
115.221 Evidence Protocols and Forensic Medical Examinations  
115.222 Policies to Ensure Referrals of Allegations for Investigations  
115.232 Volunteer and Contractor Training  
115.234 Specialized Training: Investigations  
115.235 Specialized Training: Medical and Mental Health Care  
115.241 Screening for Risk of Victimization and Abusiveness  
115.242 Use of Screening Information  
115.251 Resident Reporting  
115.252 Exhaustion of Administrative Remedies  
115.253 Resident Access to Outside Confidential Support Services  
115.254 Third-Party Reporting  
115.261 Staff and Agency Reporting Duties  
115.262 Protective Duties  
115.263 Reporting to Other Confinement Facilities  
115.264 Staff First Responder Duties  
115.265 Coordinated Response  
115.266 Protection of Ability to Protect Residents from Contact with Abusers  
115.271 Criminal and Administrative Agency Investigations  
115.272 Evidentiary Standards for Administrative Investigations  
115.276 Disciplinary Sanctions for Staff  
115.277 Corrective Action for Contractors and Volunteers  
115.278 Disciplinary Sanctions for Residents  
115.282 Access to Emergency Medical and Mental Health Services  
115.283 Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers  
115.286 Sexual Abuse Incident Reviews  
115.287 Data Collection

115.288 Data Review for Corrective Action  
115.289 Data Storage, Publication, and Destruction  
115.401 Frequency and Scope of Audits  
115.403 Audit Contents and Findings

**Number of Standards Not Met: 0**

### **Summary of Corrective Action (if any)**

There were six outstanding standards at the end of the site visit; standards 115.217, 115.232, 115.242, 115.251, 115.262, and 115.264. The facility provided documentation on July 31, 2019 for compliance review. The information is noted with each standard below:

- 115.217 Hiring and Promotion Decisions: The contractor interviewed on-site was not cleared by TDCJ or the facility by a background check. All contractors and volunteers need to have background checks. The facility provided an email chain regarding the background checks for volunteers and contractors on the process from TDCJ. Examples of background checks were provided for compliance review. The facility also provided an updated list of volunteers and contractors with five individuals not cleared for entry; they are waiting on verifications.
- 115.232 Volunteer and Contractor Training: The contractor interviewed onsite did not have training. Volunteers and contractors need to have training prior to assignment. The facility provided sixteen volunteer and contractor's training records documenting PREA training completed in July 2019. The Prison Rape Elimination Act Basic Training Acknowledgement Forms for the volunteers and contractors was provided for compliance review. After a careful review of all documentation and the information received from the facility, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.
- 115.242 Use of Screening Information: Although risk screening is occurring on residents, and the information is being utilized to make appropriate housing placements. The goal of the screening is to keep separate the residents at high risk of being sexually victimized from those at risk of being sexually abusive. This is not occurring at the facility. The common shared areas of the recreation areas and laundry, the residents can mingle without supervision. The facility needs to develop a policy and procedure to keep separate the residents at high risk of being sexually victimized from those at risk of being sexually abusive. The facility provided an amended shift schedule for first and second shifts to assign a security monitor to a grounds rover post to supervise the common areas.
- 115.251(b) Resident Reporting Staff and Agency Reporting Duties: Staff were not aware that third party and anonymous reports are to be accepted. Staff are not accepting reports from the residents. The staff need refresher training on reporting methods and their responsible to accept reports from residents and handle properly. Standard 115.262 Agency Protection Duties: Staff were not able to answer how a resident would be protected if at imminent risk. They stated they would interview the resident or just monitor the resident. The staff needs refresher training on their responsibilities when a resident is at imminent risk for sexual abuse. Standard 115.264 Staff First Responder: Staff were not able to explain the first responder duties. The staff needs refresher training on the first responder role. For 115.251(b) Resident Reporting Staff and Agency Reporting Duties, 115.262 Agency Protection Duties, and 115.264 Staff First Responder, the facility provided staff training records for compliance review. Training was conducted on resident reporting; staff and agency reporting duties; agency protection duties; and staff first responders. Training occurred during the end of June and the beginning of July. It was documented through the PREA Refresher Training Form containing staff signatures of all staff, with the date and time of training.

After a careful review of all documentation and the information received from the facility, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions. No further action was necessary for compliance. The agency met compliance; a corrective action period was not initiated or warranted.

## PREVENTION PLANNING

### Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

#### 115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?  Yes  No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?  Yes  No

#### 115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator?  Yes  No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy?  Yes  No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?  
 Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency policy 5.1.2-A Sexually Abusive Behavior Prevention and Intervention Program (PREA) for Adult Prisons and Jail and Community Confinement Facilities and the facility policies 0803-1 Sexually Abusive Behavior Prevention and Intervention Program (PREA) and 0504-1 PREA Staffing and Facility Operations mandates zero tolerance towards all forms of sexual abuse and sexual harassment. The policies outline the agency's and facility's approach to preventing, detecting, reporting, and responding to sexual abuse and harassment. The policy provides definitions of sexual abuse and general PREA definitions. Through observation of the Resident Reporting Options poster, Resident Handbook, PREA Educational Manual for Residents, and Sexual Assault Awareness Program pamphlet posted throughout the facility; the facility is providing information to the residents on zero tolerance. Staff are informed through training and policies. Each staff member also carries an informational card, PREA Staff Responsibility Card, that outlines staff responsibilities, zero tolerance, and the first responder requirements. The zero-tolerance policy is publicly posted on the agency's website.

The facility exceeds the standard with the staff of GEO and TDCJ who are responsible to oversee the sexual abuse prevention and intervention policies, procedures, and practices. GEO employs a corporate level PREA Director/PREA Coordinator that oversees the company's PREA compliance throughout all agency facilities. Under the agency's PREA Coordinator supervision are Regional PREA Coordinators for the East, West, and Central regions. Their roles vary from conducting mock audits, assisting facilities with technical assistance, and assisting the agency PREA Coordinator with various other PREA related tasks upon request. The corporate PREA office also contains one PREA Senior Contract Compliance Manager, two PREA Contract Compliance Managers, and one Data Specialist. The Data Specialist is responsible for collecting and analyzing PREA data and preparing required reports.

At the facility level, the PREA Compliance Manager (also the facility's Program Fidelity Specialist) is responsible to oversee that policies and procedures relative to the PREA and facility operations to ensure facility compliance. The position reports directly to Facility Director. The PREA Compliance Manager stated she coordinates the facility's efforts by providing PREA training for new hires and in-service for all staff, conducts orientation training with residents, reviews all of the risk assessments to ensure consistency and accuracy, maintains the At-Risk Logs, maintains the Reassessment Log, conducts investigations, and monitors retaliation. She conducts rounds throughout the facility to ensure compliance with PREA and that posters are readily accessible in each unit. If an issue is identified, she informs the Assistant Facility Director and the Facility Director. A corrective action plan would be developed. The PREA Compliance Manager is responsible for following up to ensure the correction is made. She stated she hosted two PREA sessions with residents this audit year to review PREA information. These PREA sessions are conducted every six months. During the interview with the PREA Compliance Manager, she was knowledgeable of the facility's PREA policies and procedures and her responsibilities for coordinating the facility's efforts to comply with the PREA standards. She indicated she had sufficient time and authority to manage the facility's PREA responsibilities.

The TDCJ Contract Monitor's office is on site at the facility. During an interview with the TDCJ Contract Monitor, she stated monitors for PREA compliance by conducting walk throughs of the facility, ensure posting of PREA information, talking to staff and residents, and monitoring for PREA issues and practices. The Contract Monitor conducts quarterly reviews for contract compliance. TDCJ also conducts an annual facility PREA review; a PREA audit through worksheets. If an area is determined non-compliant, the facility has twenty days to complete compliance; or a financial sanction is issued.

Through observations within the facility; review of the Resident Reporting Options poster, Resident Handbook, PREA Educational Manual for Residents, and Sexual Assault Awareness Program pamphlet; and staff and resident interviews it was determined the agency and facility are committed to zero tolerance of sexual abuse and sexual harassment. The Auditor determined compliance through the interview with the PREA Compliance Manager, review of agency and facility's policies, facility organizational chart indicating the PREA Compliance Manager's position, and the GEO's organizational chart for the corporate PREA Department.

## **Standard 115.212: Contracting with other entities for the confinement of residents**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.212 (a)**

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)  Yes  No  NA

### 115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".)  Yes  No  NA

### 115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)  Yes  No  NA
- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)  Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency/facility does not contract for the confinement of residents with private agencies or other entities, including other government agencies. This was confirmed through interviews with the agency's PREA Coordinator and the Facility Director.

### Standard 115.213: Supervision and monitoring

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No

#### 115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)  
 Yes  No  NA

#### 115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

**Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility's policy 0504-1 outlines the requirement of a staffing plan. The facility has developed a staffing plan that is based on the four criteria of this standard to include the physical layout of each facility; the composition of resident population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. The written staffing plan is part of the TDCJ contract stated the Facility Director. The facility's design capacity is 500 residents and the staffing plan is based on the full facility capacity of 500. The population during the audit was 483 residents and the average population for the last 12 months was 488. A review of the PAQ indicated the facility's staffing level is 86 staff that may have recurring contact with residents; with 53 positions being security.

The facility operates with three eight-hour shifts: 6:00 am to 2:00 pm, 2:00 pm to 10:00 pm, and 10:00 pm to 6:00 am. Each shift has a minimum of a shift supervisor and a resident monitor assigned to each housing unit. The resident monitors are the primary security staff members. There are always male resident monitors on shift. The facility has a required staff ratio by contract with the TDCJ. The ratio is 1 staff to 60 residents from 6:00 am to 10:00 pm and from 10:00 pm to 6:00 am, the ratio is 1 to 100. The Facility Director stated the staff ratio has always been met through overtime when needed and currently the facility staffing level exceeds the number required through the staffing plan. The resident monitors make hourly rounds in each housing unit. The security department is also supported through an Assistant Director of Operations/Security, Shift Supervisors, and Assistant Shift Supervisors. The facility has a Case Management Supervisor and case managers. They are also trained and understand the security requirements of the facility. Sufficient supervision of residents was observed through on-site observations of security and case managers supervising and interacting with residents. The Auditor reviewed the monthly shift roster for all shifts and determined the facility is ensuring staffing levels are being maintained in accordance with the standard. Hourly rounds are being conducted in each housing unit.

The facility management and mid-level supervisors are to conduct and document unannounced rounds. By policy 0504-1, unannounced rounds will be conducted in a staggered method, as to be unpredictable and unexpected by front-line staff and/or residents. The facility management and mid-level supervisors are to document unannounced rounds a minimum of once a month for each shift using the PREA Unannounced Supervisor Rounds Form. The Auditor reviewed the PREA Unannounced Supervisor Rounds forms to review for compliance which was met. Rounds are also documented on the Daily Shift Supervisor Unannounced Walk-through form which is a checklist of duties to be accomplished including inspection of all housing areas and facility grounds.

The Facility Director indicated that all posts are filled daily and there have been no deviations. If there is a staff shortage, coverage is provided through overtime and coverage by administration staff. All overtime is documented. If there are deviations, the Facility Director documents the deviation with the justification for the deviation. The facility will be sanctioned through the TDCJ contract if a position is vacant over 60 days. The facility currently has 16 positions vacant with 12 of them in security. The Facility Director stated the facility hires an average of 4-5 new employees a month. He noted that staffing is a challenge for the facility. Video cameras operate 24 hours a day, 7 days a week and are monitored through facility administration and the control center. The operations managers are to conduct daily reviews of the surveillance video, at random shift and times, in order to identify any problems with staff and/or residents conduct and to maintain the integrity of the security rounds/counts.

The staffing plan, PREA Facility Assessment, was developed by the leadership of the facility including the Facility Director, Assistant Facility Administrator, PREA Compliance Manager, Assistant Director of Security, and input from other staff as needed. The Facility Director stated the staffing level is also dictated by the contract with TDCJ which outlines the staffing level requirement through ratios which is considered during the staffing plan development. The last Annual PREA Facility Assessment was completed on August 15, 2018 and approved by the agency PREA Coordinator on August 17, 2018. The previous PREA Facility Assessments were completed on June 16, 2017 and October 4, 2016, with both approved through the agency's PREA Coordinator. The facility's annual assessment must be submitted to the agency's PREA Coordinator for review annually as determined by each division. The written staffing plan is maintained at the facility with access to all administrative staff; a copy of the approved staffing plan is also maintained by the agency. The Facility Director stated the physical plant of the facility is reviewed and

the facility attempts to have additional utility post monitors to provide more rounds in buildings 3 (residents at risk of being an abuser) and 6 (residents at risk of victimization). When reviewing the composition of the resident population consideration is given to separation and safety of the residents, the majority of the residents are convicted sex offenders with a minimum-security level. The team reviews the prevalence of substantiated and unsubstantiated allegations; the team has found the dorms have more allegations. And other relevant factors are considered with one being the transgender population. They are housed in general population with assigned bunks near the monitor's desk and in full view of cameras.

The facility's Assistant Director of Security reviews staffing daily to ensure mandatory posts are covered and the monitoring of post coverage stated the Facility Administrator. The TDCJ Contract Monitor also reviews the staffing plan and coverage for compliance with the contract ratios. The Facility Director also stated reviews include that security checks are occurring and documented, and documentation of unannounced rounds are occurring at different times and different shifts are reviewed. Through reviews of round logs, it documented that security rounds were completed hourly on each shift. Through interviews with staff and residents, it was confirmed that unannounced rounds are done randomly throughout the facility.

The agency's policy 5.1.2-A and facility policy 0504-1 states employees are prohibited from alerting other employees that supervisory rounds are occurring, unless such announcement is related to the legitimate operational function of the facility. This policy is covered with staff during training.

**Recommendation:** Unannounced rounds need to be documented consistency by the supervisors in the housing unit logbooks to ensure rounds are being conducted on each shift per policy.

## Standard 115.215: Limits to cross-gender viewing and searches

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?  
 Yes  No

#### 115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)  
 Yes  No  NA
- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents)  Yes  No  NA

#### 115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?  Yes  No  NA

- Does the facility document all cross-gender pat-down searches of female residents?  
 Yes  No  NA

#### 115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?  Yes  No
- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?  Yes  No

#### 115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?  Yes  No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?  
 Yes  No

#### 115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?  Yes  No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and the facility's policy 0903-1 Searches, Urinalysis, Viewing, and Contraband address resident pat-searches, strip searches, body cavity searches, and the limits to cross-gender viewing and searches.

The facility only houses male residents. The agency and facility policies prohibit strip searches except in exigent circumstances. The facility only allows pat-searches if staff believe a resident is attempting to introduce contraband to the facility and for residents returning to the facility from work, job search, or other locations outside the facility. All cross-gender pat-searches are prohibited. A staff member of the same gender will conduct the pat-search. The pat-search is to be documented on the pat-search log. Resident strip and body cavity searches are prohibited per policy and memo to file from the Facility Director. If the need occurred, the Facility Director would request authorization to remove the resident from the program when there is a reasonable suspicion that the resident is in possession of contraband and/or prohibited property and refusing to voluntarily surrender the item(s). There was no cross-gender strip searches, visual body cavity searches, or pat-down searches conducted or logged for exigent situations during the audit period. This was verified through the review of the agency's and facility's policy and procedures and interviews with staff and residents.

The policies and practice allow all residents the opportunity to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing them. Each unit has a bathroom area that have showers and toilets with privacy doors or privacy curtains. All residents are required to change their clothes in the bathroom area to ensure privacy from viewing by staff and cameras in the dorms. The opposite gender staff can't enter a bathroom area until announced and gain verbal assurance from the resident that they are fully clothed. If an opposite gender viewing occurred, the staff member must complete a written incident report describing the incident immediately and forward to the Facility Director. The incident report has to be completed by the end of the shift. This was confirmed by interviews with residents and staff. Residents felt they received a sense of privacy for these functions. Staff is also required to conduct cross-gender announcements upon entering a dorm. There is a sign at the entrance of each housing unit that states, "Female staff must announce their presence upon entering." Female staff indicated they announce female in the unit/on the floor prior to entering the unit and bathroom area. This was observed during the audit. Residents indicated in their interviews that staff announce when arriving on the floor and again announce prior to entering the bathroom area.

The agency's policy 5.1.2-A and the facility's policy 0903-1 prohibit staff from searching or physically examining transgender and intersex residents for the purpose of determining genitalia status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, by consulting the referring agency, and/or if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Interviews with staff confirmed these practices, as well as, the review of the policy and training lesson plans reinforcing these policies during the annual training. Three transgender residents were interviewed, all of them stated they were not searched for the sole purpose of determining their genital status. One resident expanded to share that the facility can not do that.

The agency's policy 5.1.2-A and facility's policy 0903-1 states that staff shall be trained in conducting pat-down searches, cross-gender pat-down searches, and searches of transgender and intersex residents in a professional and respectful manner. Other than annual training, this training is also part of the initial pre-service training and covered in shift briefings. Interviews with staff confirmed these practices, as well as, the review of the training lesson plans reinforcing these policies in the annual training, and review of staff training records. The facility utilizes the lesson plan Prison Rape Elimination Act (PREA) In-Service for providing training on searches. Training records indicated that all staff had completed the training. When staff were randomly asked how a transgender pat-down search would be completed, they indicated the transgender/intersex resident could request the gender of the staff they are most comfortable with to conduct the pat-down search, including medical staff and female staff. Staff stated or demonstrated the pat-down would be conducted using the back or blade of the hand. This search would be documented on the Statement of Search Preference Form.

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

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.216 (a)**

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)  Yes  No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?  Yes  No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?  Yes  No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?  Yes  No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?  Yes  No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision?  Yes  No

### 115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?  Yes  No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?  Yes  No

### 115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility's policy 1702-1 Intake and Orientation has established procedures to provide disabled residents equal opportunity to participate in and benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. PREA information is available in English and Spanish through the PREA Educational Manual for Residents, Resident Reporting Options poster, and Sexual Assault Awareness Program Pamphlet. At the time of the audit, the PREA What You Need to Know video was only available in English. During the audit, the facility received videos in Spanish and closed-captioned. A language line and designated staff interpreters are available for the translation of any other languages. The agency has a contract with Language Line Services for all GEO facilities and programs. Information is made available to staff who are responsible for conducting the PREA risk screening and supervisory level staff. Supervisors and case management staff are trained on the use of the interpreting services during pre-service, in-service training, and regular scheduled staff/department meetings. The facility is also provided with a Quick Reference Guide by Language Line Services to assist. The agency's PREA Divisional Coordinator maintains records of the language line service contracts and daily in information as a backup to the facility.

A telecommunication device (TTD) is available for hearing impaired residents, as well as, written materials. A resident that is deaf is provided the information through staff reading the information and may listen to the video. The video is close captioned providing residents that can read access to the PREA information. For residents with visual impairments, the PREA Educational Manual for Residents are available in large print in both languages, the

audible narrative of the video, and staff would read the information, if necessary. If a resident is cognitively or intellectually disabled, staff will verbally present PREA materials at a level the resident can understand. Extra time is spent by staff to ensure the resident understands the basics to include definitions and reporting information. The Agency Head's interview, agency's policy, and the facility's policy state the agency does not use residents as interpreters, readers of other types of resident assistants. The Agency Head indicated the agency/facility would also reach out to community-based resources (i.e. local colleges or organizations) that might be willing to assist. The Auditor interviewed five residents that were disabled and limited English proficient (LEP). The blind resident stated a staff member read the information to him. He has been housed about two years and staff are responsive when he needs assistance. Three residents were interviewed that could not read. They indicated that staff read the information to them and they watched a video. They indicated that case managers will assist them if needed. The LEP resident was interviewed through an interpreter. The resident stated he was given the information in English; however, the case manager translated and explained the information to him in Spanish. All the residents knew how to report; and all indicated they would tell a staff member.

The agency and facility policies state individuals in a GEO facility or program shall not be relied on as readers, or other type of assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the individual's safety, the performance of first responders duties, or the investigation of the individual's allegations. Any use of these interpreters under these type of circumstances shall be justified and fully documented in the written investigative report. The facility documented through the Facility's Director's memo that there were no occurrences requiring the use of the resident interpreters, readers, or assistants during the audit period.

## Standard 115.217: Hiring and promotion decisions

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?  Yes  No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?  Yes  No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?  Yes  No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in

the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?  Yes  No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above?  Yes  No

#### 115.217 (b)

- Does the agency consider 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?  Yes  No

#### 115.217 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check?  Yes  No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?  Yes  No

#### 115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?  Yes  No

#### 115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?  Yes  No

#### 115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?  Yes  No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?  Yes  No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?  Yes  No

### 115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?  Yes  No

### 115.217 (h)

- Unless prohibited by law, does the agency 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 such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)  Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Through review of the agency's policy 5.1.2-A and facility's policy 0504-1 PREA Staffing and Facility Requirements, it was determined that the facility has established a system for conducting criminal background checks for new employees, contractors, and volunteers who have contact with residents to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The job application form requires the employee to answer the administrative adjudication questions of: have not engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution and have not been civilly or administratively adjudicated or convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to refuse. The agency's employment application was updated in March 2018 with the three questions. These application forms are utilized for new hires and promotions. The Human Resources staff interviewed indicated this information is checked on all written applications, performance evaluations, and a form utilized for all promotions; PREA Disclosure and Authorization Form Promotions – PREA Related Positions. Forty-eight new employees were hired during this audit year, almost half of the staff. The background checks were completed on all the individuals. The Auditor reviewed eleven employee records. Six files were current employees, four of the employees were new hires, and one was a promoted employee. All the files had the administrative adjudication checks either through applications, the promotional form, and/or through performance evaluations. The type of documentation depended on when the employee was hired. The Human Resource staff interviewed stated personal records of employees with names starting with S through Z were destroyed during the hurricane Harvey in 2017.

The agency's policy 5.1.2-A requires a background investigation and criminal background record check for all new hires to ensure the candidate is suitable for hiring. The Human Resource staff interviewed indicated the facility utilizes a third-party company, Career Builder, for initial background checks and if background checks were completed every five years. Background checks are also conducted through TDCJ prior to an employee, contractor, and/or volunteer being approved for hire or a volunteer approved to provide services. TDCJ utilizes the TDCJ Employment Section-Clearance Area form for employees and the Non-Employee Background Questionnaire for

contractors and volunteers. The facility is notified by TDCJ when the background check is cleared and receive notification of approval for hiring, stated the Human Resource staff interview. The Auditor randomly selected eleven employee files to review for the criminal background checks prior to hiring; all were completed prior to the hiring date. The Auditor interviewed a contractor and then requested his personal file, the contractor had not been cleared by TDCJ with a background check. He was not on the approved contractor list. The facility has not completed five-year background checks on employees; they utilize a flash alert through TDCJ stated the Human Resource staff. This system captures information if any employee, contract, or volunteer is arrested. The facility receives a notification from TDCJ Contract Monitor when a flash alert is received that an individual has been arrested. The facility will place the individual on administrative leave during the investigation stated the Human Resource staff.

Employees also have a continuing affirmative duty to report. The requirement is to report immediately to the Facility Director who informs the agency and TDCJ. The continuing affirmative duty to report is also accomplished annually during the annual performance review of employees. They must complete an acknowledgement form containing the questions prior to the completion of the evaluation. The Auditor randomly selected eleven employee files to review for the three administrative adjudication questions on the application form as part of the hiring process paperwork, the background check prior to hiring, and the affirmative duty to disclose as part of the annual performance review. The employee files were compliant.

The employment application contains a statement indicating the applicant agrees not to falsify or omit information. If the applicant does falsify or omit information, employment can be denied, or the person will be subject to immediate termination. During the review of the employee personnel files, the wording was verified on the employee application forms. The policy 5.1.2-A also states and supports the practice.

The agency policy 5.1.2-A states the facility shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work, unless prohibited by law. The Human Resource staff interviewed stated all information requests, internal and external, are referred to corporate who provides the information. The agency's Human Resources Section will contact prior institutional employers to obtain information on substantiated allegations of sexual abuse or any resignation during an investigation. If contacted by an outside employer, the staff must sign a release of information prior to the agency disclosing information to the requesting employer.

The contractor interviewed on-site was not cleared by TDCJ or the facility by a background check. All contractors and volunteers need to have background checks. The facility took corrective action and reviewed the volunteer and background checks. The facility provided an email chain regarding the background checks for volunteers and contractors on the process from TDCJ. Examples of background checks were provided for compliance review. The facility also provided an updated list of volunteers and contractors with five individuals not cleared for entry; they are waiting on verifications to verify the process. The additional document demonstrated compliance. No additional action was necessary.

## Standard 115.218: Upgrades to facilities and technologies

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)  
 Yes    No    NA

### 115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)  
 Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility's policy 0504-1 indicates the facility shall will take into effect any design planning, modifications or expansions to protect residents from sexual abuse. The facility has not made a substantial expansion or modification to the existing buildings. The facility has not had any facility expansion or modifications or installing or updating a video monitoring system per memo to file and interview with the Facility Director. The Facility Director did state the facility was flooded during Hurricane Harvey in 2016. The facility had repairs to buildings and purchased new bunks and lockers.

The facility utilizes a video surveillance system with sixty-seven (67) cameras for twenty-four monitoring of housing areas, the interior of the kitchen, the dining room, the administration building (including the control room, parole office, classrooms), the grounds, and the maintenance shop. The surveillance system stores the surveillance video for thirty days, allowing supervisory staff the ability to obtain evidence in the event of an allegation. The surveillance system provides supervisors and monitoring staff with real time views of the camera footage, enabling the staff to respond to any unusual activities. Two of the cameras located in central control and the parole office have audio capability. A camera project that includes updating eight monitors, installing 18 dome cameras, installing two hard drives, and a 16 channel DVR is in progress.

## RESPONSIVE PLANNING

### Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not

responsible for conducting any form of criminal OR administrative sexual abuse investigations.)  
 Yes  No  NA

#### 115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)  Yes  No  NA
  
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)  Yes  No  NA

#### 115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?  Yes  No
  
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?  Yes  No
  
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?  Yes  No
  
- Has the agency documented its efforts to provide SAFEs or SANEs?  Yes  No

#### 115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?  Yes  No
  
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?  Yes  No
  
- Has the agency documented its efforts to secure services from rape crisis centers?  
 Yes  No

#### 115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?  Yes  No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?  Yes  No

#### 115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)  Yes  No  NA

#### 115.221 (g)

- Auditor is not required to audit this provision.

#### 115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.)  Yes  No  NA

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-E Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection and facility's policy 0803-1 PREA outlines the investigative process and the uniformed evidence protocol for the collection and preservation of evidence for administrative and criminal investigations of sexual abuse. The facility begins an administrative investigation immediately following an allegation. All criminal investigations are conducted by TDCJ or a local law enforcement agency. The allegations are reported immediately to the TDCJ Contract Monitor and the GEO PREA Coordinator and/or PREA Director. If they are unable to immediately respond to the Facility Director, the on-call administrator will make the determination to contact law enforcement to investigate. The Investigator stated the TDCJ Contract Monitor makes the decision if TDCJ will investigate the allegation. If taken, the TDCJ Office of the Inspector General (OIG) will complete the investigation. If criminal, the allegation is also referred to the Houston Police Department for criminal investigation. The facility does not have a MOU with the Houston Police Department. The Houston Police Department indicated to the facility that they are required to respond to calls-for-service from the facility, as is located within the city limits.

There were 30 allegations reported of sexual abuse and sexual harassment during the audit period. An investigation was completed on all allegations. There were no cases referred for criminal investigation nor referred for prosecution. A review of ten cases was conducted by the Auditor.

The agency's policy 5.1.2-A outlines the facility's evidence and investigation protocols of the allegation. The agency utilizes the Department of Justice (DOJ's) National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents 2<sup>nd</sup> Edition for the uniform evidence protocol as indicated by the policy. The protocols are incorporated into the agency's and facility's Coordinated Response Plan. The Coordinated Response Plan provides an extensive guideline for staff to follow for investigations and/or referring an allegation for investigation. The Facility Director indicated any PREA allegations would be investigated by a specialized trained investigator. The facility has four specialized trained investigators. Random staff interviewed acknowledged the Facility Director, Assistant Facility Director, Security Manager, and PREA Compliance Manager as the facility's investigators. Random staff acknowledged understanding of the facility's protocol for obtaining usable physical evidence by protecting the scene and asking the resident not to destroy evidence. The facility policy states it is the responsibility of TDCJ Office of Inspector General (OIG) and/or other law enforcement to conduct all criminal investigations and to ensure all forensic evidence is collected and preserved in accordance with evidence protocols established by the TDCJ OIG investigator or an alternative source qualified to provide evidence protocol. The facility does not house juvenile residents.

The facility does not have medical or mental health services on site. All alleged victims of sexual assault who require a forensic exam are taken to Harris Health System for completion of the forensic exam and emergency medical healthcare with no cost to the resident. The facility has attempted to obtain a MOU with Harris Health System starting in 2016 and the last attempt was in January 2019 as documented through emails. Services are available through the emergency department 24-hours a day 7 days a week. There were no allegations that required outside medical services or forensic medical exams.

The agency's policy 5.1.2-E indicates residents who allege sexual abuse shall be provided access to outside victim advocates and make accessible specific contact information for victim advocacy or rape crisis organizations. The facility has a MOU with Montrose Center. The MOU states the Montrose Center will provide trained specialist to help identify and prioritize the needs of the victim, and connect them with helpful resources; provide information informing the victim of their rights under the law, and referrals for legal consultation and representation when ready; provide the victim with a support advocate to accompany them during medical exams, legal and or court appointments; and provide confidential emotional support services related to sexual abuse consistent with those that are provided to the community. The MOU was executed November 2018. The residents may also be referred to an outside local agency for services through a Victim Advocate Referral Form. This information is provided to the residents upon intake to the facility and posted throughout the facility. When victim advocacy services are provided through the forensic exam and investigatory interviews, the victim's consent is obtained prior in writing or on audio tape for documentation. The interview with the PREA Compliance Manager indicated that the services are free of charge to the resident and the hotline is available 24-hours a day for the residents. The PREA Compliance Manager confirmed the practice for forensic exams and victim advocacy services.

The Auditor interviewed four residents that reported sexual allegations. One was sexual abuse and the other three were sexual harassment. All residents acknowledged that medical and mental health services were offered. All of the residents refused the services. A memo to file noted no residents requested victim advocacy services during the audit period.

All allegations of sexual abuse that include penetration or touching of the genital areas are referred to an outside law enforcement agency per policy 5.1.2-E. All PREA related allegations resulting in a criminal investigation is handled through TDCJ and/or Houston Police Department. All allegations of staff sexual abuse are referred to the agency's Office of Professional responsibility and to TDCJ.

**Recommendation:** The facility should continue to attempt to develop a MOU with Harris Health System for medical services for sexual abuse allegations.

**Recommendation:** The facility should attempt an MOU with Houston Police Department. The facility should also request that the police department follow the requirements of this standard provisions, if they are the investigating agency.

## Standard 115.222: Policies to ensure referrals of allegations for investigations

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?  Yes  No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?  Yes  No

#### 115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?  Yes  No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?  Yes  No
- Does the agency document all such referrals?  Yes  No

#### 115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).]  
 Yes  No  NA

#### 115.222 (d)

- Auditor is not required to audit this provision.

#### 115.222 (e)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policies 5.1.2-A and 5.1.2-E Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection and facility policy 0803-1 outlines the procedures for investigating and documenting incidents of sexual abuse. Policies 5.1.2-A and 5.1.2-E state all allegations of sexual abuse that includes penetration, touching of the genital areas are referred for investigation to an outside law enforcement agency with legal authority to conduct criminal investigations. A staff member will report the allegation to a supervisor who will make the required notifications which begins the investigation process. The facility will document all investigation referrals. The facility begins an administrative investigation immediately following an allegation. The allegations are reported immediately to the TDCJ Contract Monitor and the GEO PREA Coordinator and/or PREA Director. The Investigator stated every single allegations is investigated administratively by the facility. If criminal, the allegation is referred to the Houston Police Department, as well as, TDCJ OIG for criminal investigation. The PREA Compliance Manager and her role as an investigator, is responsible for staying informed of an outside investigation. She would make weekly contact with the agency to inquiry of the progress of the case. A review of ten investigation cases was conducted by the Auditor.

There were 30 allegations reported of sexual abuse and sexual harassment during the audit period. Investigations were completed on all allegations. Of the 30 reported allegations; 17 were resident on resident and 13 staff on resident allegations. Eight of the cases were still open at the corporate level at the time of the audit. Of the closed cases, there were 9 staff on resident and 13 resident on resident. The resident on resident allegations were 8 sexual harassment and 5 sexual abuse. The administrative findings of the 5 resident on resident allegations of sexual abuse were 2 unsubstantiated and 3 unfounded. The administrative findings of the resident on resident allegations of sexual harassment were 6 unsubstantiated and 2 unfounded. The staff on resident allegations were 2 sexual harassment and 7 sexual abuse. The administrative findings of the 7 staff on resident allegations of sexual abuse were 3 unsubstantiated and 4 unfounded. The administrative findings of the staff on resident allegations of sexual harassment were 2 unfounded. Of those eight open cases, the facility had completed the administrative investigation and was waiting on the corporate review to close. There were no cases referred for criminal investigation nor referred for prosecution. A review of ten cases was conducted by the Auditor.

On the agency's website, [www.geogroup.com/PREA](http://www.geogroup.com/PREA), is a page dedicated to PREA under the Social Responsibility tab. The webpage contains the company's policies 5.1.2-A and 5.1.2-E for public information. The page also contains the zero-tolerance policy, how to report sexual abuse or sexual harassment, and how an employee may report sexual abuse or sexual harassment. There is a paragraph that explains the investigation process that states if the allegation potentially involves criminal behavior, GEO will ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations. The policy 5.1.2-E also provides the protocols for sexual abuse investigations.

## TRAINING AND EDUCATION

### Standard 115.231: Employee training

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

### 115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?  Yes  No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment  Yes  No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?  Yes  No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?  Yes  No

### 115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility?  Yes  No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?  Yes  No  N/A

### 115.231 (c)

- Have all current employees who may have contact with residents received such training?  Yes  No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?  Yes  No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?  Yes  No

#### 115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A; facility policy 0503-1 Staff, Volunteer, and Contractor Training; and training curriculum Sexual Abuse and Assault Prevention and Intervention (PREA) address all the PREA requirements and outlines the training requirements. Training records, staff interviews, and the training curriculum reviewed indicated the training includes the zero tolerance policy; definitions and examples of prohibited and illegal sexual behavior; right of residents and staff to be free from sexual abuse and from retaliation for reporting of prohibited and illegal sexual behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional signs of sexual abuse and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents; and requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes.

The initial training occurs at the academy, each staff member attends the academy pre-service training prior to being assigned to the facility. The pre-service training includes a four-hour section, Prison Rape Elimination Act (PREA) Pre-Service. All employees are provided at least 20 hours of annual in-service training to ensure training is refreshed each year of service; including the Prison Rape Elimination Act (PREA) In-Service refresher training. Each employee is required to attend in-service annually. Additional training occurs during staff meetings with different PREA topics refreshers. Staff during interviews acknowledged the numerous methods they received training and understood their responsibilities for preventing, detecting, and responding to allegations of sexual abuse. The Pre-Audit Questionnaire indicated all staff had completed training. After interviews with the PREA Compliance Manager and staff and review of training records; it was determined all facility staff have received training. A selection of eleven staff training records was reviewed; all had completed the pre-service training and annual in-service.

Staff document the completion of training through a signature on the Staff Training Meeting Sign-In Sheet and the completion of the individual PREA Basic Training Acknowledgement Form which is also signed by a witness. Each staff member is provided and must carry the PREA Staff Responsibility Card; that outlines general PREA information and first responder duties.

There were a number of inconsistencies in the answers from staff on a variety of topics. The Auditor suggested a refresher training for staff on those topics: the dynamics of sexual abuse in a confinement center, use of resident interpreters, residents can report through third party and anonymously, and the actions to take when an offender is at imminent risk for sexual abuse. The facility conducted refresher training on resident reporting; staff and agency reporting duties; agency protection duties; and staff first responders. Training occurred during the end of June and the beginning of July. It was documented through the PREA Refresher Training Form containing staff signatures of all staff, with the date and time of training that was provided to the Auditor to review for compliance.

The facility exceeds the training standard by requiring all staff to complete annual training instead of the standard's two-year requirement, refresher training at staff meetings, and the PREA informational card carried by staff.

## Standard 115.232: Volunteer and contractor training

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?  Yes  No

#### 115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?  Yes  No

#### 115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

All contractors and volunteers who have contact with residents receive PREA training prior to assuming their responsibilities. The agency policy 5.1.2-A and facility policy 0504-1 states all volunteers and contractors shall receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program prior to assignment. The facility policy 504-1 also states the refresher training shall include updates to sexual abuse and sexual harassment policies. The training ensures that volunteers and contractors are notified of the agency's zero-

tolerance policy regarding sexual abuse and sexual harassment and are informed of how to report such incidents. The Auditor interviewed one volunteer and one contractor. The contractor stated he had not received any training. It was reviewed that he was not on the contractor approval list from TDCJ. The volunteer acknowledged receiving training. The training consisted of standards of conduct, sexual harassment policy, ethics, confidentiality of offender identity and information, emergency and fire procedures, and PREA. The PREA education covered prevention, identification, interventions, and response; and was two hours long. She had to read and acknowledge her understanding of the information. The volunteer was knowledgeable on PREA, the responsibilities for reporting, the reporting process, who to report to, and the agency's zero tolerance policy. She indicated if she was told or witnessed an incident, she would report to the shift supervisor and the department head she works under. Training records were reviewed and confirmed for the volunteer. The training file documented the completion of training through a signature on the PREA Basic Training Acknowledgement Form and the Contractor/Volunteer Training Record form.

The contractor interviewed onsite did not have training. Volunteers and contractors need to have training prior to assignment. For compliance the facility conducted training with volunteers and contractors. The facility provided sixteen volunteer and contractor's training records documenting PREA training completed in July 2019. The Prison Rape Elimination Act Basic Training Acknowledgement Forms for the volunteers and contractors was provided for compliance review. After a careful review of all documentation and the information received from the facility, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

## **Standard 115.233: Resident education**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.233 (a)**

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?  Yes  No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?  Yes  No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?  Yes  No

#### **115.233 (b)**

- Does the agency provide refresher information whenever a resident is transferred to a different facility?  Yes  No

#### **115.233 (c)**

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?  Yes  No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?  Yes  No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?  Yes  No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?  Yes  No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?  Yes  No

#### 115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions?  Yes  No

#### 115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The facility provides a comprehensive PREA education to the residents beginning at intake into the facility. The agency's policy 5.1.2-A and facility's policy 1702-1 Intake and Orientation address the PREA education requirements for residents at intake. The facility provides the resident PREA information in written and verbal instruction. At intake into the facility, the residents are provided PREA information as a group after the risk screening. This information is provided verbally through the PREA Compliance Manager and case managers who reads and explains all the PREA information to the residents. The residents watch the PREA What You Need to Know video that covers the PREA information and staff verbally explains the information during this process. The staff answers any questions the resident has on PREA. The resident is provided the facility handbook and the PREA Education Manual for Residents (available in English and Spanish), for written education materials. The PREA Educational Manual for Residents provided to the resident which includes what is sexual abuse; cross gender pat-searches, examples of sexual abuse; consensual sexual relationships are not permitted; prevention; reporting and investigation; what to expect after you report; sexual abuse grievances; emergency grievances; and reporting

options and resources. The resident must sign acknowledging the information received on the Acknowledgement of Receipt of PREA Educational Manual Form which also outlines the zero tolerance, how to report, how to make a confidential report via phone and/or writing, and the right to be free from retaliation. The Intake Coordinator interviewed stated the educational information is provided as soon as the resident arrives at the facility or next day. It is always accomplished within 24 hours. The Auditor observed the intake process of five residents and the orientation class.

During the audit period, 3,141 residents were admitted to the facility and the PAQ noted that all residents received education. The facility did not have a resident transferred from another community confinement facility. If a resident was transferred, the resident would receive the same education as any resident that is admitted per policies 5.1.2-A and 1702-1. The random residents interviewed acknowledged receiving education on the same day as intake or the next day through the orientation class including watching a video, receiving the PREA Resident Educational Manual, and postings on the walls. The Auditor also reviewed eleven resident files for the education acknowledgement. About half of the residents received education on the day of arrival (6) and the other residents (5) the next day.

Staff during interviews explained the steps that would be taken to effectively communicate with disabled residents when necessary. A telecommunication device (TTD) is available for hearing impaired residents, as well as, written materials. A resident that is deaf is provided the information through staff reading the information and may listen to the video. The video is close captioned providing residents that can read access to the PREA information. For residents with visual impairments, the PREA Educational Manual for Residents are available in large print in both languages, the audible narrative of the video, and staff would read the information, if necessary. If a resident is cognitively or intellectually disabled, staff will verbally present PREA materials at a level the resident can understand. Extra time is spent by staff to ensure the resident understands the basics to include definitions and reporting information. The Agency Head's interview, agency's policy, and the facility's policy state the agency does not use residents as interpreters, readers of other types of resident assistants. The Agency Head indicated the agency/facility would also reach out to community-based resources (i.e. local colleges or organizations) that might be willing to assist. The Auditor interviewed five residents that were disabled and limited English proficient (LEP). The blind resident stated a staff member read the information to him. He has been housed about two years and staff are responsive when he needs assistance. Three residents were interviewed that could not read. They indicated that staff read the information to them and they watched a video. They indicated that case managers will assist them if needed. The LEP resident was interviewed through an interpreter. The resident stated he was given the information in English; however, the case manager translated and explained the information to him in Spanish. All the residents knew how to report; and all indicated they would tell a staff member.

The residents have continuous and readily available PREA education through the facility handbook, Sexual Assault Awareness Program brochure, and the PREA Educational Manual for Residents provided to each resident at admission. Information is also available through posters including the Resident Reporting Options and No Means No throughout the facility. The PREA informational posters are posted in English and Spanish throughout the facility. The manual and posters are also provided in large print.

Random residents interviewed and during discussion with residents on the facility tour acknowledged they have received PREA information upon arrival including the handbook and watching a video. They were able to explain how to report an incident and were aware of the zero-tolerance policy.

The facility exceeds the standard with the numerous ways the resident receives education from the intake into the facility and throughout their stay. The personal education presentation by staff and the time taken to answer any questions of the resident. The residents were knowledgeable of the reporting methods and the information provided in the PREA Educational Manual for Residents.

## **Standard 115.234: Specialized training: Investigations**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

### 115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

### 115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

### 115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

### 115.234 (d)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency policies 5.1.2-A and 5.1.2-E Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection state all allegations are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations. The facility begins an administrative investigation immediately following an allegation. The allegations are also reported to the TDCJ, who may also investigate. If determined criminal, the TDCJ OIG and Houston Police Department is contacted for the criminal investigation.

The agency's policy and lesson plan PREA Specialized Training Investigating Sexual Abuse in Adult/Juvenile Correctional Settings reflects that investigators are to be trained in conducting sexual abuse investigations in confinement settings. The specialized training lesson plan includes sections on identifying how trauma can affect a victim's cooperation in an investigation; forensic medical exam process; role of the victim advocates; best practice and policy requirements on evidence collection in confinement settings; understanding of Miranda and Garrity; techniques for interviewing and interrogating during investigations of sexual abuse; criteria required for administrative action and prosecutorial referral; and what a final investigative report should contain. The facility has four investigators on staff; Facility Director, Assistant Facility Director, Assistant Manager of Security, and PREA Compliance Manager. The facility can also utilize specialized trained investigators from the agency. The agency has 111 specialized trained investigators. The investigators have completed the general PREA training and the required specialized training for investigators. The specialized training is a four-hour training block with a test. The Investigator interviewed stated the training is through a webinar and a test had to be completed at the end of the training. She stated the training included the process of an investigation, how to conduct interviews, Miranda and Garrity warnings, evidence collection, and how to determine if criminal. The specialty training was verified through the interviews with the Investigator and the Facility Director and the review of the training certificates and Prison Rape Elimination Act Basic Training Acknowledgement form with signatures for the course.

## **Standard 115.235: Specialized training: Medical and mental health care**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.235 (a)**

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment?  Yes  No  N/A
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse?  Yes  No  N/A
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment?  Yes  No  N/A
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment?  Yes  No  N/A

#### **115.235 (b)**

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? N/A if agency medical staff at the facility do not conduct forensic exams.)  Yes  No  NA

#### 115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?  Yes  No  N/A

#### 115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231?  Yes  No  N/A
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.]  Yes  No  NA

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The facility does not have medical and mental health staff. All residents are referred to the outside local medical providers for medical care and mental health services. All alleged victims of sexual assault who require a forensic exam are taken to Harris Health Center for completion of the forensic exam and emergency medical healthcare with no cost to the resident. The facility has a MOU with Montrose Center for victim advocacy services and emotional counseling.

The agency does have a policy that addresses specialized training for medical and mental health practitioners; policy 5.1.2-A states all full-time medical and mental health practitioners who work regularly in the facility shall receive specialized training in addition to the general training mandated for employees. The healthcare staff will receive specialized training for sexual abuse and sexual assault, through the lesson plan GEO Specialized Medical and Mental Health PREA Training. The lesson plan Specialized Medical and Mental Health PREA Training outline that training will include detecting signs of sexual abuse and assault; preserving physical evidence of sexual abuse; responding professionally to victims of sexual abuse; and proper reporting of allegations or suspicions of sexual abuse and assault. The specialized training is an on-line course. GEO healthcare staff do not conduct forensic exams.

# SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

## Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?  Yes  No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?  Yes  No

### 115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?  
 Yes  No

### 115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?  
 Yes  No

### 115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?  
 Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?  
 Yes  No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?  Yes  No

#### 115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?  Yes  No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?  Yes  No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?  Yes  No

#### 115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?  Yes  No

#### 115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral?  Yes  No
- Does the facility reassess a resident's risk level when warranted due to a: Request?  Yes  No
- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse?  Yes  No

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?  
 Yes  No

#### 115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?  Yes  No

#### 115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The screening process for the risk of victimization and abusiveness is outlined in the agency's policy 5.1.2-A and facility's policy 1702-1 Resident Intake and Orientation. This screening occurs at intake into the facility with the use of the GEO PREA Risk Assessment Tool. The facility completes the PREA education orientation with all the residents and then staff complete risk assessments of the residents in the orientation. The risk screening is to be conducted within twenty-four (24) hours per policy and the TDCJ contract. Seven staff are trained to complete risk assessments; PREA Compliance Manager, Case Manager Supervisor, and five case managers. The staff interviewed indicated that the risk screening will occur within 24 hours but usually complete within hours of arrival as part of the orientation process. The facility had 3,141 residents admitted during the audit period, the PAQ indicated that risk screening was completed on all residents. The Auditor also reviewed eleven resident files for the education acknowledgement. About half of the residents were risk screened on the day of arrival and the other half the next day. The residents interviewed stated the risk screening was conducted the first day or next day.

During intake, the risk screening staff reviews the Pre-Sentence Investigation (PSI), any other available records (i.e. medical records, institutional files) and completes the PREA Risk Assessment Tool as part of the intake paperwork process. The PREA Risk Assessment Tool conforms to the PREA standard requirements. The screening forms includes questions regarding mental, physical, and developmental disabilities; age of the resident; physical build of the resident; whether the resident has been previously incarcerated; whether the resident's criminal history is exclusively nonviolent; whether the resident has prior convictions against an adult or child; whether or not the resident has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the resident has previously experienced sexual victimization; and the residents own perception of vulnerability. The intake screening also considers prior acts of sexual abuse, prior convictions of sexual abuse, and history of prior institutional violence or sexual abuse. The facility staff explained the scoring of the risk assessment was adjusted; this change changed that the sex offenders would not automatic place a resident on the At-Risk log. The new

scoring emphasizes two victimization and two abusiveness questions. The Case Manager Supervisor interviewed stated the review also includes the PSI, progress report, and the resident's institutional record for the risk factors. The risk screening tool is scored based on the number of yes responses. In section one for At Risk of Victimization, if a resident has three or more yes responses to questions 1-11 or yes to question 2 (have you ever been a victim of sexual assault) are considered at risk of victimization. In section two for At Risk of Abusiveness, if a resident has three or more yes for questions 12-17 or answer yes to question 12 (sex offender with adult victims or victimized another while incarcerated) are identified for risk of abusiveness. The Case Manager Supervisor indicated that most residents are sex offenders. During the observed risk screening of residents, the staff asked each question, provided clarifying information to the resident, and answered the resident's questions. The Auditor observed the risk screening of five residents from TDCJ placement. The resident signs the tool acknowledging the answers are correct. A resident that scores at risk for victimization or risk for abusiveness are tracked on a PREA At-Risk Victimized log and residents who are identified from screening to be a potential abuser are tracked on a PREA At-Risk Abuser log. The form also documents if the resident is referred for medical or mental health services. The referral is noted on the risk assessment tool and the referral form Referral Verification. Of the five resident assessments observed; one resident was hard of hearing but understood the questions being asked, he was screened as at-risk for victimization and was referred for counseling in which he refused. The case manager explained the risk screening scores after the resident asked why he scored at risk. The second resident screened no risk. The third resident had a low cognitive skills; the case manager took the time to explain each question and made sure the resident understood the question. The resident scored at no risk. Fourth resident scored at no risk. The fifth resident scored at risk for victimization. The case manager offered a mental health referral which was declined by the resident. The random resident interviews, most residents indicated they remember being asked these questions on the day of their arrival. The Auditor reviewed the PREA Risk Assessment Tools within eleven resident files and found all files compliant and risk assessments completed within the appropriate timeframes.

The Case Manager Supervisor interviewed stated the resident's risks of victimization and abusiveness are reassessed within 30 days from the date of the initial assessment and any other time when warranted based on any additional, relevant information or following an incident of abuse or victimization. This is supported by agency policy 5.1.2-A and facility policy 1701-1 that states a reassessment is to be conducted by a staff member within 30 days. The reassessment is conducted using the GEO PREA Vulnerability Reassessment Questionnaire. The average time a resident is in custody is 55 days. Of the eleven residents' files reviewed, nine of the residents were held for a timeframe that required a reassessment. The reassessments were completed within the appropriate timeframes. The PAQ indicated that 1,355 residents were reassessed of the 1,355 residents that had a length of stay of over thirty days.

Through review of policy 5.1.2-A, facility policy 1701-1, and confirmed through staff interviews, that disciplining residents for refusing to answer or not providing complete information in response to certain screening questions is prohibited. The Case Manger Supervisor and the PREA Compliance Manager stated the resident does not have to answer questions and can refuse. The information will try to be obtained through other means and they will encourage the resident to answer by explaining it is help determine housing placement to protect them.

Agency policy 5.1.2-A, facility policy 1701-1, and staff interviews confirmed appropriate controls have been implemented to ensure that sensitive information is not exploited by staff or other residents. The Case Manager Supervisor and PREA Compliance Manager interviewed indicated the Risk Assessment Tool and the Vulnerability Reassessment Questionnaire are maintained in the resident file locked in the file room within the classification area. The Auditor observed the security of the files. Other than the Case Manager Supervisor, the only other staff with access to resident files are case managers, PREA Compliance Manager, and facility administrators. Other staff must have permission from the Case Manager Supervisor. All files reviewed must be signed out for review and cannot be removed from the room. The PREA Compliance Manager stated the access to the information is only to those who need to know in making housing, work, and programming decisions.

## Standard 115.242: Use of screening information

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?  Yes  No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?  Yes  No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?  Yes  No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?  Yes  No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?  Yes  No

#### 115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident?  Yes  No

#### 115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?  Yes  No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?  Yes  No

#### 115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?  Yes  No

#### 115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents?  Yes  No

#### 115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status?  Yes  No
- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status?  Yes  No
- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility's policy 1702-1 addresses the assessment process and the use of the screening information to determine housing, recreation, voluntary work, and other activities to ensure the safety of the resident. When the risk assessment indicates the resident scores as a potential victim or abuser, it is reviewed by the Case Manager Supervisor and forwarded to the PREA compliance Manager to place the resident on the at-risk logs. If a resident is identified at risk for victimization or abusiveness, they are placed on a At Risk Log. The PREA Compliance Manager maintains a PREA At-Risk of Being Victimized log for residents who are identified as being potential victims (126 at the time of the audit); a PREA At-Risk for Abusiveness Log for residents who are identified from screening to be a potential abuser (32 at the time of the audit); and a PREA At-Risk of Being Victimized log for residents who are identified as being a victim and abuser (16 at the time of the audit). The PREA Compliance Manager stated the logs are updated daily and reviewed weekly for accuracy. The at-risk logs contain

current housing locations and will be used to assist in making housing placements per the Case Manager Supervisor and PREA Compliance Manger. The facility has dedicated specific housing units for residents at-risk for victimization, at-risk of abusiveness, and residents that score positive for both. If the resident is identified at high risk of sexual victimization, the resident is housed in building 6. If the resident is identified as a potential sexual abuser, the resident is housed in building 3. If a resident scores for both, the resident if housed in building 5. The interviews with the Case Manager Supervisor and the PREA Compliance Manager indicated that housing and program assignments are made on a case by case basis with consideration of the PREA risk factors. In review of completed risk assessments in the resident files, the Auditor determined the facility is utilizing collected data, such as the residents physical characteristics (build and appearance), age, whether the resident has mental, physical or development disability, previous assignment in specialized housing, alleged offense and criminal history, whether the resident is perceived to be Lesbian/Gay/Bi-Sexual/Transgender/Intersex (LGBTI) or is gender non-conforming to determine housing, recreation, work, and other activity decisions. Through staff interviews and review of resident files, it was determined that the facility addresses the needs of the resident consistent with the security and safety of the individual resident regarding housing. 115.242 Use of Screening Information: Although risk screening is occurring on residents, and the information is being utilized to make appropriate housing placements. The goal of the screening is to keep separate the residents at high risk of being sexually victimized from those at risk of being sexually abusive. This is not occurring in the common areas of the facility. In the common shared areas of the recreation areas and laundry, all residents, no matter the risk screening, can mingle without supervision. The facility needs to develop a policy and procedure to keep separate the residents at high risk of being sexually victimized from those at risk of being sexually abusive. To correct the issues, the facility provided an amended shift schedule for first and second shifts to assign a security monitor to a grounds rover post to supervise the common areas to ensure the safety of the resident.

The agency's policy 5.1.2-A and facility's policy 1702-1 indicates that staff shall consider the resident's gender self-identification and make housing assignments for a transgender and/or intersex resident on a case-by-case basis based on the resident's health and safety and whether the placement would present management or security problems. When a resident self-identifies during the intake process, the resident's views of his/her safety is given serious consideration in housing assignment. The Case Manager Supervisor stated the resident's needs are discussed with the resident. Case managers also meets with these residents at least monthly to determine if there are any concerns. The Assistant Facility Director also will meet with and reassess the transgender resident every six months utilizing the PREA Vulnerability Reassessment Questionnaire. The PREA Compliance Manager stated a transgender resident has not been housed longer than six months, therefore, no reassessments were conducted. The current transgenders housed at the facility were housed less than six months.

The At-Risk Log for LGBTI had fifteen residents listed: five gay, seven bi-sexual, and three transgender. The Auditor interviewed three transgender and three gay residents. Two of the three transgender stated staff asked questions about their safety and covers it again monthly. Of the six residents interviewed, the residents stated they were not placed in specialized housing and all felt safe at the facility most of the time. They did note that staff are not respective and do not address the residents in the pronouns they prefer.

Transgender and intersex residents have the opportunity to shower separate from other residents. The form, Statement of Shower/Search/Pronoun Preference is completed for transgender and intersex residents at intake. The resident is able to state the gender identification, pronoun preference, staff preference for searches, and whether the resident wants to shower separately. The resident, staff completing the form, and a staff witness sign the form. Interviews with the Case Manager Supervisor and PREA Compliance Manager noted that transgender/intersex residents may shower in the bathroom during designated shower times, during count, or at night-time when the showers are closed to the general population. Transgender residents interviewed indicated they have privacy for bathroom functions including showering most of the time.

The agency does not place LGBTI residents in housing units solely based on their sexual orientation. Transgender and intersex residents are housed with the general population per the PREA Compliance Manager; and are not separated. The Auditor asked further about the housing placement of LGBTI residents since the At-Risk Log of LGBTI showed thirteen of the fifteen residents were housed in building 6. The PREA Compliance Manger stated

they are not housed there based on gender orientation; it was based on the risk screening that identified them at-risk for victimization. The agency's policy 5.1.2-A and facility's policy 1702-1 indicates that LGBTI residents shall not be placed in housing units solely based on their identification as LGBTI; unless such a dedicated unit exists in connection with a consent decree, legal settlement, or legal judgement for the purpose of protecting such residents.

## REPORTING

### Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?  Yes  No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?  Yes  No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?  Yes  No

#### 115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?  Yes  No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?  Yes  No
- Does that private entity or office allow the resident to remain anonymous upon request?  Yes  No

#### 115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?  Yes  No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?  Yes  No

#### 115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?  Yes  No

## Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The facility has established procedures allowing for multiple internal and external ways for residents to report sexual abuse, retaliation, staff neglect, and violations of responsibilities that may have contributed to such incidents as supported by the agency's policy 5.1.2-A. PREA allegation reporting methods are shared with residents at intake through the PREA Education Manual for Residents (available in English and Spanish), Resident Reporting Options handout, the No Means No poster, the What You Need to Know Video available in English, (Spanish and closed caption videos were obtained during the audit), and verbally explained by the staff during the orientation process. Reporting information is also available on PREA informational posters in English and Spanish throughout the facility viewed by the Auditor during the tour. Residents can report verbally and in writing to facility staff; submit a grievance; utilize third party reporting; verbally or written to the parole officer; calling the TDCJ Ombudsman, calling the Houston Police Department, and the RAINN National Hotline Network. The resident may report outside the agency by calling Houston Police Department, the TDCJ Ombudsman, RAINN National Hotline Network, and telling the parole officer.

Calling any of the reporting numbers allows residents to remain anonymous upon request. The facility has pay phones that are not recorded and do not require a PIN. In addition, residents have personal mobile telephones they are able to use for reporting. Residents may file an anonymous grievance or other written statements. During the formal resident interviews, the residents acknowledged receiving information on how to report at intake, in the PREA Educational Resident Manual, and on posters. They were able to identify reporting methods including telling a staff member, call the hotlines, writing a grievance, and/or telling family or a friend. Also, during the informal interviews with residents while touring the facility, they indicated they knew the reporting process and felt comfortable reporting to a staff member. The reporting numbers are posted within the housing units readily available to the resident and on a sticker on each pay phone. The residents have accessibility to phones through their own personal cell phones, pay phones in the housing units, and pay phones available in the courtyard pavilion. On the pay phones are stickers providing phone numbers for reporting agencies and emotional support services. The numbers include RAINN National Hotline Network, Houston Police Department Sexual Assault Information Line, Texas Department of Criminal Justice (TDCJ) PREA Ombudsman Office, and TDCJ Agency toll free number. The Auditor tested the phone. The Auditor was able to reach RAINN. The number for the TDCJ agency toll-free number did not work. The phone connection was repaired by the last day of the audit. The Auditor recommended that a staff member be responsible for checking the phones periodic to ensure they are working properly.

The reporting methods were demonstrated through a review of policies and procedures, PREA Educational Manual for Residents, posters throughout the facility, and interviews with residents and staff. Of the thirty allegations reported during the audit period; five were reported through a written request, four through the grievance process, three through the hotline, one was a third-party report, seven were verbally to staff, one through email, and one reported at another agency. These reporting methods demonstrate the numerous ways the residents know how to report.

Staff indicated through interviews they were aware of the methods available for residents to report sexual abuse and sexual harassment. Staff were also knowledgeable on the multiple-ways residents could report to staff and their responsibility in the process. They indicated they would report immediately to a supervisor. After verbal reporting, an incident report would be completed and forwarded to the supervisor and submitted through the PREA Portal. Staff were not aware that third party and anonymous reports are to be accepted. The staff need refresher training on reporting methods and their responsible to accept reports from residents and handle properly. The

facility conducted refresher training to the staff and provided training documentation to the Auditor to demonstrate compliance.

Staff can privately report by calling the employee hotline, through the internet to [www.reportonline.com/geogroup](http://www.reportonline.com/geogroup); or contacting the agency PREA Coordinator. Staff were aware of the methods to privately report sexual abuse. This information is also posted on the agency website and provided during staff training. The reporting requirements and process is provided to staff through training, the agency's policy 5.1.2-A, staff handbook, and the PREA Staff Responsibility Card.

## Standard 115.252: Exhaustion of administrative remedies

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.  Yes  No  NA

#### 115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the

90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)  Yes  No  NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)] , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)  Yes  No  NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)  Yes  No  NA

### 115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)  
 Yes  No  NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)  
 Yes  No  NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)  
 Yes  No  NA

### 115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)  
 Yes  No  NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)  Yes  No  NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)  
 Yes    No    NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)  Yes    No    NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)  Yes    No    NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)  Yes    No    NA

### 115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)  Yes    No    NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility policy 0805-1 Grievance Process outlines the administrative procedure for resident grievances regarding sexual abuse. The facility provides the residents information of the grievance process during orientation and is also provided through the PREA Education Manual for Residents and Resident Handbook. The facility does not impose a time limit for the submission of a grievance regarding an allegation of sexual abuse. A resident can file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or compliant. The PREA Education Manual for Residents states there is no time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. Residents can submit the grievance to the Grievance Coordinator or the Facility Director. Residents are informed if the allegation involves the Facility Director, the grievance may be submitted directly to the TDCJ Contract Monitor, GEO PREA Coordinator, and/or GEO Residential Reentry Services Regional Director. The policies state the residents have a right to submit grievances to someone other than the staff member who is the subject of the compliant and such grievance is also not referred to a staff member who is subject of the compliant.

A copy of all grievances related to sexual harassment, sexual abuse, and/or sexual activity shall be forwarded to the Facility Director or PREA Compliance Manager who will forward the allegation for investigation. If the grievance indicates a resident is subject to substantial risk of imminent sexual abuse, the Facility Director will take immediate corrective action to protect the potential victim. The resident will be informed in writing that due to nature of the grievance; an investigation of your report will be conducted immediately, the report will be forwarded to the Facility Director and Corporate PREA Coordinator; and once the investigation is completed, a written notice of outcome will be provided. Policies state the facility shall issue a final agency decision on the merits of any portion of a grievance

alleging sexual abuse within 90 days of the initial filing of the grievance and the computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal. The facility may claim an extension of time to respond, of up to 70 days, if the normal time-period for response is insufficient to make an appropriate decision; the facility shall notify the resident in writing of any such extension and provide a date by which a decision will be made. At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level. Third parties on behalf of a resident may also submit grievances. If the resident declines to have the request processed; it is documented in writing by the Facility Director or the PREA Compliance Manager with another staff witness. There were no grievances filed on behalf of a resident this audit period.

The agency's and facility's policies provide written procedures and timeframes for handling time-sensitive grievances that involve an immediate threat to resident health, safety, or welfare related to sexual abuse. If the grievance is a substantial risk of imminent sexual abuse to the resident, it is handled as an emergency grievance. The grievance is forwarded to the Facility Director for immediate corrective action to protect the potential victim. The Facility Director stated the residents would be separated and a no contact separation order would be created. Emergency grievances will be given top priority and will be investigated, and an initial response provided within 48 hours of the date of receipt. A final decision will be provided within five calendar days. The agency policy states the resident may receive a disciplinary report for filing a grievance relating to alleged sexual abuse in bad faith.

There were four grievances filed by residents during the audit period. All four were referred for investigations immediately. Investigations were completed on all of the allegations. The grievances and investigation outcomes were two staff-on-resident sexual abuse; one was unfounded and the other unsubstantiated. One was resident-on-resident sexual harassment that was unfounded. The last one was staff voyeurism that was determined unsubstantiated. None of the grievances were emergency grievances alleging that the resident was subject to a substantial risk of imminent sexual abuse. The initial responses were completed within the five days and met all other timeframes.

## **Standard 115.253: Resident access to outside confidential support services**

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.253 (a)**

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?  Yes  No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?  Yes  No

#### **115.253 (b)**

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?  Yes  No

## 115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?  Yes  No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy, 5.1.2-A and facility's policy 0803-1 states the facility shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to most appropriately address victim's needs. The agency's policy 5.1.2-E and facility's policy 0803-1 indicates residents who allege sexual abuse shall be provided access to outside victim advocates and make accessible specific contact information for victim advocacy or rape crisis organizations. The facility has a MOU with Montrose Center. The MOU states the Montrose Center will provide trained specialist to help identify and prioritize the needs of the victim, and connect them with helpful resources; provide information informing the victim of their rights under the law, and referrals for legal consultation and representation when ready; provide the victim with a support advocate to accompany them during medical exams, legal and or court appointments; and provide confidential emotional support services related to sexual abuse consistent with those that are provided to the community. The MOU was executed November 2018. This information is provided to the residents upon intake to the facility and posted throughout the facility. The No Means No poster provides a phone number and address for the Montrose Center and states the Southeast Texas Transitional Center has partnered with The Montrose Center to provide survivors of sexual abuse with emotional support services. The Education Manual for Residents states the facility will provide you with access to support and assistance of a Victim Advocate during an exam and investigation process upon your request. It provides the residents with the hotline number to The Montrose Center. The residents may also be referred to an outside local agency for services through a Victim Advocate Referral Form. The residents also can contact the RAINN National Hotline Network.

When victim advocacy services are provided through the forensic exam and investigatory interviews, the victim's consent is obtained prior in writing or on audio tape for documentation. The interview with the PREA Compliance Manager indicated that the services are free of charge to the resident and the hotline is available 24-hours a day for the residents. The PREA Compliance Manager confirmed the practice for victim advocacy services.

The calls and mail to the TDCJ Ombudsman and The Montrose Center are not monitored. A poster in all of the housing units, states that payphones are not monitored. A memo to file noted no residents requested victim advocacy services during the audit period.

The facility provides residents information about local and national organizations that can assist residents who have been victims of sexual abuse through the PREA Education Manual for Residents. Victim advocacy service information is provided to the residents on the Resident Reporting Options posters throughout the facility. Most residents interviewed were not aware of outside support services available to them. However, the facility provides this information in multiple ways to the residents. Two of the four residents that reported sexual abuse stated the

facility offered a referral to an outside agency; the residents refused. Upon review of the investigation file, all the residents were offered a referral for emotional support services and all declined the referrals.

## Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?  Yes  No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A states that third-party reporting information will be posted publicly on the agency's website. The website provides information regarding reporting sexual abuse. The website states "to report an allegation of Sexual Abuse/Sexual Harassment on behalf of an individual who is or was housed in any GEO facility or program or if you were previously housed in a GEO facility or program and need to report an allegation of sexual abuse/harassment, you may contact the Facility Administrator's Office in the facility where the alleged incident occurred or where the individual is housed. Please see our Locations page for each facility's contact information. Reports can be made over the phone, in person, in writing or anonymously if desired. You can also contact our Corporate PREA Coordinator." A phone number and address are provided. The information is displayed on The Prison Rape Elimination Act of 2003 posters in visitation area. Family members or other individuals may report verbally or in writing any time they have knowledge or suspect a resident has been sexually abused, sexually harassed, or requires protection. Outside parties can report verbally or in writing to the Facility Director or to the agency's PREA Coordinator. Residents interviewed were aware of this method of reporting. There was one third-party report this audit period. A resident reported to a case manager that he witnessed another resident being forced to have sex by another resident. The allegation was investigated and determined unfounded.

## OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

## Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?  Yes  No

### 115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?  Yes  No

### 115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?  Yes  No  N/A
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services?  Yes  No  N/A

### 115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?  Yes  No

### 115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?  Yes  No

### Auditor Overall Compliance Determination

**Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

**Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility's policy 0803-1 outlines the reporting requirements of staff which states all employees are required to report immediately in accordance with facility and corporate policy any knowledge, suspicion, or information regarding sexual abuse that occurred in the facility; retaliation against residents or staff who reported or participated in an investigation about such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Employees are required to report to designated supervisors or officials. Reporting requirements are covered in the annual in-service training, pre-service training, and staff meetings for all staff. The allegation is then reported through the Serious Incident Reporting procedure. Specialized and random staff interviews confirm that staff are knowledgeable in their reporting duties, the process of reporting, and to whom to report.

Random staff interviewed indicated they would report immediately to their supervisor and/or the shift supervisor and then write an incident report. This reporting information is provided on the staff's PREA Staff's Responsibility Card also. Once reported, the Facility Director makes notifications to the TDCJ Contract Monitor and the GEO Regional Reentry Services Regional Director. Staff can report privately outside the chain of command by utilizing the facility's employee hotline, calling the corporate PREA Coordinator, and reporting to the Facility Director. The facility policy states employees reporting sexual abuse or sexual harassment shall be afforded the opportunity to report such information to the Assistant Manager of Security or other facility management privately, if requested. During the interviews, most staff indicated they would report privately through the hotline, through the agency's website, or call the corporate PREA Coordinator. Of the thirty allegations during the audit period; seven were reported verbally to a staff member who reported the allegation immediately as documented in the review of the investigation files.

The facility does not employ medical and mental health staff. All medical and mental health services are provided by outside community agencies. However, the agency's policy states unless precluded by federal, state, or local law, medical and mental health practitioners are required to report allegations of sexual abuse in which the victim is under the age of 18 or considered a vulnerable adult to designated state or local services and agencies under applicable mandatory reporting laws. The Facility Director stated the facility has never had an incident with a resident under the age of 18 or considered a vulnerable adult. He stated if an allegation would occur, it would be reported to TDCJ OIG, contact the Houston Police Department, and if appropriate would contact the Department of Aging and Disability Services. There were no incidents this audit period per a memo to file and the Facility's Director interview. The agency's policy states medical and mental health practitioners are also required to inform individuals in a GEO facility or program of the practitioner's duty to report and the limitations of confidentiality, at the initiation of services.

The agency's policy 5.1.2-A states that staff are not to reveal any information related to a sexual abuse report to anyone other than to supervisors or official. Reporting requirements including confidentiality are covered in the annual in-service training, pre-service training, and staff meetings. Staff interviewed indicated information would only be shared with the supervisor and other staff on a need-to-know basis.

The agency's policy 5.1.2-A states the facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymously reports to the designated investigators or outside agency responsible for investigating incidents. The Facility Director stated he would be the one responsible for assigning the allegations for investigation to the investigators. The Facility Director and the Investigator indicated that all allegations no matter how they are reported are investigated.

## Standard 115.262: Agency protection duties

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility policy 0803-1 requires that if a staff member has reasonable belief that a resident is subject to substantial risk of imminent sexual abuse, the staff member will take immediate action to protect the resident. The majority of the staff interviewed were not able to answer how a resident would be protected if at imminent risk. They indicated they would interview the resident of just monitor the resident. These responsibilities are covered for all staff in the annual in-service training, pre-service training, and staff meetings. The Facility Director stated an immediate corrective action would be taken which would be to remove the resident from the situation to keep the resident safe and contact law enforcement, TDCJ, and the corporate office. During the audit period, no resident reported feeling at imminent risk of sexual abuse, or any staff reported that a resident was subject to substantial risk of imminent sexual abuse, therefore, there were no protective measures to implement per memo to file and interviews.

The facility conducted staff refresher training during the end of June and the beginning of July on agency protection duties. The training was documented through the PREA Refresher Training Form containing staff signatures of all staff, with the date and time of training. The Auditor determined compliance with the additional training documentation provided.

## Standard 115.263: Reporting to other confinement facilities

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?  Yes  No

#### 115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?  Yes  No

### 115.263 (c)

- Does the agency document that it has provided such notification?  Yes  No

### 115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility policy 0803-1 requires upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director or designee will notify the Facility Administrator or designee of the facility where the alleged abuse occurred. The notifications should take place as soon as possible, but no later than 72 hours after receiving notification. The Facility Director indicated an investigation would be started and notifications would be made immediately to the other facility. The notification will be documented and forwarded to the agency's PREA Coordinator and the PREA Compliance Manager. The Facility Director also indicated there were no instances this audit period, as noted on the PAQ also. The facility received one notification of an allegation of resident-on-resident sexual harassment that occurred at the facility from another community correction facility. The facility started and completed the investigation and determined the allegation was unsubstantiated.

### Standard 115.264: Staff first responder duties

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?  Yes  No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?  Yes  No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth,

changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  Yes  No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?  Yes  No

#### 115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-A and facility policy 0803-1 outlines the detailed procedures for security and non-security staff when responding to an allegation of sexual abuse. The supervisory staff responding to the incident is required to separate the alleged victim and abuser; conduct a brief inquiry with each resident to ascertain if the sexual behavior was consensual or nonconsensual; preserve and protect the crime scene; and request the alleged victim and alleged abuser to take no action to destroy evidence; and ensure that the Facility Director and other designated individuals are notified. First responder responsibilities are covered for all staff in the annual in-service training, pre-service training, and staff meetings. The first responder responsibilities are also outlined on the PREA Staff's Responsibility Card carried by all staff. Through random interviews with staff, staff were not able to explain the first responder duties. The staff needs refresher training on the steps of a first responder.

Policies outline that if the first responder is not a security staff member, the staff shall request that the alleged victim not take any actions that could destroy physical evidence, and then notify a security staff member. The random non-security staff interviewed indicated they would contact a shift supervisor immediately and request the resident not to destroy any evidence. The Auditor interviewed two staff that were first responders. The Case Manager started the allegation was reported during case management office hours. She reported the allegation to the PREA Coordinator and wrote a written statement. She kept the resident in her office until a security staff responded. She did ask the resident not to destroy any evidence. The other security staff member interviewed stated he separated the victim and the abuser by taking the victim to the shift office. Residents were not allowed in the area and it was protected as a crime scene with a staff member remaining on watch. The residents were asked not to destroy evidence and a staff member stayed with the victim and the alleged abuser to ensure the protection of evidence.

Although the PAQ noted 17 allegations that a resident was sexually abused, upon reviewing the investigation files, there were 12 sexual abuse allegations. A memo to file indicated that there were no incidents which required implementing all first responder duties during this review period. Of the four residents interviewed that reported sexual abuse; two stated staff responded immediately and separated the resident by taking the resident out of the

housing unit, the other two stated the staff took no action. The one resident stated he reported it over and over to different staff members and no one took any action until he reported it to the PREA Compliance Manager.

As noted in the beginning narrative, the Auditor shared with the administration the comments made by selected staff that residents are just sex offenders. These comments along with the fact that staff could not explain the first responder duties and how to protect a resident at imminent risk raises concerns to the safety of the resident. Sixteen residents noted they did not feel staff would take the appropriate actions or felt safe. This may be a direct correlation of some of the staff 's personnel feeling about the residents and their criminal charges.

The facility conducted staff refresher training during the end of June and the beginning of July on first responder duties. The training was documented through the PREA Refresher Training Form containing staff signatures of all staff, with the date and time of training. The Auditor determined compliance with the additional training documentation provided.

**Recommendation:** The facility should continue to provide training to staff and monitor the climate of the facility.

## Standard 115.265: Coordinated response

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The facility has created a written institutional plan to coordinate actions taken by the multidisciplinary team including first responders, medical and mental health care by outside agencies, investigators, and facility leadership in response to an incident of sexual abuse. The PREA Coordinated Response Plan provides written guidelines to staff responding to allegations and occurrences of sexual abuse, sexual harassment, and sexual activity within the facility. The Coordinated Response Plan includes the actions to take after report of sexual abuse, the initial response, the Facility's Director's role when assuming the control of the incident, crime scene and evidence protection, referral to the designated community facility for medical treatment, notifications required when sexual abuse is alleged, evidence protocol, responsibilities when sexual harassment is alleged, and responsibilities when sexual activity is alleged. Coordination with staff is started through notifications and staff reporting to handle the appropriate activities under their responsibilities. This is supported through the agency's policy 5.1.2-A which also states the PREA Compliance Manager is a required participant and the Corporate PREA Coordinator may be consulted as part of the coordinated response. The facility indicated the Coordinated Response Plan is covered at pre-service and annual in-service with staff. The Facility Director stated the Coordinated Response Plan is reviewed

annually and approved by the corporate office. The last review was April 26, 2018 supported by the Facility Director's signature and date on the plan. The Facility Director stated the plan assigns duties of each responsible position and notifications to be made, including community agencies. It is a checklist format that documents the dates and times of actions taken. During staff interviews, staff detailed their responsibilities in their coordinated efforts during an incident.

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

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?  Yes  No

#### 115.266 (b)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The facility does not have a collective bargaining agreement. The agency's policy 5.1.2-A states, employees, contractor, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring resident contact pending the outcome of an investigation. Any "no contact" orders shall be documented. It also states that GEO shall not enter into or renew any collective bargaining agreement or other agreement that limits the facility's ability to remove alleged employee sexual abusers from contact with any resident pending the outcome of an investigation or a determination of whether and to what extent discipline is warranted. The Facility Director stated and the PAQ noted there were no instances where a staff member, volunteer, or contractor was removed for allegations of sexual abuse. A memo to file and the Facility Director's interview confirmed the facility does not have a collective bargaining agreement.

## Standard 115.267: Agency protection against retaliation

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?  Yes  No
- Has the agency designated which staff members or departments are charged with monitoring retaliation?  Yes  No

### 115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?  Yes  No

### 115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?  Yes  No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff?  Yes  No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?  Yes  No

#### 115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks?  Yes  No

#### 115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?  Yes  No

#### 115.267 (f)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The Agency Head's interview stated that designated staff at each facility are assigned to monitor the individual who reported the allegation for possible retaliation. They meet with the individual in private and if any issues are discovered, they are required to ensure immediate corrective action is taken to correct the issue. The agency's policy 5.1.2-A and facility's policy 0803-1 states that that no employees, contractors, volunteers, and residents shall retaliate against any person, including a resident who reports, complains about or participates in an investigation into an allegation of sexual abuse. The facility policy designates the PREA Compliance Manager as the staff member to monitor retaliation. The agency policy states a Facility Human Resource staff, or the Investigator would monitor staff. Staff is informed of protection from retaliation through training in pre-service and annual in-service.

The PREA Compliance Manager stated for employees, she monitors if employees are being harassed, shift changes, call offs, performance reports, and discipline to determine if retaliation is occurring. For residents, she monitors discipline, program changes, and housing changes. If retaliation is occurring, it is reported to the Facility Director and an investigation is started. The policies identify protective measures that can be taken including housing changes, removal of alleged staff abusers from contact with victims, and emotional support services for residents and employees who fear retaliation. The Facility Director indicated protective measures would include immediate separation, transferring the abuser, and place no contact orders. If retaliation is suspected or determined, protective measures would be taken immediately; and an investigation would be started stated the Facility Director. The Facility Director stated any allegation involving a staff member, the staff member would be

placed on-leave during the investigation, if warranted or moved to a non-resident post during the investigation for retaliation. He stated monitoring would occur weekly and would be documented. The emotional support services for staff would be through Employee Assistance Program (EAP) and for residents through the Rape and Crisis Center.

Policies outline the monitoring timeframes. For residents, the PREA Compliance Manager shall meet weekly with the resident. The meetings will be documented on the Protection Form Retaliation Log with any notes or issues discussed. The resident/alleged victim must sign the form acknowledging the monitoring contact. Staff will be monitored every 30 days for at least 90 days and documented on the Employee Protection from Retaliation Log. Once completed, the log will be retained in the investigation file of the corresponding PREA incident. The retaliation monitoring will be for at least 90 days; however, the time frame can be extended if warranted. Monitoring shall terminate if the allegation is determined unfounded. The PREA Compliance Manager stated that residents are monitored once a week for 90 days and staff is monitored monthly for 90 days. If needed, monitoring will continue past 90 days.

The four residents that reported sexual abuse interviewed, all acknowledged being monitored weekly by the PREA Compliance Manager. One also expanded that the PREA Compliance Manager also checks on him when she comes to the housing unit. They saw a staff member weekly and they had to sign for documenting the meeting.

The Auditor reviewed the monitoring forms with the PREA Coordinator. Monitoring visits were conducted weekly and detailed notes are maintained for changes that occurred. The residents signed the monitoring form documenting the in-person monitoring visit. The facility exceeds the standard with weekly in-person monitoring meetings with residents; the details on the monitoring forms; and having the resident sign acknowledging the monitoring visit.

## INVESTIGATIONS

### Standard 115.271: Criminal and administrative agency investigations

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

##### 115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]  Yes  No  NA

##### 115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?  Yes  No

**115.271 (c)**

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?  Yes  No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses?  
 Yes  No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?  Yes  No

**115.271 (d)**

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?  Yes  No

**115.271 (e)**

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?  
 Yes  No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?  Yes  No

**115.271 (f)**

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?  Yes  No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?  Yes  No

**115.271 (g)**

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?  Yes  No

**115.271 (h)**

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?  
 Yes  No

### 115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?  Yes  No

### 115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?  Yes  No

### 115.271 (k)

- Auditor is not required to audit this provision.

### 115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policies 5.1.2-A and 5.1.2-E state all allegations are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. If the investigation is not conducted by an outside law enforcement agency, the facility will complete the administrative investigation by a specialized trained investigator. Upon an allegation reported, the facility will immediately begin an administrative investigation. The Investigator stated the investigation would be started immediately and notifications are made to TDCJ OIG and the Houston Police Department. If criminal, the allegation is referred to the TDCJ and the Houston Police Department for criminal investigation. The Investigator stated as soon as a criminal investigation is completed, an administrative investigation would be conducted. The policy also states investigations shall be conducted promptly, thoroughly, and objectively for all allegations, including third party, and anonymous reports. Through review of the investigation files, all the allegations were referred for investigation the day of the allegation report. The reports are completed timely, however, the date of completion shows an extended time period. This is a result of the review by the corporate office. The facility can not close the report until corporate reviews the report and makes the final determination of the investigation. The PREA Compliance Manager maintains a tracking log of all allegations including type of allegation, report number and the outcome of the investigation on the Monthly PREA Incident Tracking Log. The logs were reviewed by the Auditor.

The agency's policy and lesson plan PREA Specialized Training Investigating Sexual Abuse in Adult/Juvenile Correctional Settings reflects that investigators are to be trained in conducting sexual abuse investigations in confinement settings. The facility has four investigators on staff; Facility Director, Assistant Facility Director, Assistant Manager of Security, and the PREA Compliance Manager. The facility can also utilize specialized trained investigators from the agency. The agency has 111 specialized trained investigators. The investigators have completed the general PREA training and the required specialized training for investigators. The specialty training was verified through the interviews with the PREA Compliance Manager/Investigator, review of training certificates, and Prison Rape Elimination Act Basic Training Acknowledgement form with investigators' signatures for the course.

The investigator stated in the interview that the investigation would start immediately upon receiving an allegation. Notifications would be made immediately to Facility Director. Upon initiating the investigation, the investigator stated statements would be collected immediately; conduct interviews with alleged victim, alleged abuser, and witnesses; and review video footage. The process would also include review of the evidence collected, re-interviewing as needed; and write the investigation report. The investigator stated the investigative report would include a background summary, narrative of the statements, notifications to other agencies; evidence collected; and the final outcome findings.

The agency's policy 5.1.2-E states the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as individual in a GEO facility or program or staff. No agency shall require an individual in a GEO facility or program who alleges sexual abuse to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an allegation. The Investigator stated the creditability of individuals is based on the corroboration of the evidence collected throughout the investigation. And an alleged victim is never required to submit to a polygraph exam, it is against policy. The four residents interviewed that reported sexual abuse stated they were not required to take a polygraph test.

The agency's policy 5.1.2-E contains a section titled Investigative Reports that outline all the items required for investigations as listed in the standard. The policy outlines that administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse and shall be documented in a written report that includes at a minimum a description of physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The Investigator stated throughout the investigation consideration is given to whether staff actions or failures contributed to the sexual abuse by reviewing video footage, conducting interviews, and review of policy and evidence collected. The Investigator stated the written investigative report would include a summary of allegations, findings of the investigation interview summaries, video evidence, evidence attachments, and if criminal, information about the criminal investigation. This was supported by the review of the investigation cases by the Auditor. The report is uploaded to the GEO Track System portal. The written report must be submitted to the agency's PREA Coordinator within 60 days after the allegation occurred. The final determination of the investigation is determined at the agency level. The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated, which was supported through policy and the investigator's interview. All written reports are retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years; however, for any circumstance, files shall be retained no less than 10 years, per policy 5.1.2-E.

All allegations that are potentially criminal are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations, which is the TDCJ OOIG and the Houston Police Department. The outside agencies would complete the investigation and document in a written report with an outcome of the investigation. The Investigator stated the written reports of outside agencies provides details of the incident, outcome of the investigation, and who completed the investigation. The facility does not get copies of the reports in most cases, an outcome of the investigation is provided to the facility. The Investigator stated it would be the responsibility of the outside law enforcement agencies to refer cases for prosecution. The TDCJ OIG will refer to the appropriate district attorney for criminal prosecution. Three of the residents interviewed that reported an

allegation stated they were kept informed; one was told the staff was removed from the post, one was told the alleged abuser was transferred, and the other was told the alleged abuser was discharged.

The agency's policy 5.1.2-E states the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. The Facility Director and Investigator shared that the investigation would continue until completion with an outcome. One of the investigations reviewed was completed even through the alleged abuser was released from the facility.

The agency's policy 5.1.2-E states the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. The facility shall request copies of completed investigative reports. Upon receipt, the investigative report will be forwarded to the agency's PREA Coordinator for review and closure. The Facility Director stated the facility makes contact with the outside agency at least monthly of the progress of the case. The Investigator stated her responsibilities are to remain informed of the case progress by following up with the law enforcement agency about once a week for periodic checks.

There were 30 allegations reported of sexual abuse and sexual harassment during the audit period. Of the 30 reported allegations; 17 were resident on resident and 13 staff on resident allegations. Eight of the cases were still open at the corporate level at the time of the audit. Of the closed cases, there were 9 staff on resident and 13 resident on resident. The resident on resident allegations were 8 sexual harassment and 5 sexual abuse. The administrative findings of the 5 resident on resident allegations of sexual abuse were 2 unsubstantiated and 3 unfounded. The administrative findings of the resident on resident allegations of sexual harassment were 6 unsubstantiated and 2 unfounded. The staff on resident allegations were 2 sexual harassment and 7 sexual abuse. The administrative findings of the 7 staff on resident allegations of sexual abuse were 3 unsubstantiated and 4 unfounded. The administrative findings of the staff on resident allegations of sexual harassment were 2 unfounded. When an investigation is completed at the local level, the facility must submit to the corporate office for review and a final outcome determination. Of those eight open cases, the facility had completed the administrative investigation and was waiting on the corporate review to close. There were no cases referred for criminal investigation nor referred for prosecution. A review of ten cases was conducted by the Auditor.

**Recommendation:** The facility should maintain documentation in the investigation file of when the report is forwarded to the corporate office. This would document the timely completion of the investigation by the facility.

**Recommendation:** The facility should obtain a MOU with Houston Police Department if the agency will be conducting criminal investigations for the facility.

## Standard 115.272: Evidentiary standard for administrative investigations

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?  Yes  No

### Auditor Overall Compliance Determination

**Exceeds Standard** (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The Investigator stated the standard of proof for administrative investigations is a preponderance of evidence, 51%. The agency policy 5.1.2-E confirms that no standard higher than a preponderance of evidence will be imposed in determining allegations of sexual abuse as substantiated. The review of the investigation files supported the practice.

## Standard 115.273: Reporting to residents

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?  Yes  No

#### 115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)  Yes  No  NA

#### 115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?  Yes  No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?  Yes  No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?  Yes  No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident

whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?  Yes  No

#### 115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?  
 Yes  No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?  
 Yes  No

#### 115.273 (e)

- Does the agency document all such notifications or attempted notifications?  Yes  No

#### 115.273 (f)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-E and facility's policy 0803-1 outlines the reporting of investigation outcomes to residents. The resident is notified whether the allegation was determined substantiated, unsubstantiated, or unfounded through a written notification by the facility administrator or designated staff member on the Notification of Outcome of Allegation Form. The PREA Compliance Manager stated it is part of her responsibility to notify the resident the outcome of the investigation. The resident receives the original and a copy is maintained as part of the investigative file. The resident would be met with privately and informed of the investigative outcome. The Notification of Outcome of Allegation is completed with the resident signing acknowledging receiving the outcome and the staff issuing the notice would also sign the form with the date of notification. The PREA Compliance Manager stated residents are notified of the investigation outcome if the resident is still in detention and the notification is mailed to a released resident if the facility has an address. The Auditor reviewed the completed notifications in the investigation files which documented the PREA Compliance Manager made the notifications for all officially closed cases.

If the alleged abuser was an employee, the policy requires the victim to be informed of the status of the staff member to include whether the staff member is no longer posted within the resident's housing unit, the staff member is no longer employed at the facility, the facility learns that the staff member has been indicted on a charge related to sexual abuse within the facility, and/or the agency learns the staff member has been convicted on a charge related

to sexual abuse within the facility. This notification is also documented on the Notification of Outcome of Allegation. If the allegation was sexual abuse by another resident, the policy requires the victim to be informed whether the alleged abuser has been indicted on a charge related to sexual abuse within the facility and/or convicted on a charge related to sexual abuse within the facility. This notification is also documented on the Notification of Outcome of Allegation. Three of the residents interviewed that reported an allegation stated they were informed that the staff was removed from the post; one was told the alleged abuser was transferred, and the other was told the alleged abuser was discharged. The Auditor interviewed four residents that reported sexual abuse; one acknowledged receiving notifications of the outcome being unsubstantiated. The other three noted their cases were still open and they were kept informed that the case was still open.

The facility will request the outcome of a criminal investigation conducted by an outside law enforcement entity. The resident will be informed of the outcome of the case. An updated notification may be needed at the conclusion of a criminal proceeding, if the resident is still in custody at the facility or if the facility has the resident's address the notification will be mailed after release or transfer.

The notifications to the resident are not made timely from the date of the completed investigation by the facility. The facility is required to make the notification after corporate reviews the investigation report and determines a final outcome.

The facility exceeds the standard by the measures that are taken to inform the resident of the outcome of the investigation. The PREA Compliance Manager takes the extra measure to search and research to obtain an address to mail the outcome to the resident. Also, the resident is provided the notification in person and the results are explained the resident and then the resident signs for the outcome for documentation of the notification.

## DISCIPLINE

### Standard 115.276: Disciplinary sanctions for staff

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

##### 115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?  Yes  No

##### 115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?  Yes  No

##### 115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?  Yes  No

### 115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal?  Yes  No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-E and Employee Handbook covers that staff shall be subject to disciplinary sanctions for substantiated violations of sexual abuse and harassment policies, up to and including termination for any employee found guilty of sexual abuse. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. The Facility Director stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact resident post or placed on administrative leave until the investigation is completed. If the case was substantiated, the staff member would be terminated. The agency's policy stated the disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The policies also direct that the facility shall report all terminations and resignations for such conduct to law enforcement and licensing bodies, unless the activity was clearly not criminal.

During the audit period, there were no violations by staff of the agency's policies related to sexual abuse or sexual harassment as documented through a memo to file and interviews with the Facility Director and Human Resources staff.

### Standard 115.277: Corrective action for contractors and volunteers

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

### 115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?  Yes  No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal?  Yes  No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?  Yes  No

#### 115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policies 5.1.2-A and 5.1.2-E details the corrective action for contractors and volunteers who have engaged in sexual abuse. Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and reported, unless the activity was clearly not criminal. Substantiated allegations would be reported to local law enforcement, unless the activity was clearly not criminal. All reasonable efforts would be made to report to any relevant licensing bodies. In the case of any other violation of GEO Sexual Abuse or Sexual Harassment policies by a contractor or volunteer, the facility shall notify the applicable GEO contracting authority who will take remedial measures and shall consider whether to prohibit further contact with individuals in a GEO facility or program. The TDCJ Contract Monitor would also be notified. The Facility Director stated that the contractor or volunteer would not be allowed at the facility during investigation or contact with any residents. If substantiated, the volunteer or contractor shall be removed from all duties and clearance revoked permanently. If criminal, the case would be referred to local law enforcement. The volunteer interviewed confirmed knowledge of the policies and remedial measures taken for engaging in sexual abuse or sexual harassment of a resident through the training received. Noted by a memo to file and the PAQ, there were no instances where a volunteer or contractor was removed for allegations of sexual abuse. The Facility Director did note that two contractors had clearance to the facility revoked for inappropriate dress, however, they were not PREA related.

#### Standard 115.278: Interventions and disciplinary sanctions for residents

##### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?  Yes  No

#### 115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?  Yes  No

#### 115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?  Yes  No

#### 115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits?  Yes  No

#### 115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?  Yes  No

#### 115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?  Yes  No

#### 115.278 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)  
 Yes  No  NA

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency's policy 5.1.2-E and PREA Educational Manual for Residents outlines the resident disciplinary sanctions. It states a resident who are found guilty of engaging in sexual abuse involving other individuals in a GEO

facility or program (either through administrative or criminal investigations) shall be subject to formal disciplinary sanctions. The Facility Director stated the TDCJ Contract Monitor and /or Parole Officer would be notified. TDCJ will determine whether to subject the resident to formal disciplinary sanctions. If the resident is subject to disciplinary sanctions, the resident would be referred to the internal disciplinary process. TDCJ may revoke parole by issuing a technical violation and/or transfer the resident to another facility. The policy also notes that all steps in the disciplinary process and sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the resident to conform with rules and regulations in the future. The Facility Director also indicated sanctions are commensurate within the disciplinary process for the level of prohibited act. The facility utilizes an interdisciplinary guidelines for sanctioning that is provided to the residents through the Resident Handbook and House Rules. The Facility Director indicated in the interview that disciplinary sanctions could include extra duties and restrictions for 24-hours.

Policy 5.1.2-E states the internal disciplinary process shall 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 Facility Director stated staff would look at the resident history and if the resident was on medications; consideration would also be given to residents with special needs. If the case is substantiated, the resident would still receive some type of sanctions stated the Facility Director. The agency policy states if the facility offers counseling or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending resident to participate. The facility does not offer counseling, the resident would be referred to an outside agency. The Parole Officer will determine if the resident will be required to participate.

The policy also outlines a resident shall not be disciplined for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying. The facility may not deem that sexual activity between residents is sexual abuse unless it is determined that the activity was coerced, per policy. The PREA Educational Manual for Residents states that consensual relationships are not permitted and against policy.

During the audit period, no residents were referred to the internal disciplinary process for sexual abuse or sexual activity. This was documented through the PAQ and memo to file.

## MEDICAL AND MENTAL CARE

### Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?  
 Yes  No

#### 115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?  Yes  No
- Do security staff first responders immediately notify the appropriate medical and mental health practitioners?  Yes  No

#### 115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?  Yes  No

#### 115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The facility does not have medical or mental health services onsite. The medical and mental health services are available to the resident through community resources. The agency's policy 5.1.2-A and facility's policy 0803-1 states that reentry community correction facilities shall utilize local community facilities to provide emergency medical treatment and crisis intervention if onsite medical and mental health providers are not available. Following a reported PREA allegation, a Resident Referral Verification form will be utilized to document the offer that onsite or offsite mental health services was made to the resident victim. The referral forms are forwarded to TDCJ who approves the referral, except in emergency situations.

All alleged victims of sexual assault who require a forensic exam are taken to Harris Health System for completion of the forensic exam and emergency medical healthcare with no cost to the resident. The facility has attempted to obtain a MOU with Harris Health System starting in 2016 and the last attempt was in January 2019 as documented through emails. Services are available through the emergency department 24-hours a day 7 days a week. There were no allegations that required outside medical services or forensic medical exams. The Auditor review of the resident investigation files for referrals showed that referrals were made utilizing the Resident Referral Verification forms. The four residents that reported sexual allegations, only one was sexual abuse. This resident stated medical and mental health services were offered and he refused the services. A memo to file states the facility had no victims requiring immediate access to medical services for the audit period.

The facility has a MOU with Montrose Center. The MOU states the Montrose Center will provide trained specialist to help identify and prioritize the needs of the victim, and connect them with helpful resources; provide information

informing the victim of their rights under the law, and referrals for legal consultation and representation when ready; provide the victim with a support advocate to accompany them during medical exams, legal and or court appointments; and provide confidential emotional support services related to sexual abuse consistent with those that are provided to the community. There was documentation of residents that reported referred for counseling services through the Victim Advocate Referral form and the Emergency Activity Sheet. The Facility Director stated the Harris Health Center started mental health tele-med in the fall of 2018 that can be utilized also.

All staff are trained in CPR, first aid, and AED usage. During the staff interviews, some staff were knowledgeable of the steps of a first responder including the referral of the resident to medical services. The facility provided updated refresher training for all staff on first responder roles and provided documentation of the training to the Auditor.

The agency policy 5.1.2-A and facility policy 0803-1 states victims of sexual abuse in custody shall receive, timely, unimpeded access to emergency medical treatment and crisis intervention services. The services would include offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis. Following a reported PREA allegation, a Resident Referral Verification Form will be utilized to document the offer for offsite medical and mental health services was made to the resident victim. The form will also document the acceptance or refusal of these services. The policies also state all services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

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

### **All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

#### **115.283 (a)**

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?  Yes  No

#### **115.283 (b)**

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?  Yes  No

#### **115.283 (c)**

- Does the facility provide such victims with medical and mental health services consistent with the community level of care?  Yes  No

#### **115.283 (d)**

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)  Yes  No  NA

#### **115.283 (e)**

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)  Yes  No  NA

#### 115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?  Yes  No

#### 115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?  Yes  No

#### 115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The facility does not employ medical and mental health staff. The medical and mental health services are available to the resident through community agencies. The agency's policy 5.1.2-A and facility's policy 0803-1 states that reentry community correction facilities shall utilize local community facilities to provide emergency medical treatment and crisis intervention if onsite medical and mental health providers are not available. Following a reported PREA allegation, a Resident Referral Verification form will be utilized to document the offer that onsite or offsite medical and mental health services were made to the resident victim. The referral form is forwarded to TDCJ for approval, except in emergency situations.

The agency policy 5.1.2-A and facility policy 0803-1 states each facility shall offer medical and mental health evaluations and treatment where appropriate to all victims of sexual abuse. The intake staff are trained to do health screenings which are conducted upon arrival to the facility. If the resident reports prior victimization or is scored as a potential abuser, the resident is referred for mental health services. The referral must take place within 48 hours and the shift supervisor must be notified prior to housing. Of the eleven resident files reviewed, ten residents were referred for mental health services: seven of the residents declined the referral, and the refusals were documented in writing in the resident file. Of the four residents that reported sexual allegations; three residents stated the facility offered a referral for victim advocacy services to an outside agency; the residents refused and stated they did not

need support services. Of the five intakes observed by the Auditor, two residents were offered a referral for mental health services, both refused the referral.

The agency policy outlines the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The program shall help such victims with access to medical and mental health services consistent with the community level of care. Resident victims of sexual abuse while incarcerated shall be provided referrals for tests for sexually transmitted infections as medically appropriate. Staff will also provide residents with requested level of support through assisting with making appointments, transportation needs, and victim advocacy or staff accompaniment. On-going treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall attempt to coordinate a mental health evaluation of all known resident-on-resident abusers who remain in the facility within 60 days of learning of such abuse history and connect abusers with treatment when deemed appropriate by outside mental health practitioners. These health care services will be provided in a manner that is consistent with the level of care the individual would receive in the community per agency policy 5.1.2-A. All refusals for medical and mental health services shall be documented.

All alleged victims of sexual assault who require a forensic exam are taken to Harris Health System for completion of the forensic exam and emergency medical healthcare with no cost to the resident. The facility has attempted to obtain a MOU with Harris Health System starting in 2016 and the last attempt was in January 2019 as documented through emails. Services are available through the emergency department 24-hours a day 7 days a week. There were no allegations that required outside medical services or forensic medical exams. The Auditor review of the resident investigation files for referrals showed that referrals were made utilizing the Resident Referral Verification forms. The four residents that reported sexual allegations, only one was sexual abuse. This resident stated medical and mental health services were offered and he refused the services. A memo to file states the facility had no victims requiring immediate access to medical services for the audit period. There were no allegations that required outside medical services, forensic medical exams, or treatment plans related to sexual abuse per memo to file.

The facility has a MOU with Montrose Center. The MOU states the Montrose Center will provide trained specialist to help identify and prioritize the needs of the victim, and connect them with helpful resources; provide information informing the victim of their rights under the law, and referrals for legal consultation and representation when ready; provide the victim with a support advocate to accompany them during medical exams, legal and or court appointments; and provide confidential emotional support services related to sexual abuse consistent with those that are provided to the community. There was documentation of residents that reported referred for counseling services through the Victim Advocate Referral form and the Emergency Activity Sheet. The Facility Director stated the Harris Health Center started mental health tele-med in the fall of 2018 that can be utilized also.

Residents in need of medical treatment can make appointments with local doctors and utilize the hospital's emergency room. If there is a medical emergency, 911 would be called. The resident would be transported by the EMS with staff escort. Non-emergency incidents may be transferred by facility staff. Medications are stored and given to residents by the Resident Medical Advocate that reports to the facility. Residents are allowed to have approved keep-on-person medications. Mental health, drug abuse, and sex offender treatment services are provided through local outside agencies.

## **DATA COLLECTION AND REVIEW**

## Standard 115.286: Sexual abuse incident reviews

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?  Yes  No

#### 115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation?  Yes  No

#### 115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?  Yes  No

#### 115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?  Yes  No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?  Yes  No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?  Yes  No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts?  Yes  No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?  Yes  No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?  Yes  No

#### 115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency policy 5.1.2-A and facility policy 0803-1 outlines the requirement, procedures, and timeframes for sexual abuse incident reviews. Designated staff are required to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation determined unsubstantiated and substantiated. The Facility Director stated the team consists of the Facility Director, Assistant Facility Director, and the PREA Compliance Manager. The agency's PREA Coordinator may be consulted as part of the review. The review is completed within 30 days of the conclusion of the investigation. The review team utilizes the PREA After Action Review Report to complete and document the review. The form captures the allegation findings; a short summary of allegation/incident; involved residents; the items reviewed; name of the participants in the after action review by name and title; any recommendations including a change in policy or practice that could better assist in the prevention, detection, and response to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff in the area where the incident allegedly occurred; and whether the actions taken by staff in regards to this incident were reasonable and appropriate based on policy. The form contains a section to make recommendations as a result of the after-action review. The review is forwarded to the agency's PREA Coordinator within ten days after the review. The facility's PREA Compliance Manager is responsible for implementing any recommendation for improvement or document its reasons for not doing so. The After-Action Review Report is maintained in the investigative file. The Auditor reviewed the investigation files and noted that incident reviews are completed on cases when the investigation process is completed through the agency review.

The Incident Review Team members stated they review the outcome of the case, steps taken during investigation, and corrective actions. They also identified all the components reviewed in an After-Action Review. They noted they review for motivation including gang related, sexual orientation, race, housed appropriately, and occurred from previous incident. For the incident physical area, they review for blind spots, barriers, and camera coverage. When reviewing adequacy of staffing, and was staff following policy, adequate coverage, is further training needed, staff in correct area for post, and was the allegation reported correctly. For monitoring technology, if additional cameras are needed in the area, do cameras need adjusted, and the placement of mirrors. The incident review team interviewed stated there are no trends noted for locations. They did state a trend identified if allegations over pat-searches when returning to the facility when staff find contraband on the resident.

## Standard 115.287: Data collection

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?  Yes  No

#### 115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?  Yes  No

#### 115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?  Yes  No

#### 115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?  Yes  No

#### 115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)  Yes  No  NA

#### 115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)  Yes  No  NA

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency policy 5.1.2-A outlines the procedures for data collection. The facility collects and retains data related to sexual abuse as directed by the agency's PREA Coordinator. This data includes case records associated with claims of sexual abuse including investigative reports, resident information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary. The PREA Compliance Manager stated she is responsible for compiling data collected on sexual activity and sexual abuse incidents. The Monthly PREA Incident Tracking Log, is forwarded monthly to the agency's PREA Coordinator that documents the facility's PREA statistical information. The PREA Compliance Manager stated she is also responsible for reporting all incidents to TDCJ through a significant incident report. The PREA Compliance Manager

will create and update the PREA Survey in the PREA Portal for every allegation of sexual abuse and sexual activity. The data is secured in a locked file cabinet in a secure office with restricted access as observed by the Auditor. The established retention schedule is 10 years for these files. Policy states, upon request, GEO shall provide such data from previous calendar year to the Department of Justice no later than June 30.

The agency does not contract for the confinement of residents.

Policy 5.1.2-A outlines the procedures for conducting an annual review of all sexual abuse investigations and resulting incident reviews. The 2018 Annual Review of Sexual Abuse Investigations and Corrective Action Plan was completed on May 23, 2019. The document is divided into three sections; comparisons of data from 2017 and 2018, findings, and corrective action plan. The agency's PREA office compiles an annual PREA report for the company which includes breakdowns by facility. This report is available on the GEO website [www.geogroup.com/PREA](http://www.geogroup.com/PREA).

The 2015, 2016, and 2017 PREA Annual Reports were reviewed by the Auditor prior to the audit. The 2018 Annual PREA Report was posted for review on the agency's website just prior to the on-site audit and was reviewed by the Auditor.

## Standard 115.288: Data review for corrective action

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?  Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?  Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?  Yes  No

#### 115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse  Yes  No

#### 115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?  Yes  No

#### 115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency policy 5.1.2-A outlines the procedures for data collection. The facility collects and retains data related to sexual abuse as directed by the agency's PREA Coordinator. This data includes case records associated with claims of sexual abuse including investigative reports, resident information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary. The agency's PREA Division reviews all data collected in order to assess and improve the effectiveness of the agency's sexual abuse prevention, detection, response policies, practices, and training including; identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings and corrective actions for the facility, as well as, the agency as a whole, per policy 5.1.2-A. The agency's PREA Coordinator stated all facilities conduct sexual abuse incident reviews after each substantiated or unsubstantiated case. Any recommendations for improvement, problem areas identified, or corrective actions needed are documented and forwarded to the agency's PREA Coordinator to review. Annually each facility prepares a report of their findings and recommendations from their incident reviews and these reports are reviewed by the agency's PREA Coordinator and the appropriate division head for US Corrections, Reentry Community Confinement, and Youth services. Data collected from these reports, plus the data from all of the allegations reported each year, are contained in the secure PREA database and are aggregated and analyzed to improve the PREA program.

The agency's PREA Coordinator indicated the agency has prepared an Annual Report since 2013. The reports include the total number of allegations received from all our facilities and the outcome of each allegation. Policy 5.1.2-A outlines the procedures for conducting an annual review of all sexual abuse investigations and resulting incident reviews. The 2018 Annual Review of Sexual Abuse Investigations and Corrective Action Plan was completed on May 23, 2019. The document is divided into three sections; comparisons of data from 2017 and 2018, findings, and corrective action plan. The agency's PREA office compiles an annual PREA report for the company which includes breakdowns by facility. The Annual Report is approved and signed by the Senior Vice President of U.S. Corrections and Detention and International Operations and Senior Vice President of GEO Care. The Annual Reports are available on the GEO website [www.geogroup.com/PREA](http://www.geogroup.com/PREA). Agency policy notes that GEO may redact specific material from the reports when publications would present a clear and specific threat to the safety and security of a facility; but must indicate the nature of the material redacted. The agency's PREA Coordinator stated the agency only reports numbers and incident types; victims, perps, staff names, and any type of personal identifiable information is omitted for confidentiality purposes.

The 2018 PREA Annual Report is available for review on the agency's website.

## Standard 115.289: Data storage, publication, and destruction

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained?  
 Yes  No

#### 115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?  Yes  No

#### 115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?  Yes  No

#### 115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?  Yes  No

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The PREA Compliance Manager secures all facility data in locked file cabinet in a locked office with restricted access as observed by the Auditor and through the PREA Portal for every allegation of sexual abuse and sexual activity. The agency's PREA Coordinator indicated that all data collected from facility reports plus the agency's data from all of the allegations reported each year are contained in the agency's secure PREA database. The data is aggregated and analyzed to improve the agency's PREA program. The data is made readily available through the Annual Report which is posted on the agency's website [www.geogroup.com/PREA](http://www.geogroup.com/PREA). Agency policy notes that the agency may redact specific material from the reports when publications would present a clear and specific threat to the safety and security of a facility; but must indicate the nature of the material redacted. The agency's PREA Coordinator stated the agency only reports numbers and incident types; victims, perps, staff names, and any type of personal identifiable information is omitted for confidentiality purposes. The established retention schedule is 10 years for data collected or longer if required by state statute.

The 2015, 2016, 2017, and 2018 PREA Annual Reports were reviewed by the Auditor prior to the audit. The 2018 Annual PREA Report is available for review on the agency's website.

## AUDITING AND CORRECTIVE ACTION

### Standard 115.401: Frequency and scope of audits

#### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

##### 115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*)  Yes  No

##### 115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*)  Yes  No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.)  Yes  No  NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.)  Yes  No  NA

##### 115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?  Yes  No

##### 115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?  Yes  No

##### 115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and residents?  Yes  No

##### 115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?  Yes  No

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The agency policy 5.1.2-A states that during the three-year period starting on August 2013, and each three-year period thereafter, GEO Contract Compliance Department shall ensure that each facility is audited at least once by a PREA Auditor who has been certified through the Department of Justice. The review of the agency's website confirms that PREA audits are being conducted on the agency's facilities with audit dates over the last three years. According to agency's PREA Coordinator, during the three-year period beginning on August 20, 2013, GEO ensured that each of its facilities were audited at least once and continues to ensure that its facilities are audited every three years. This is the second PREA audit for this facility. The first audit was conducted in May 2016 and posted on the agency's website.

During the audit, the facility and agency provided the auditor full access to all areas of the facility and the Auditor was able to observe practices. Prior to the audit, during the audit, and after the on-site audit, the agency and facility provided the Auditor requested documents. Private interview space was provided to the Auditor for conducting staff and resident interviews. Staff interviews were held in an administrative conference room in the administrative building. Resident interviews were conducted in an office outside the control center. Posted signs advised residents they could send confidential information or correspondence to the auditor. The auditor received no correspondences.

Based on the above information, the agency/facility meets the Standard 115.401 Frequency and scope of audit requirements.

## Standard 115.403: Audit contents and findings

### All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

#### 115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued

in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.)  Yes  No  NA

**Auditor Overall Compliance Determination**

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

A review of the agency’s website [www.geogroup.com](http://www.geogroup.com) under the Social Responsibilities - PREA Page confirms that the agency publishes PREA final reports and makes them available through the website to the public. The auditor observed on the agency’s website final reports of the agency’s other facilities. The agency meets the requirements of this part of Standard 115.403 (f) Audit contents and findings.

<b>AUDITOR CERTIFICATION</b>
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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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Barbara A. King  
**Auditor Signature**

September 20, 2019  
**Date**