PREA AUDIT REPORT ☐ **Interim** **X Final**

ADULT PRISONS & JAILS

Date of report: August 7, 2017

Auditor Information			
Auditor name: Dudley Kesler			
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Email: dudley.kesler@namamotogroup.com			
Telephone number: (618) 614-0170			
Date of facility visit: August 1-3, 2017			
Facility Information			
Facility name: Casper Re-Entry Center			
Facility physical address: 10007 Landmark Lane, Casper, WY 82604			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: (307) 268-4840			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	X Private for profit
	☐ Private not for profit		
Facility type:	X Prison	☐ Jail	
Name of facility's Chief Executive Officer: Joshua Brown			
Number of staff assigned to the facility in the last 12 months: 73			
Designed facility capacity: 342			
Current population of facility: 249			
Facility security levels/inmate custody levels: Minimum, Minimum-Restricted, Medium, Community			
Age range of the population: 18-75			
Name of PREA Compliance Manager: Dulci Garcia		**Title:** Training Coordinator/PREA Complaince Manager	
Email address: dulci.garcia@cecintl.com		**Telephone number:** 307-268-4871	
Agency Information			
Name of agency: The GEO Group Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: One Park Place, Suite 700, 621 Northwest 53rd Street, Boca Raton Florida 33487			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 561-893-0101			
Agency Chief Executive Officer			
Name: George C. Zoley		**Title:** Chairman of the Board, CEO and Founder	
Email address: gzoley@geogroup.com		**Telephone number:** 561-893-0101	
Agency-Wide PREA Coordinator			
Name: Phebia L. Moreland		**Title:** Director, Contract Compliance/PREA Coordinator	
Email address: pmoreland@geogroup.com		**Telephone number:** 561-893-0101	

AUDIT FINDINGS

NARRATIVE

The on-site visit for the Prison Rape Elimination Act (PREA) compliance audit of the Casper Re-entry Center was conducted on August 1-3, 2017 by Nakamoto Group Inc. auditor Dudley Kesler. An in-briefing meeting was held with the facility Executive Staff, PREA Manager, and a Corporate Compliance Officer.

The standards used for this audit became effective August 20, 2012. This auditor discussed the information contained in the Pre-Audit Questionnaire with the facility PREA Compliance Manager. As part of the audit, a review of all agency and local facility PREA policies was conducted, as well as a tour of the facility.

During the auditing period there were 11 allegations of sexual harassment reported. Of those, two were determined to be unfounded, five were substantiated, and four were unsubstantiated. All the investigative files were reviewed and found to be comprehensive and well organized.

A total of 29 residents were interviewed from all housing areas. All residents were aware of the PREA program and indicated they had been provided with adequate resources to report an incident of sexual abuse or sexual harassment if necessary.

A total of 42 staff were interviewed including 10 residential managers (from both 12 hour shifts), three administrative staff, and 29 specialized staff. The administrative staff interviewed included the Director, Human Resource Manager, and PREA Compliance Manager. The specialized staff included first responders, intake staff, screening staff, the retaliation monitor, an incident review team member, segregated housing unit staff, investigative staff, a representative from the local hospital, and a representative from the local advocacy group.

During the tour, a blind spot was discovered in the rear of the gymnasium. Maintenance staff installed a concave mirror to allow viewing access into this area. This mirror was installed in a very expedient manner and the blind spot was alleviated.

DESCRIPTION OF FACILITY CHARACTERISTICS

Casper Re-entry Center (CRC) provides intensive Therapeutic Community (TC) model residential treatment, case management, work release, day reporting and transitional services to misdemeanant and felony offenders with substance use disorders. The treatment component consists of individual assessments, individual and group counseling, substance abuse treatment, educational services, vocational training, skills-based trainings, family services, Fatherhood Initiative program, NA/AA groups, anger management, and aftercare/Alumni services. The center also has a specialized program for Native Americans that are referred from the Bureau of Indian Affairs (BIA). This CRC program presents a focused effort on providing effective and culturally sensitive treatment service. Residents' course and progress in treatment is contingent upon comprehensive multi-disciplinary case planning to include: regularly updated treatment plans, behavioral evaluations, merit/demerit reports, pre/post test results, journaling, individual and group treatment progress, attendance, general walk-around behavior, status hearings, incentives/sanctions, and competency-based phase progression/regression.

The Casper Re-Entry Center has a capacity of 342 males and females. There are currently 223 males and 26 female residents housed at this facility. This population is derived from the Wyoming Department of Corrections, County & City offenders, as well as Federal Bureau of Prisons inmates.

CRC was established in 1985. The Center expanded and moved to the current building in January 2005. The facility is roughly divided into equal populations of secure residents and community corrections residents. The community corrections residents work outside the facility and return at the end of their work shift.

SUMMARY OF AUDIT FINDINGS

When the on-site audit was completed, an "out-briefing" meeting was held with the Director, Associate Director, various department heads, Corporate Compliance Officer, PREA Compliance Manager, and the Corporate PREA Compliance Coordinator (via telephone). The auditor was provided with extensive and lengthy files prior to the audit for review to support a conclusion of compliance with the PREA. All facility staff were found to be extremely courteous, cooperative and professional. All areas of the facility were found to be clean and well maintained. At the conclusion of the audit, the auditor thanked the CRC staff for their hard work and dedication to the PREA process.

Number of standards exceeded: 0

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

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

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

Policy 1200.06 addresses this standard. The agency's zero tolerance against sexual abuse is clearly established and the policy also outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. In addition to the facility PREA Compliance Manager, there is a designated Corporate PREA Coordinator. The facility PREA Compliance Manager reports to the Director. Zero tolerance posters were noted throughout every area of the institution. Staff receive initial training and annual training, as well as, updates throughout the year.

Standard 115.12 Contracting with other entities for the confinement of inmates

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

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

Not applicable- This facility does not contract with other entities for the confinement of residents.

Standard 115.13 Supervision and monitoring

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

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

Policy 1200.06 addresses this standard. Agency policy requires each facility to review the staffing plans on an annual basis. An interview with the Director revealed compliance with PREA standard. It was also noted that other safety and security issues are always a primary focus when they consider and review their staffing plan. The facility has been provided with all necessary resources to support the programs and procedures to ensure compliance with PREA standards. The audit included an examination of all video monitoring systems, resident

access to telephones, and rosters. Interviews with executive staff confirmed unannounced rounds to all areas of the institution are conducted on a weekly basis, with no warning to line staff. Video cameras with monitoring capabilities are visible in select areas of the facility. The cameras are recorded and monitored at the control center.

Standard 115.14 Youthful inmates

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

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

Not applicable - There are no youthful residents housed at this facility.

Standard 115.15 Limits to cross-gender viewing and searches

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

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

Policy 1200.06 addresses this standard. Cross-gender strip or cross-gender body cavity searches are prohibited, except in emergency situations or when performed and documented by a medical practitioner. Staff indicated they received cross-gender pat search training during initial and annual training. The auditor observed that each unit has individual shower stalls with curtains for privacy purposes. Residents, residential managers, and administrative staff stated residents are allowed to shower, dress and use the toilet privately, without being viewed by the opposite gender. Residents and staff reported staff of the opposite gender announce their presence before entering a housing unit. Staff were well aware of the policy prohibiting the search of a trans-gender or inter-sex resident for the sole purpose of determining the residents genital status.

Standard 115.16 Inmates with disabilities and inmates who are limited English proficient

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

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

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

Policy 1200.06 addresses this standard. CRC takes appropriate steps to ensure residents with disabilities and residents with Limited English Proficiency (LEP) have an opportunity to participate in and benefit from the facilities efforts to prevent, detect and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings and resident handbooks are in both English and Spanish. Staff interviewed were well aware of the policy that, under no circumstances, are inmate interpreters or assistants to be used when dealing with PREA issues.

Standard 115.17 Hiring and promotion decisions

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

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

Policy 1200.06 address this standard. The Human Resource Manager was interviewed and stated that all components of this standard have been met. All employees, contractors and volunteers have had background checks completed. Background checks are conducted before approving staff promotions. A tracking system is in place to ensure that updated background checks are conducted every five years.

Standard 115.18 Upgrades to facilities and technologies

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

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

Not applicable - There has been no significant upgrades to this facility since the previous audit.

Standard 115.21 Evidence protocol and forensic medical examinations

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

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

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

Policy 1200.06 addresses this standard. First responders were interviewed concerning this standard and all were knowledgeable of the procedures required to secure and obtain usable physical evidence, when sexual abuse is alleged. Staff were aware the facilities investigators or local law enforcement conduct investigations relative to sexual abuse allegations. All forensic medical examinations are conducted by a SANE/SAFE nurse through an agreement with Wyoming Medical Center located in Casper Wyoming. An interview with the supervisory nurse at Wyoming Medical Center confirmed they have Sexual Assault Nurse Examiners (SANE) to conduct forensic examinations if needed. There were no forensic exams conducted during the past 12 months.

Standard 115.22 Policies to ensure referrals of allegations for investigations

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

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

Policy 1200.06 addresses this standard. Administrative or criminal investigations are completed on all allegations of sexual abuse/harassment. The Special Investigative Officers of the local law enforcement may conduct investigations. During the reporting period, there were 11 incidents involving allegations of sexual harassment or abuse. Two were determined to be unfounded, five were found to be substantiated, and four were determined to be unsubstantiated. Eight allegations involved staff on resident, (or inappropriate relationships), and three involved resident on resident allegations. All the investigation packets were reviewed and found to be complete, thorough, and very well organized.

Standard 115.31 Employee training

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

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

Policy 1200.06 addresses this standard. The CRC provides extensive PREA standards training for all new staff. Additionally, contractors and volunteers are provided training relative to their duties and responsibilities. In addition, all staff are mandated to receive training annually and the curriculum includes PREA requirements. The auditor reviewed the training curriculum, training sign-in sheets and other related documentation as well as interviewed staff that indicated they received PREA training. All staff were considered to be well versed in their individual areas of responsibility concerning PREA.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 addresses this standard. Training documentation for contractors and volunteers were reviewed and found to be in compliance with this standard. The training is documented and copies of training sign-in sheets and other related documents were reviewed by this auditor. An interview with the human resources manager was conducted who was well aware of the training requirements for contractors and volunteers. There were no contractors or volunteers available to be interviewed during the audit.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 1200.06 addresses this standard. The facility puts forth its best efforts in educating the residents about the PREA. Residents receive information during the intake process that includes a handbook, printed in both English and Spanish. There are PREA posters throughout the facility and, in each housing unit, a "hotline" telephone number which may be called to report abuse or harassment, is posted on the bulletin boards. All residents interviewed indicated they had received a handbook and training during orientation relative to PREA and were considered well trained in the PREA standards.

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 address this standard. The staff investigators have received PREA specialized training through the Community Education Center entitled "Investigating Sexual Abuse and Sexual Harassment". This auditor reviewed training certificates of completion and training

outlines. All training documentation was complete and thorough.

Standard 115.35 Specialized training: Medical and mental health care

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

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

Policy 1200.06 address this standard. All mental health and medical staff are required and have received specialized training on medical and mental health issues as they relate to PREA. Staff also receive training annually and documentation is on file. The auditor reviewed the training lesson plan, training sign-in sheets for Medical and Mental Health Practitioners.

Standard 115.41 Screening for risk of victimization and abusiveness

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

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

Policy 1200.06 addresses this standard. All residents are assessed at intake for their risk of being sexually abused and/or harassed by other residents or being sexually abusive towards other residents. A unit staff member screens all new arrivals within their first 72 hours. They are almost always seen the first day of their arrival. The staff reviews all relevant information from other facilities and reassess residents risk level within 30 days of their arrival. Residents identified as high risk for sexual victimization or at risk of sexually abusing other residents are referred to the mental health staff for additional assessment. Staff and resident interviews, as well as a review of documentation, support the finding that facility is in compliance with this standard.

Standard 115.42 Use of screening information

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

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corrective actions taken by the facility.

Policy 1200.06 address this standard. Agency policy and institution procedures require the use of a screening instrument to determine proper housing, bed assignment, work assignment, education and other program assignments, with the goal of keeping residents at high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Housing and program assignments are made on a case by case basis and residents are not placed in housing units based solely on their sexual identification or status.

Standard 115.43 Protective custody

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

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

Policy 1200.06 addresses this standard. CRC has one Special Housing Unit (SHU) with two cells. Policy states inmates at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made and there's no available means of separating the resident from the abuser. Interviews with staff indicate residents are only placed in Administrative Segregation during investigations which usually only last a few days. Any residents requiring additional time in Administrative or Disciplinary Segregation are transferred to other facilities.

Standard 115.51 Inmate reporting

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

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Policy 1200.06 addresses this standard. A review of documentation and staff/resident interviews indicated that there are multiple ways (verbally, in writing, anonymously, privately and from a third party) for residents to report sexual abuse/sexual harassment. The facility has procedures in place for staff to document all allegations. There are posters and other documents on display throughout the facility (observed by auditor) which also explain reporting methods.

Standard 115.52 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Polcy 1200.06 addressed this standard. CRC shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. The agency may apply otherwise-applicable time limits on any portion of the grievance that does not allege an incident of sexual abuse. The agency does not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. A resident who alleges sexual abuse may submit the grievance without submitting it to the staff member who is subject of the complaint, and such grievance is not referred to a staff member who is the subject of the complaint. The agency 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

Standard 115.53 Inmate access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 addresses this standard. The facility has an agreement with the local chapter of the Self Help Center to provide counseling services for sexual assault victims. The organization offers counseling to male and female victims of sexual assault/sexual harassment. An interview with a representative of the Self Help Center confirmed they have a Memorandum Of Understanding with CRC and they perceive the PREA environment at CRC as being very positive.

Standard 115.54 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 1200.06 address this standard. Brochures visible for residents and visitors indicates "To Report an incident of Sexual Harassment or Sexual Abuse on behalf of a Resident, ask to speak with the Director of the Facility or call the CEC PREA hotline at 973-575-3928". A corporate website is also available to report incidents of sexual abuse or sexual harassment. Staff and residents interviewed were aware of the procedures for third-party reporting.

Standard 115.61 Staff and agency reporting duties

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

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

Policy 1200.06 addresses this standard. Staff interviewed were well aware of their duty to immediately report all allegations of sexual abuse, sexual harassment and retaliation relevant to PREA standards. The facility executive staff interviewed were well aware of the need to investigate any reports of abuse or harassment, including third party reports.

Standard 115.62 Agency protection duties

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

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

Policy 1200.06 addresses this standard. Staff interviewed were well aware of their duties and responsibilities, as it relates to them having knowledge of a resident being at imminent risk for being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the resident. They also stated they would separate the potential victim/predator, secure the scene to protect possible evidence, not allow residents to destroy possible evidence and contact the operations supervisor, medical and psychology staff.

Standard 115.63 Reporting to other confinement facilities

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

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

Policy 1200.06 addresses this standard. Policy requires that any allegation by a resident that they were sexually abused, while confined at another facility, must be reported to the head of the facility where the alleged abuse occurred, within 72 hours of receipt of the allegation. During the reporting period, there was one incident that a resident alleged being abused while confined at another facility. Notifications

were made and investigations were conducted. A review of the investigative file indicated a full investigation was completed.

Standard 115.64 Staff first responder duties

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

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

Policy 1200.06 addresses this standard. All staff interviewed were extremely knowledgeable concerning their first responder duties and responsibilities, upon learning of an allegation of sexual abuse or sexual harassment. Staff indicated they would separate the residents, secure the scene, not allow residents to destroy any evidence, contact the supervisor, and refer the resident to medical and psychology staff, if needed.

Standard 115.65 Coordinated response

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

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

Policy 1200.06 addresses this standard. A PREA flow chart has been developed and is utilized during an incident to ensure all necessary steps are taken. The documentation was reviewed by the auditor. The policy and checklist describe the coordinated actions to be taken by first responders, medical/mental health staff, investigators and facility administrative staff, in the event of an incident of sexual abuse.

Standard 115.66 Preservation of ability to protect inmates from contact with abusers

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

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

Policy 1200.06 addresses this standard. CRC has not and will not enter into any agreement which limits the 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.

Standard 115.67 Agency protection against retaliation

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

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

Policy 1200.06 addresses this standard. The policy prohibits any type of retaliation against any staff person or resident who has reported sexual abuse or sexual harassment or cooperated in any related investigations. The PREA Compliance Manager is charged with monitoring retaliation. During the interview, the Compliance Manager indicated she follows up with 90 day reviews to ensure policy is being enforced and conducts periodic status checks on the frequency of unjust incident reports, housing reassignments and negative performance reviews/staff job reassignments. If there was a concern of a potential for possible retaliation, the Program Manager indicated she would monitor the situation indefinitely. There have been no incidents of retaliation in the past 12 months.

Standard 115.68 Post-allegation protective custody

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

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

Policy 1200.06 addresses this standard. Interviews with staff and an examination of the facility indicated that there is a viable alternative to the placement of residents in involuntary segregated placement. Staff consider separate housing of the victim/predator, to include transfer of the residents. In the past 12 months there were no residents held in involuntary segregated placement for one to 24 hours awaiting completion of assessment and none held in involuntary segregated placement for longer than 30 days, while awaiting alternative placement.

Standard 115.71 Criminal and administrative agency investigations

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 1200.06 addresses this standard. The investigator conducts administrative investigations within the facility and refers criminal investigations to the local law enforcement to determine if prosecution will be pursued. There were no criminal prosecutions during this auditing period. Interviews with executive staff reveals the facility fully cooperates with any outside agency who initiates an investigation. The Investigator serves as the facility liaisons who provides requested information to the outside agency and provides access to the residents.

Standard 115.72 Evidentiary standard for administrative investigations

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

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

Policy 1200.06 addresses this standard. Interviews with staff involved with investigations revealed the evidence standard is a preponderance (51%) of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.73 Reporting to inmates

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

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

Policy 1200.06 addresses this standard. A review of documentation available for administrative investigations completed during the auditing period revealed all residents who had made allegations were notified in writing of the outcome of the investigation. The interviews with staff and review of the documentation supports the finding that the facility is in compliance with this standard.

Standard 115.76 Disciplinary sanctions for staff

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

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

Policy 1200.06 addresses this standard. Staff are subject to disciplinary sanctions for violating agency sexual abuse or sexual harassment policies. There were eight allegations of staff sexual harassment or inappropriate relationships with residents during the reporting period. Appropriate discipline was applied for those who were found guilty of harassment or inappropriate relationships.

Standard 115.77 Corrective action for contractors and volunteers

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

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

Policy 1200.06 addresses this standard. In the past 12 months, there have not been any contractors or volunteers accused of sexual abuse or sexual harassment of a resident. Policy and interviews with executive staff indicate any contractor or volunteer who is accused of sexual harassment or abuse will be removed pending the completion of an investigation and any who are found guilty will be permanently removed and referred for prosecution.

Standard 115.78 Disciplinary sanctions for inmates

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

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

Policy 1200.06 addresses this standard. There were three allegations of resident on resident sexual harassment or abuse during this rating period. Two were substantiated and appropriate disciplinary measures were administered. Policy does not allow consensual sex of any nature. CRC does not discipline residents who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Interviews with members of the executive staff support a finding that the facility is in compliance with this standard.

Standard 115.81 Medical and mental health screenings; history of sexual abuse

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 addresses this standard. Interviews with medical and specialized staff confirm the facility has a thorough system for collecting medical and mental health information and has the capacity to provide continued re-assessment and follow-up services. In the past 12 months all residents disclosing prior victimization during screening were offered follow-up services without financial cost to the resident. All information is handled confidentially and interviews with staff support a finding that the facility is in compliance with this standard.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 addresses this standard. Information and access to care is offered to all resident victims, as clinically indicated. The treatment is offered at no financial cost to the resident. An agreement with the local Self Help Center indicates that agency will provide an advocate to comfort the victim if requested. Interviews with staff support a finding that the facility is in compliance with this standard.

Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 addresses this standard. CRC offers medical and mental health evaluations and, as appropriate, treatment to all residents who have been victimized by sexual abuse. Services are consistent with a community level of care, without financial cost to the resident. A review of documentation and interviews with medical/mental health staff support the finding that this facility is in compliance with this standard.

Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 addresses this standard. The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was proven to be unfounded. Based on interviews with members of the incident review team, the review is conducted within 30 days of the conclusion of the investigation and consideration is given as to whether the incident was motivated by race, ethnicity, gender identity, status or gang affiliation. The team also makes a determination as to whether additional monitoring technology should be added to enhance staff supervision. The review team consists of the Director, Health Services Administrator, Clinical Director, affected department head and PREA compliance manager. The review team seeks additional information from other staff as needed to ensure a thorough review.

Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06. The facility collects accurate uniform data for every allegation of sexual abuse/sexual harassment by using a standardized instrument. The data collected includes the information necessary to answer all questions from the most recent version of the Survey of Sexual Violence, conducted by the Department of Justice. The agency aggregates all data annually and reviews it annually.

Standard 115.88 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 1200.06 addresses this standard. CRC reviews and assesses all sexual abuse/sexual harassment data at least annually to improve the effectiveness of its sexual abuse prevention, detection and response policies and to identify any trends, issues or problematic areas and take corrective action if needed. The facility PREA Compliance Manager forwards data to the Corporate PREA Coordinator. The data is then prepared and placed on the Agency website.

Standard 115.89 Data storage, publication, and destruction

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

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

Policy 1200.06 addresses this standard. The Corporate PREA Coordinator reviews data compiled by the facility PREA Compliance Managers and issues a report to the corporate directors on an annual basis. The data is retained in a secure file and published on the company website. The reports cover all data noted in this standard.

AUDITOR CERTIFICATION

I certify that:

- X The contents of this report are accurate to the best of my knowledge.
- X No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- X I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Dudley Kesler _____ August 7, 2017

Auditor Signature Date

THE STATE OF WYOMING

MATT MEAD
GOVERNOR

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October 4, 2017

To Whom it May Concern

The audit report for the Casper Reentry Center dated August 7, 2017, indicated in standard 115.71 that no PREA allegations were referred for criminal prosecution during the audit period. However, incidents reported in April 2016 and June 2016 was referred for criminal prosecution and are still pending at this time. Additionally, the showers listed in standard 115.15 were noted as all being individual shower stalls. Two male units in the building are open type showers with shower curtains separating the shower from the toilet facilities and there are no shower curtains separating the shower heads for those two showers. All other showers in the facility are individual showers.

Carrie Stanley
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