PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	11/16/2021	**To:**	11/18/2021
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	El Paso Field Office
Field Office Director:	Juan Acosta
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	11541 Montana Ave. Suite E. El Paso Tx 79936
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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Cibola County Correctional Center (CCCC)		
Physical address:	2000 Cibola Loop Milan NM 87021		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	915-225-1901		
Facility type:	IGSA		
PREA Incorporation Date:	10/27/2016		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-285-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Assistant Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-285-(b) (6), (b)

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	Click or tap here to enter text.

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

Directions: Discuss the audit process to include the date of the audit, names of all individuals in attendance, audit methodology, description of the sampling of staff and detainees interviewed, description of the areas of the facility toured, and a summary of facility characteristics.

The Prison Rape Elimination Act (PREA) audit of the Cibola County Correctional Center (CCCC) was conducted on November 16-18, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt for Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C), and Assistant Program Manager, (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards during the three years audit period ending November 15, 2021. The CCCC is privately owned by CoreCivic and operates under contact with the DHS, Immigration and Customs Enforcement (ICE), Office of Enforcement and Removal Operations (ERO). The facility processes adult male detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the CCCC are from Nicaragua, Senegal, and Turkey. The facility does not house juveniles, females, or family detainees. This was the second PREA audit for the CCCC and the facility is located in Milan, New Mexico

On November 16, 2021, an entrance briefing was held in the CCCC staffing conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing via telephone and then turned it over to the Auditor. In attendance were:

CoreCivic Staff

Robert Nilius - Warden
(b) (6), (b) (7)(C) - Assistant Warden
(b) (6), (b) (7)(C) - Chief of Unit Management
(b) (6), (b) (7)(C) - Assistant Shift Supervisor - Intake Property Transport
(b) (6), (b) (7)(C) - Quality Assurance Manager

ICE Staff

(b) (6), (b) (7)(C) – ICE Supervisory Detention and Deportation Officer (SDDO)
(b) (6), (b) (7)(C) - ICE SDDO
(b) (6), (b) (7)(C) – ICE ERAU Team Lead

Creative Corrections

Thomas Eisenschmidt - Certified PREA Auditor

The Auditor introduced himself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. Approximately four weeks prior to the audit, ERAU Team Lead, (b)(6), (b)(7)(C), provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA is 2.1.1 Sexual Abuse and Assault Prevention and Intervention (SAAPI). All documentation, policies, and the PAQ was reviewed by the Auditor. A tentative daily schedule was provided by the Lead Auditor for the interviews with staff and detainees. The Auditor also reviewed the facility's website, http://www.corecivic.com/the-prison-rape-elimination- act-of-2003-prea. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews. On the day of the audit, there were 94 detainees housed at the CCCC. CCCC, owned and operated by CoreCivic, is located at 2000 Cibola Loop, Milan, New Mexico. The current rated capacity for the part of the facility portioned to detain DHS ICE detainees is 111 adult males. Other portions of the Center house United States Marshal Service (USMS) inmates (male) and male and female Cibola County Jail Detainees. There is no comingling of the populations. Each of the populations is satellite fed on their respective living units as the CCCC has no dining room facilities. The Center maintains only one operational housing unit, for ICE detainees, that is divided into four (4) secure living units (Alpha , Bravo, Charlie, and Delta). The A and B dorm living area is comprised of cells with a capacity of 38 beds. These units each contain 3 showers and have no cameras in the cells. (b) (7)(E) The C and D living areas are dormitory style living areas with a capacity of 40 beds in C and 41 beds in D. (b) (7)(E) The Center also maintains a celled Restrictive Housing Unit (RHU) with a capacity of 84 beds, if needed. During the site visit, the Auditor observed signage requiring cross gender staff to announce themselves prior to entering the living areas. The Auditor also observed female staff announcing themselves prior to entering the living areas during the tour. (b) (7)(E)

The facility currently maintains a staff complement of 233 employees, to include security and non-security personnel for the entire complex. According to the PAQ and the interview with the PSA Compliance Manager there are 60 CoreCivic staff, 19 Medical Staff, 1 Mental Health Staff and 2 contractors working with the ICE detainee population. Volunteers have not been at the CCCC for the past two years.

At the conclusion of the tour, the Auditor was provided with staff and detainee rosters and randomly selected personnel from each to participate in formal interviews. A total of 27 staff were interviewed, including twelve random staff (including line-staff and first-line supervisors) and 15 specialized staff. Those specialized staff included: The Warden, PSA Compliance Manager, Human Resources, Learning and Development Manager, Intake staff (2), Case Manager, Administrative Investigator, Grievance Coordinator, Unit Manager, Classification Supervisor, SDDO (2), Medical staff, and Mental Health staff. A total of 20 random detainees were interviewed. All 20 detainees interviewed were limited English proficient (LEP) and required the use of a language line through Language Services Associates (LSA) provided by Creative Corrections. There were no transgender, gay, bisexual, intersex, or detainee victims available for interview at the time of the site visit. Since there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The facility utilizes trained

investigators to complete all allegations of sexual abuse. The information provided by the Team Lead indicated that there were 15 sexual abuse allegations and subsequent investigations completed during the extended audit period which was reported to the Auditor on a spreadsheet is a merged version of the facility's investigative spreadsheet and what is reported in the agency's case management database for the same period of time. The facility had 11 case files onsite for the Auditor to review. Of these 11 files, 3 were found to be combined cases involving the same victims but were listed as separate incidents by the JICMS database. Also of the 15, 1 was reported and investigated outside the facility so the file was not available for review. The Auditor reviewed 11 files, 5 in detail, to make compliance determinations for related standards. Of the 15 reported investigations, 2 were staff-on-detainee and 13 were detainee-on-detainee. The staff-on-detainee allegations were both unfounded. Of the 13 detainee-on-detainee allegations, 11 were unsubstantiated, one 1 was unfounded and 1 was substantiated. The spreadsheet provided by ICE indicated 14 investigations were completed by the facility and 1 outside investigation. The interview with the PSA Compliance Manager indicated all allegations are referred to an outside law enforcement (Milan Police Department (PD)), for criminal prosecution if warranted. If the Milan PD declines to investigate, the facility conducts an administrative investigation using trained personnel. The investigations reviewed by the Auditor, for the audit period, indicated ICE was notified of the allegations with referral to OPR as well as the Milan Police Department.

SUMMARY OF AUDIT FINDINGS

Directions: Discuss audit findings to include a summary statement of overall findings and the number of provisions which the facility has achieved compliance at each level: Exceeds Standard, Meets Standard, and Does Not Meet Standard.

Number of Standards Exceeded: 1
§115.31 Staff training

Number of Standards Not Applicable: 2

§115.14 Juvenile and family detainees
§115.18 Upgrades to facilities and technologies

Number of Standards Met: 35

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training

§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.71 Criminal and Administrative Investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection

Number of Standards Not Met: 3

§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.33 Detainee education
§115.86 Sexual abuse incident reviews

PROVISIONS

Directions: In the notes, the auditor shall include the evidence relied upon in making the compliance or non-compliance determination for each provision of the standard, 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 the standard. These recommendations must be included in the Corrective Action Plan Final Determination, accompanied by information on specific corrective actions taken by the facility. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable. For any provision identified as Not Applicable, provide an explanation for the reasoning.

§115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator.

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

Notes:

(c): The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS (SEXUAL ABUSE PREVENTION AND RESPONSE) mandating, "zero-tolerance towards all forms of sexual abuse." The policy outlines the facility approach to accomplish this goal through hiring practices and ensuring employees, contractors, volunteers and detainees are trained and informed of the zero-tolerance policy regarding sexual abuse and assault, the means to report it, and consequences for violations. The Warden confirmed that this policy was reviewed and approved by the agency and provided the Auditor with documentation of the policy review by the ICE Assistant Field Office Director (AFOD). The random staff and detainees interviewed indicated they are aware of the facility's policy on sexual abuse.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "the facility shall designate a Prevention of Sexual Assault (PSA) Compliance Manager who shall serve as the facility point-of-contact for the local ICE field office and ICE PSA Coordinator." During his interview, the PSA Compliance Manager verified he is the point of contact for the agency's PREA Coordinator, and he has sufficient time and authority to oversee efforts for the facility to comply with their zero-tolerance policy.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that states, "Each facility will ensure sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The CoreCivic Facility Support Center (FSC) will develop, in coordination with the facility, comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and shall review those guidelines at least annually. Each facility will ensure sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating staffing levels and determining the need for video monitoring, the following factors shall be take into consideration: Generally accepted detention and correctional practices; Any judicial findings of inadequacy; All components of the facility's physical plant; The composition of the detainee population; The prevalence of substantiated and unsubstantiated incidents of sexual abuse; Recommendations of sexual abuse incident review reports; and Any other relevant factors, including but not limited to the length of time detainees spend in agency custody." The Auditor was provided the most recent (August 9, 2021) detainee supervision review documenting the review was conducted assessing the subpart (c) requirements. There were no recommendations for changes to policy or operations in this review. The Auditor was provided and reviewed the Cibola supervision guideline, and during the three days the Auditor was on-site he observed, on each of the twelve-hour shifts, the adequate supervision of the detainees.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "supervisors, shall conduct frequent unannounced facility rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds shall be documented in the applicable log (e.g., Administrative Duty Officer, post log, shift report, etc.). This practice shall be implemented for all shifts and all areas where detainees are permitted. Employees shall be prohibited from alerting other employees that supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility." The Auditor reviewed logbooks, in areas detainees have access, while on-site and found supervisor signatures on different shifts daily indicating that PREA rounds are being made. The interview with the shift supervisors confirmed they make rounds of every location, staggering times and locations. The interviews with 10 random line staff confirmed they were aware of the policy prohibiting them from alerting other staff that supervisors were making rounds.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

CCCC does not accept juveniles or family detainees. This was confirmed in the PAQ and with interviews conducted with the Warden, PSA Compliance Manager, and personal observations while on-site.

§115.15 - Limits to cross-gender viewing and searches.

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

Notes:

(b)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. All cross-gender frisk/pat searches will be documented in a logbook." The Auditor interviewed 12 security staff (male and female) who acknowledged cross-gender pat-down searches are not permitted at CCCC. The Auditor received documentation from the PSA Compliance Manager indicating that cross-gender pat-down searches were not conducted at CCCC during the audit period.

(c) This subpart is not applicable as CCCC is an adult male facility.

(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "Strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches shall be documented." The PSA

Compliance Manager and the Warden confirmed the facility had no instances of cross-gender strip searches or body cavity searches conducted during the previous 12 months.

(g) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Employees of the opposite gender must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." These cross-gender announcement requirements are posted at the entrance of each of the detainee living areas. The Auditor observed female staff announcing themselves prior to entering the male housing areas during the tour. The interviews with staff confirmed the requirement of female staff announcing their presence prior to entering detainee living areas. The random detainee interviews confirmed that most female staff announce themselves prior to entering.

(h) This subsection is non-applicable. CCCC is not a Family Residential Facility.

(i)(j) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall not search or physically examine a detainee for the sole purpose of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. All pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and policy, including officer safety. The gender of the staff member searching a transgender or intersex detainee will depend on the specific needs of the individual detainee and on the operational concerns of the facility. Under most circumstances, this will be a case-by-case determination, which may change over the course of incarceration and should take into consideration the gender expression of the detainee." The Auditor reviewed the CCCC training curriculum for searches and found it met the policy and standard requirements. During the 12 random security staff interviews, each confirmed their knowledge of the prohibition of searching detainees to determine their genital status and their responsibility to perform all pat-down searches in a professional and respectful manner. These security staff also detailed the search training they received to include cross gender, transgender and intersex techniques. The interview with the Learning and Development Manager indicated all staff searches, including the training they receive on searching is based on ICE policy PBNDS 2.10 "Search of Detainee." The Auditor reviewed 6 security staff training files and found completed search training documentation in each of the files. At the time of the audit, there were no transgender or intersex detainees present at the facility to interview.

§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "The facility shall ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. When necessary, to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall accommodate the detainee by: Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary; and providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication." The intake staff interviews also confirmed that when confronted with a detainee that may be hearing impaired or deaf, information is provided to them in writing or through use of the text telephone (TTY). Those detainees who are blind or with limited sight are provided individualized service by the intake staff to include reading information to the detainee if needed. These intake staff indicated when dealing with a detainee with low intellect or limited reading skills it would require referral to a supervisor, medical, or mental health staff based on the detainee limitation.

(b) Policy 14-2-DHS requires, "The facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." The Auditor interviewed two intake staff. Both these individuals indicated that when they encounter a detainee who is LEP they would utilize their interpretive language service to assist them with interviews if a staff interpreter was unavailable. They also indicated when providing information on the efforts to prevent, detect, and respond to sexual abuse, in a language not covered by ICE National Detainee Handbook (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) that already provides this information, they utilize their interpretive language contract to provide the detainee with this meaningful access information to prevent, detect, and respond to sexual abuse. At the time of the audit, the facility only had the DHS-prescribed Sexual Abuse and Awareness Information pamphlet available in English and Spanish, although the pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. Based on a follow-up interview with the PSA Compliance Manager after the onsite visit, the facility now has the pamphlet in all nine languages available for dissemination. The Auditor questioned both of them on what specific information is provided to the detainee. Both of these individuals were not specific and could not detail any specific information that is provided. They were also unable to demonstrate what is specifically provided to each detainee. The Auditor also interviewed two detainees who indicated they spoke a language not covered by the ICE National Detainee Handbook. The review of these two detainee's files only contained a signed English form with no notation of interpreter use. During the site visit, the PSA Compliance Manager explained he was developing a manuscript with the information requirements of this subpart and the orientation requirements of 115.33 to be provided to detainees who are LEP.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. To become compliant, the facility needs to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainee who are LEP. The facility needs to provide evidence of the new process implementation that was being developed by the PSA Compliance Manager at the time of the audit, and evidence that the process is being complied with; documentation of the interpretation service use to deliver the script and signature of detainee's participation for five detainees who speak languages other than English and Spanish and particularly any who speak a language that is not covered by the ICE National Detainee Handbook. In order for the facility to be fully compliant, equal access to all information aspects of the SAAPI program, the facility needs to demonstrate how the information from the facility's handbook is conveyed to LEP detainees if they speak a language other than English or Spanish.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." The Auditor interviewed 12 front line detention officers (DO); each confirmed they were aware of the restrictions on interpreters as outlined in the CCCC facility policy. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period the audit period was extended to capture closed investigations that occurred since the facility's last audit. In 2 of the 11 investigation files reviewed, the detainee was provided an interpreter through their contracted language line.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS, Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive that require, "To the extent permitted by law, CoreCivic will decline to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact with detainees, who: has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity 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; or has been civilly or administratively adjudicated to have engaged in the activity as outlined above." The 14-2-DHS further requires, "all applicants and employees who may have direct contact with detainees shall be asked about previous misconduct, as outlined above in written applications or interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. To the extent permitted by law, CoreCivic may decline to hire or promote and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information." The 14-2-DHS and standard subpart (b) require all new hires, staff awaiting promotions, and all facility staff on an annual basis to complete and submit a self-declaration form indicating he/she has not engaged in any prohibited conduct. The individual will respond directly to questions about previous misconduct, as required per the standard and, as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in November 2021 that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity 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; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. The Human Resources (HR) staff person interviewed stated the facility would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated the employee is required to sign a release of information document in this case. She also stated the facility, along with ICE, would request information from prior institutions where the prospective candidate was previously employed during background checks. She confirmed that as outlined in CCCC policy 14-2-DHS, the facility would decline to hire or promote and may terminate employment based on material omissions regarding such as misconduct, or the provision of materially false information. She also stated that as a condition of employment, each employee has a continuing affirmative duty to disclose to either her or their supervisor any behavior outlined in subpart (a). The Auditor interviewed 12 random staff, and each was aware of this duty to report. The Auditor reviewed 10 employee files and found ICE approvals to hire the staff member prior to their actual start date as well as a signed self-declaration that the employee has not engaged in behavior outlined in subpart (a) as required by policy; to comply with their duty to report, the 14-2H-DHS Self-Declaration of Sexual Abuse form serves as verification of an employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct as described in this policy.

(c)(d) (e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "Before hiring new employees who may have contact with detainees, CoreCivic shall perform a criminal background records check. CoreCivic shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with detainee. CoreCivic shall conduct criminal background records checks at least every five years of current employees and unescorted contractors who may have contact with detainees or have in place a system for otherwise capturing such information." The HR staff stated ICE completes all background checks for all staff and contractors prior to hiring and then again, every five years. Review of documentation provided by ICE's PSU confirmed that the nine randomly selected employees (seven facility staff and two ICE staff) background checks were performed prior to them reporting to work. Documentation also confirmed the due dates for the five-year background rechecks. The Auditor determined the provided background check information was compliant with the standard.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) These subparts of the standard are not applicable based on the facility PAQ and interview with the Warden confirming CCCC has not expanded or modified the existing facility or updated video monitoring equipment since the previous audit in 2017.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires," The investigating entity shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal [p]rosecutions. The protocol shall be developmentally appropriate for youth where applicable, and as appropriate, shall be adapted from or otherwise based on the most recent edition of the 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." The Warden confirmed the policy outlining the investigation protocols was reviewed and approved by ICE and provided this documentation to the Auditor. The Facility Investigator is new and confirmed he utilizes evidence collection procedures he was trained on, and as required in policy, to ensure he obtains the physical evidence needed to properly conduct administrative investigations. The agency's policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not

perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-month period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The facility reported 11 allegations and the spreadsheet provided by ICE indicated there were 15 allegations for the extended audit period. The number of allegations reported by the facility were not the same as the numbers provided by the Team Lead which is explained in the opening report narrative. Of the 15 reported investigations, 2 were staff-on-detainee and 13 were detainee-on-detainee. The staff-on-detainee allegations were both unfounded. Of the 13 detainee-on-detainee allegations, 11 were unsubstantiated, 1 was unfounded and 1 was substantiated. The Auditor's thorough review of five of these cases determined that uniform evidence procedures were used to include ensuring detainees do not destroy useable evidence were followed during the administrative investigations.

(b)(d) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires," The investigating entity shall attempt to make available to the victim a victim advocate from a rape crisis center. The investigating entity may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services." CCCC has a written MOU with the Rape Crisis Center of Central New Mexico to provide detainee victims of sexual abuse access to a victim advocate for emotional support services during the examination and any law enforcement interview. The Auditor spoke with a representative of the Rape Crisis Center who validated the MOU and indicated her agencies would provide emotional support, crisis intervention and community referrals. She indicated the agency has not had any contact with detainees during the previous 12 months. In each of the five thoroughly investigated files, the Auditor found notations that indicated detainees were informed of the victim advocate on the day of the allegation.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "The investigating entity shall offer all victims of sexual abuse access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners." The Auditor reviewed an MOU between CCCC and the Albuquerque SANE Collaborative entered into February 2021, with no sunset date, requiring, "an examiner (SANE) for comprehensive care; prophylaxis treatment for sexually transmitted disease; timely collection of forensic evidence; forensic photography and testimony." In addition, agency will facilitate advocacy services as needed.

(e) The Auditor determined compliance with this subpart of the standard based on review of the MOU with the Milan Police Department. This MOU requires that in any incident involving the Prison Rape Elimination Act (PREA), CCCC will contact the Milan PD and provide them with all allegations of sexual abuse involving potentially criminal behavior. In return, the investigating agency (Milan PD) will provide any additional assistance if needed. This MOU was established in May 2020 with no sunset date. Although the MOU does not specifically address the requirement of subpart (e), the facility provided written documentation to the Milan PD requesting their Department comply with subparts (a) through (d) of the standard. CCCC has heard nothing back from them. In each of the five randomly selected investigative files reviewed during the audit period, the Auditor found notifications to the Milan Police Department.

§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.

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

Notes:

(a)(b)(d)(e) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse." The policy further requires, "Retention of such reports [sexual abuse allegation investigations] for as long as the alleged abuser is detained or employed by the agency or facility, plus five (5) years. Coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." As part of the facility's Coordinated Response, the policy further requires, "All allegations of sexual abuse or assault shall be immediately and effectively reported to ICE/Enforcement and Removal Operations (ERO). In turn, ICE/ERO will report the allegation as a significant incident and refer the allegation for investigation." As noted in standard 115.21, policy 14-2-DHS requires all allegations be reported to the Milan Police Department to be evaluated for criminality. Additionally, all allegations are to be reported to the Joint Intake Center (JIC), which assesses allegations to determine which fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Investigative Inquiry Unit (AIU) for action, and the agency would assign an administrative investigation to be completed. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The number of allegations reported by the facility were not the same as the numbers provided by the Team Lead. The facility reported 11 allegations and the spreadsheet provided by ICE indicated there were 15 allegations for the extended audit period. Of the 15 reported allegations, 2 were staff-on-detainee and 13 were detainee-on-detainee. The staff-on-detainee allegations were both unfounded. Of the 13 detainee-on- detainee allegations, 11 were unsubstantiated, 1 was unfounded and 1 was substantiated. All 15 allegations were referred to ICE OPR and none were deemed criminal. The Auditor randomly selected five investigative case files for review and determined they were completed in accordance with the standard and policy 14-2-DHS.

(f) The Auditors based compliance on these subparts of the standard after review of policy 14-2-DHS that requires, "Staff suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Contractors and civilians suspected of perpetrating sexual abuse. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault, but have violated other sexual abuse policies. Incidents by a contractor or volunteer shall be reported to law enforcement agencies, unless the activity was clearly not criminal. The facility shall also report such incidents to the ICE Field Office

Director." The interview with the Warden and PSA Compliance Manager confirmed that CCCC notifies the ERO PREA Field Coordinator on every allegation. The interview with the ERO PREA Field Coordinator also confirmed that whenever an allegation of sexual abuse is made at CCCC she is notified as required and is responsible to make the notifications to these ICE personnel as required by this subpart. Of the five investigative files randomly selected for thorough review; the Auditor chose one investigation involving a staff member. This case file review found documentation that ICE was notified of the incident.

(c) The Auditor determined compliance with this subpart based on the protocols for ICE investigations and CoreCivic investigations being found on their respective web pages: (www.ICE.gov/prea) and (http://www.corecivic.com/the-prison-rape-elimination- act-of-2003-prea).

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all new employees, and shall also be included in annual refresher training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards, and shall include: detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need- to-know in order to make decisions concerning the detainee victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, (LGBTI) or gender nonconforming detainees; instruction on reporting knowledge or suspicion of sexual abuse and/or assault; and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and or assault." The Auditor interviewed the Learning and Development Manager who confirmed employees complete the 14-2A-DHS Policy Acknowledgement form serving as verification of the employee's review and understanding of this training and the agency's zero tolerance policy. The random 12 CCCC staff and 2 ICE staff interviewed by Auditors confirmed they had received PREA pre-service training and annual refresher training. They confirmed the instruction they received included the requirements outlined in subpart (a) of the standard. The Auditor reviewed 8 staff training files and found completed 14-2A-DHS documents in each. The interview with the Learning and Development Manager and the review of the training curriculum confirmed the subpart (a) requirements are part of the training curriculum.

§115.32 - Other training.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. Civilians/contractors/volunteers shall be required to confirm, by either electronic or manual signature, their understanding of the received training. Signed documentation will be maintained in the civilian or contractor's file." The Auditor interviewed the Learning and Development Manager who indicated that employee and contractor PREA training is identical and covers all standard 115.31 subpart (a) requirements. The Auditor observed the signed training acknowledgement completed by two contractors during a training file review. The Auditor also interviewed two contractors during the site visit; both detailed the training they received and confirmed they receive it annually. Volunteers have not been at the facility for the past two years. The Learning and Development Manager provided the Auditor the training curriculum each volunteers receives, regardless of the level of detainee contact they have. The training provided addresses the facilities' response policies and procedures relating to sexual abuse prevention detection, intervention and response.

§ 115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f) Policy 14-2-DHS requires, "Upon admission, all detainees shall be notified of the facility's zero tolerance policy on sexual abuse and assault through the orientation program and detainee handbook. Detainees will be provided with information (orally and in writing) about the facility's SAAPI Program. Such information shall include, at a minimum: the facility's zero-tolerance policy for all forms of sexual abuse or assault; the name of the facility PSA Compliance Manager, and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the OHS/Office of Inspector General (OIG) and the ICE/Office of Professional Responsibility (OPR) investigation processes; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." The standard requires this information be provided as well. As noted in standard 115.16, the Auditor interviewed two intake staff who indicated all detainees arriving at CCCC receive the CoreCivic Handbook, only available in Spanish and English, the DHS-prescribed ICE Sexual Abuse and Assault Awareness Information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed ICE Sexual Abuse Awareness Information pamphlet is available in English and Spanish only at CCCC. The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The intake staff indicated to the Auditor that when intake staff is confronted with a detainee that may be hearing impaired or deaf, most CCCC orientation information is provided to them in writing or if that is not successful information would be provided through the use of the text telephone (TTY). When staff encounters a detainee who is blind or with limited sight the staff member would attempt to provide individualized service to the detainee to include reading information if needed. These two intake staff also confirmed that when dealing with a detainee with low intellect or limited reading skills would typically involve assistance of a supervisor, medical or mental health staff based on the degree of limitation of the detainee. Both these individuals indicated that when they encounter a detainee who is LEP and not covered by any of the languages the ICE National Detainee handbook is available in, they utilize their interpretive language contract when dealing with the detainee. However, when the Auditor questioned both of them on what information is specifically provided to the LEP detainee to ensure all aspects of the facility's efforts to prevent, detect and respond to sexual abuse, both were not specific with what information is provided and unable to demonstrate what is specifically told each detainee. The Auditor also interviewed two detainees who indicated they spoke a language not covered with the ICE National Detainee handbook. The review of these two

detainee's files only contained a signed English form with no notation of interpreter use. The facility was unable to demonstrate the required information outlined in subpart (a) in this standard was provided to these two detainees not speaking a language covered by the ICE National Handbook. During the site visit, the PSA Compliance Manager informed the Auditor that he was finishing a manuscript with the information outlined in this standard subpart (a), information required in standard 115.16 and additional orientation information to be provided to detainees whose language is not covered by the ICE National Detainee handbook.

Does Not Meet (a)(b): The facility has not demonstrated that they provide subpart (a) and (b) requirements to all detainees, which requires notification, orientation, and instruction be provided in formats accessible to all detainees, including those who are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. This information must include instruction on prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; Explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of-contact line officer, the DHS Office of Inspector General, and the Joint Intake Center; Information about self-protection and indicators of sexual abuse; Prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and The right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. To become compliant, the facility needs to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainee who are LEP. The facility needs to provide evidence of the new process implementation that the PSA Compliance Manager stated he was developing at the time of the audit, and evidence that the process is being complied with. Over the next 60 days, documentation of the interpretation service used to deliver the script and signature of detainee's participation for five detainees who speak languages other than English and Spanish and particularly any who speak a language that is not covered by the ICE National Detainee handbook should be presented for compliance review.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "the facility shall post on all housing unit bulletin boards the following notices: the DHS-prescribed sexual abuse and assault awareness notice; the name of the PSA Compliance Manager and Information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available)." The Auditor observed the DHS-prescribed sexual abuse and assault awareness notices posted and the zero-tolerance notices posted, the latter of which contained the PSA Compliance Manager's name. The 20 random detainee interviews also confirmed their knowledge of the posters and the required information. Contact information was also observed for the Rape Crisis Center of Central New Mexico in each of the detainee living areas as well.

§115.34 - Specialized training: Investigations.

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

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "the facility shall provide specialized training on sexual abuse and effective cross-agency coordination to Facility Investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training covers: interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process." CCCC had just hired an Investigator who was in the orientation process during the site visit. He had not received his Investigative training by the time the Auditor conducted the on-site PREA audit. The PSA Compliance Manager and Warden confirmed if the facility had an allegation prior to his training, the facility would utilize the Investigator at a different CoreCivic facility within an hour drive. Also, in an emergency, the CCCC Warden is a trained Investigator. The Auditor asked for and received a copy of the training document for the Warden and Investigator used by CCCC from the other facility. The Auditor was also provided the successful completion certificate for the CCCC investigators who conducted the investigations reviewed by the Auditor. Agency policy 11062.2 states "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The Auditor reviewed the ICE OPR Investigation Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The Auditor reviewed the agency provided rosters of trained investigators on SharePoint and determined the documentation was in accordance with the training requirements of this standard.

§115.35 - Specialized training: Medical and mental health care.

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

(a)(b) These subparts of the standard do not apply to CCCC as the facility medical department is operated by CoreCivic.

(c) The Auditor determined compliance with this subpart of the standard based on the interview with the Health Services Administrator (HSA) and review of policy 14-2-DHS that requires, "in addition to the general training provided to all employees, all full and part-time Qualified Health Care Professionals and Qualified Mental Health Professionals, who work in the facility, shall receive specialized medical training: how to detect and assess signs of sexual abuse; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; how and to whom to report allegations of sexual abuse; and how to preserve physical evidence of sexual abuse." The HSA indicated that facility medical staff at CCCC would stabilize the alleged victim for transport to the outside hospital and her staff is not involved in the primary treatment of victims of sexual assault. This policy, 14-2-DHS, was approved by the AFOD.

§115.41 - Assessment for risk of victimization and abusiveness.

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

(a)(b)(c)(d)(e) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "All detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within twelve (12) hours of admission to the facility. The facility shall consider, to the extent that the information is available, the following

criteria to assess detainees for risk of sexual victimization: Whether the detainee has a mental, physical, or developmental disability; The age of the detainee; The physical build and appearance of the detainee; Whether the detainee has previously been incarcerated or detained; The nature of the detainee's criminal history; Whether the detainee has any convictions for sex offenses against an adult or child; Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; Whether the detainee has self-identified as having previously experienced sexual victimization: and the detainee's own concerns about his or her physical safety the initial screening shall consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive. The facility shall reassess each detainee's risk of victimization or abusiveness between sixty (60) and ninety (90) days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." The Auditor interviewed two Intake staff (who perform the vulnerability assessment) and the Classification Supervisor. All three indicated the classification process is normally completed within two hours of arrival and would never occur after 12 hours. Each also confirmed that in addition to this screening instrument, staff tasked with screening conduct a thorough review of all available records provided by ICE that can assist them with the risk assessment to include any information about prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility. The Classification Supervisor confirmed detainees are kept separate from general population in the intake area until the vulnerability assessment and classification processes are completed. The Auditor reviewed 10 detainee detention files and found completed risk assessments were conducted utilizing the 14-2B-DHS form, Sexual Abuse Screening Tool, and on the day of the detainee's arrival. The interview with the 20 random detainees confirmed their classification and risk assessment were completed within their first couple hours after arriving at CCCC. All of the random detainees confirmed that they remained in the intake area until they were classified. Of the 10 detention files, one belonged to a detainee housed at CCCC beyond 90 days. The Auditor found a reassessment completed between the 60-90 days, as required by standard and policy. The five randomly selected investigative case files reviewed confirmed a vulnerability reassessment was completed within 12 hours of the allegation in each case. The 14-2B-DHS form, Sexual Abuse Screening Tool, was reviewed by the Auditor and found to comply with the subpart (c) and (d) requirements.

(f) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2 that requires, "detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked about whether the detainee has a mental, physical or developmental disability; identifies as LGBTI or gender non-conforming; experienced prior sexual victimization or has any concerns about his physical safety." The Classification Supervisor and the two intake officers confirmed detainees are not disciplined for refusing to answer any of the questions asked from the 14-2B-DHS form, Sexual Abuse Screening Tool.

(g) The Auditor determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "The facility shall implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees." The PSA Compliance Manager and the Classification Officer informed the Auditor that completed 14-2B-DHS forms are maintained in the detainee's central file, with a copy forwarded to the detainee's medical record. These files are secured under a restricted key.

§115.42 - Use of assessment information.

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

Notes:

(a) The Auditor determined compliance on this subpart of the standard after a review of policy 14-2-DHS that requires, "The facility shall use the information from the 14-2B-DHS- DHS Sexual Abuse Screening Tool conducted at initial screening in the consideration of housing, recreation, work program, and other activities." The Classification Supervisor confirmed assignments are made for work and housing based on each individual detainee's risk assessment. The instructions for completion of the document informs the staff member, conducting the risk assessment, that it is important that any PREA classification, whether it indicates the potential for being at risk of victimization or the potential of being sexual abusive be noted to provide the correct initial housing for placement and recreation. CCCC does not have any work or other activities extending beyond their living units. The Auditor reviewed 10 detainee detention files in which the initial assessment and reassessment files are kept. The files demonstrated individualized assessments were conducted on each detainee to ensure the safety of the detainee on the day of their arrival at CCCC.

(b)(c) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "In deciding whether to house a transgender or intersex detainee in a male housing unit/area or female housing unit/area, or when making other housing and programming assignments for such detainees, the facility shall consider the transgender or intersex detainee's gender self-identification and an assessment of the effect of placement and shall consider on a case-by-case basis whether such a placement would ensure the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions on transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. Placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review whether any threats to safety were experienced by the detainee." There were no transgender or intersex detainees present at CCCC during the site visit. The Warden, SDDO and the PSA Compliance Manager confirmed that transgender or intersex detainees are typically not placed at CCCC. If a detainee discloses during intake that he is a transgender or intersex, ICE is immediately notified and arrangements to move the detainee are made. They also stated that until the detainee was transferred, medical and mental health staff would be consulted prior to making any decision on housing, considering the safety and security needs of the facility. They also stated the facility would allow for transgender and intersex detainees to shower separately from other detainees during count times, if necessary, or at times convenient to facility operation.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "Use of Administrative Segregation to protect detainees at high risk for sexual abuse and assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. Detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director (FOD) to determine if ICE can provide additional assistance. Such detainees may be assigned to Administrative Segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of thirty (30) days. Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If access to

programs, privileges, education, or work opportunities is restricted, the facility shall document the reason." The Warden confirmed that the use of segregation for the placement of any vulnerable detainee would not be the normal response. He indicated he would move the detainee to another housing unit, to a medical bed, or contact the FOD through the AFOD to expedite the transfer of the detainee to another facility. He also indicated during the audit period, segregation has not been utilized to place any detainees at high risk for sexual abuse and assault. The Auditor did not observe any vulnerable detainees present in the segregation unit, for protective custody during the site visit.

(d)(e) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "If involuntary segregated housing is warranted then the facility will take the following actions: a supervisory staff member shall conduct a review within seventy-two (72) hours of the detainee's placement in segregation to determine whether segregation is still warranted and a supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in Administrative Segregation and every week thereafter for the first thirty (30) days and every ten (10) days thereafter." The Warden confirmed that any placement of a vulnerable detainee in segregation would require, as stipulated in policy, the reviews and the notification to the FOD within 72 hours.

§115.51 - Detainee reporting.

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

Notes:

(a)(b) The Auditors determined compliance with these subparts of the standard based on review of policy 14-2-DHS that requires, "Detainees who are victims of sexual abuse have the option to report an incident to a designated employee other than an immediate point-of-contact line officer by using any of the following methods: Submitting a request to meet with Health Services staff and/or reporting to a Health Services staff member during sick call; Calling the facility's twenty-four (24) hour toll-free notification telephone number; Verbally telling any employee, including the facility Chaplain; Forwarding a letter, sealed and marked "confidential", to the Facility Administrator or any other employee; Calling or writing someone outside the facility who can notify facility staff; Contacting the respective consular office; and/or Forwarding a letter to the Facility Support Center (FSC) PREA Coordinator at the following at 10 Burton Hills Boulevard, Nashville, TN 37215. Detainees shall be encouraged to immediately report pressure, threats, or instances of sexual abuse as well as possible retaliation by other detainees or employees for reporting sexual abuse and staff neglect or violation of responsibilities that may have contributed to such incidents. Detainees may anonymously report any pressure, threat or instance of sexual violence/misconduct directly to the DHS OIG at 1-800-323-8603." The PSA Compliance Manager informed the Auditor the contact and reporting information is provided to detainees in the orientation materials provided at intake, at orientation in the housing unit, and on posters throughout the facility. While on-site, the Auditor interviewed two detainees who claimed they were never provided information on how to report sexual abuse by staff during intake or orientation, although they were aware of how to report this information from other detainees. The Auditor reviewed their detention files and found signed documents, in English, by these LEP detainees that they received this information as noted in 115.16 and 115.33. The Auditor asked them through an interpreter if they were aware of how to report an allegation of sexual abuse if needed for themselves or someone else and they indicated they were aware.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 14-2-DHS that requires, "Employees must take all allegations of sexual abuse seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports. All reports of sexual abuse will be reported to the Facility Investigator. Employees having contact with the alleged victim should behave in a manner that is sensitive, supportive, and non-judgmental." As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The PSA Compliance Manager and facility PAQ confirmed that the facility had 15 reported allegations of sexual abuse during the adjusted timeframe. The Auditor did a cursory review of 11 sexual abuse case files at CCCC. Each of these allegations were made in the following manner: 8 were reported to security staff, 2 through the grievance office and 1 reported to ICE staff. The file review indicated in the instances where the allegation was made verbally, the staff member placed the allegation into written format. The Auditor interviewed 12 random staff who confirmed their knowledge of the facility policy requirement that they are to accept and immediately report allegations of sexual abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after a review of policy 14-2-DHS that states, "Detainees will be permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. To prepare a grievance a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representative. The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility shall issue a decision on the grievance within five (5) days of receipt and shall respond to an appeal of the grievance decision within thirty (30) days. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process." The Grievance Supervisor confirmed her office accepts, as a grievance, any allegation of sexual abuse, assigns it a grievance number, and processes it as an emergency grievance. The Grievance Supervisor further stated that she does not impose a time limit on when a detainee may submit a grievance regarding the allegation of sexual abuse regardless of when it occurs and would ensure medical emergencies are referred to the medical department immediately. The Grievance Supervisor also indicated two of the allegations of sexual abuse reported within the extended audit period were reported through the grievance system and were processed by her office as emergency grievances in both cases; she stated a response was issued within the standard and policy time requirements, including notification to the ICE SDDO who in turn makes all ICE notifications. According to the interview with the Grievance Supervisor decisions on this type of grievance (emergency) are responded to within two days of receipt and responses to an appeal of the grievance decision are responded to within four days.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that states, "CoreCivic shall maintain or attempt to enter into Memorandums of Understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support for immigrant victims of crimes. Each facility shall establish, in writing, procedures to include outside agencies in the facility's sexual abuse prevention and intervention protocols, if such resources are available. Detainees shall be provided access to outside victim advocates for emotional support services related to sexual abuse by giving

detainees mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, state, or national victim advocacy or rape crisis organizations. Such information shall be included in the CCCC facility's Detainee Handbook. The facility shall enable reasonable communication between detainees and these organizations and agencies, in as confidential a manner as possible. Detainees shall be informed, prior to giving them access, of the extent to which such communications shall be monitored and the extent to which reports on abuse will be forwarded to authorities in accordance with mandatory reporting laws." The PSA Compliance Manager confirmed and provided a written MOU with the Rape Crisis Center of Central New Mexico dated 8/2019. The Auditor observed, during the facility tour, the contact information for this Rape Crisis Center in each of the detainee living areas. The posted information sheet informs the detainee that the Center is a mandatory reporter for any allegation of sexual abuse. The CCCC facility Detainee Handbook outlines that detainees may report allegations of sexual abuse and notifies them of the extent that the calls to the Center may be monitored. The Auditor's review of five randomly selected investigative files noted the alleged victims were provided contact information for the Rape Crisis Center of Central New Mexico.

§115.54 - Third-party reporting.

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

Notes:

The Auditor determined compliance with the standard after a review of policy 14-2-DHS that requires," Each facility shall establish a method to receive third-party reports of sexual abuse and shall post this information on the facility PREA link found on the CoreCivic website." The Auditor noted third-party reporting information, in Spanish and English, located in the CCCC visiting area. A review of both the ICE web page (https://www.ice.gov) and CoreCivic web page (http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea) confirmed both web pages provide a means for the public to report incidents of sexual abuse/harassment on behalf of any detainees as well. Most of the 20 random detainees interviewed were aware that family members and friends could report sexual abuse on their behalf. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The facility reported they had zero incidents of sexual abuse reported by a third during the adjusted audit cycle. This was further verified through the Auditor's review of 11 sexual abuse allegations case files.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "Employees must take all allegations of sexual abuse seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports. All reports of sexual abuse will be reported to the Facility Investigator. Employees having contact with the alleged victim should behave in a manner that is sensitive, supportive, and non-judgmental. All employees are required to immediately report: any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility in accordance with this policy, whether or not the area is under CoreCivic's management authority; retaliation against detainees or employees who have reported such an incident and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, and as specified in this policy, to make treatment, investigation, and other security and management decisions." The interviews with each of the random staff confirmed their knowledge of their reporting requirements of the standard and the facility policy. Each staff person was also aware of their right to go outside the chain of command, through the CoreCivic ethics reporting telephone line, to report sexual abuse if necessary. They also confirmed that apart from reporting to a designated supervisor or official, they are not to reveal any information related to a sexual abuse allegation to anyone. The 14-2-DHS policy was approved by the AFOD. As noted earlier, there were no reported allegations during the previous 12 months, but the Auditor thoroughly reviewed five (5) investigative files during the adjusted audit cycle. Those files demonstrated all five of the allegations were reported to security staff and also confirmed that each staff member responded to the incident in accordance with agency policy and training curriculum each receives.

(d) The Auditor determined compliance on this subpart of the standard after a review of policy 14-2-DHS that requires, "If the alleged victim is under the age of eighteen (18) or considered a vulnerable adult under a state or local vulnerable person's statute, the allegation shall be reported to the designated state or local services agency under applicable mandatory reporting laws." There are no juveniles housed at CCCC. The interview with the Warden confirmed, if the facility encountered an incident of sexual abuse involving a vulnerable adult, CoreCivic's counsel's office would be contacted to determine reporting obligations under the reporting laws of New Mexico.

§115.62 - Protection duties.

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

Notes:

The Auditors based compliance on this standard after a review of policy 14-2-DHS that requires, "When it is learned that a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee." The Auditor questioned the Warden, PSA Compliance Manager, random supervisors, and random staff about the handling of detainees they believed may be at substantial risk of imminent sexual abuse. The Warden and supervisors indicated that detainee placement in the medical unit would be the likely immediate response by the facility to eliminate the threat. Movement from the facility would be considered after the situation was evaluated. According to each of them, CCCC did not have a detainee who was at substantial risk of imminent sexual abuse, requiring the facility to take immediate action to protect the detainee during the previous 12 months. The documentation available, including investigative files over two years old did not demonstrate segregation was used to protect any alleged victim of sexual assault. The one allegation that was substantiated resulted in the abuser being removed to another facility as CCCC's allowed custody level (low) does not permit for any detainee with violence in their history to be housed there.

§115.63 - Report to other confinement facilities.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "If the allegation of sexual abuse involves events that took place while the alleged victim was not in CoreCivic custody (e.g. while housed at another provider's facility, or state, or federal facility), the Facility Administrator of the facility that received the allegation shall ensure that the following actions are taken: Contact the facility head or appropriate office of the facility where the alleged abuse took place as soon as possible, but no later than seventy-two (72) hours after receiving the allegation; Determine from the facility administration at that facility whether the allegation was reported and investigated; If the

allegation was reported and investigated by the appropriate officials, the receiving facility shall document the allegation, the name and title of the person contacted, and that the allegation has already been addressed. Under this circumstance, further investigation and notification need not occur; If the allegation was not reported or not investigated, a copy of the statement of the detainee shall be forwarded to the appropriate official at the location where the incident was reported to have occurred; All such contacts and notifications shall be documented on the 5-1B Notice to Administration; including the allegation, any details learned from contact with the site where the alleged abuse took place, and the facility's response to the allegation and if an allegation is received from another facility, he/she will ensure the allegation is investigated. All allegations of sexual abuse or assault shall be immediately and effectively reported to ICE/Enforcement and Removal Operations (ERO). In turn, ICE/ERO will report the allegation as a significant incident and refer the allegation for investigation." The Warden, PSA Compliance Manager, and the PAQ indicated CCCC did not receive any reports of sexual abuse from a detainee on arrival at the facility, occurring at another facility. There were also no allegations made at other facilities reported to have occurred at CCCC, during the audit period, according to these interviews and a review of the PAQ as well. The Warden and PSA Compliance Manager confirmed all allegations of sexual assault are reported to ICE Supervisory Detention and Deportation Officer (SDDO) at CCCC. The interview with the SDDO confirmed that he makes all required notifications to ICE personnel as required by the standard.

§115.64 - Responder duties.

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

Notes:

(a) The Auditor determined compliance on this subpart of the standard after a review of policy 14-2-DHS that requires, "Any employee who discovers or learns of sexual abuse, or an allegation of sexual abuse, shall ensure that the following actions are accomplished: the alleged victim is kept safe, has no contact with the alleged perpetrator and is immediately escorted to the Health Services Department; and the Health Services Department is responsible for medical stabilization and assessment of the victim until transported to an outside medical provider, if medically indicated, for collection of evidence and any necessary medical treatment. CoreCivic will request, in writing, that the examination be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE). If a SAFE or SANE provider is not available, the examination may be performed by other qualified medical practitioners. If the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall, to the best of their ability, ensure that the victim does not wash, shower, remove clothing without medical supervision, use the restroom facilities, eat, drink or brush his/her teeth. In order to preserve any evidence, the alleged perpetrator should not be allowed to wash, shower, brush his/her teeth, use the restroom facilities, change clothes, or eat or drink while secured in segregation in a single cell (if available). The highest-ranking authority on-site is immediately notified and will further ensure to protect the safety of the victim and the integrity of the crime scene and any investigation." The random security staff interviews confirmed and detailed their responsibilities when responding to any allegation of sexual abuse, as outlined in the policy and required by the standard. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The five randomly selected sexual abuse allegations reviewed by the Auditor that occurred within the adjusted audit cycle appeared to confirm that the first responder followed the requirements of policy 14-2-DHS.

(b) The Auditor determined compliance on this subpart of the standard after a review of policy 14-2-DHS that requires, "If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." The Auditor interviewed two non-security staff and each confirmed, if an incident of sexual abuse was reported to them, they would secure the alleged victim and immediately call for a security staff member. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. There were two allegations of sexual abuse reported to non-security staff during the adjusted audit cycle. In each of those incidents, the non-security staff immediately notified security as required by the standard.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The Auditor determined compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "Each facility will establish a Sexual Assault Response Team (SART) which includes the following positions: PSA Compliance Manager; Medical representative; Security representative; Mental health representative; and Victim Services Coordinator. The SART responsibilities include responding to reported incidents of sexual abuse and assault; responding to victim assessment and support needs; ensuring policy and procedures are enforced to enhance detainee safety; and participating in the development of practices and/or procedures that encourage prevention and intervention of sexual abuse and assault and enhance compliance with DHS PREA Standards." The Auditor interviewed a member of the SART team, who detailed his responsibilities during a sexual assault and how he interacts with other members during a response to a sexual assault. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor did a cursory review of 11 sexual abuse allegation case files that occurred during the adjusted audit cycle and determined the staff's response was coordinated as outlined in the 14-2-DHS policy.

(c)(d) The Auditor based compliance on these subparts of the standard after a review of policy 14-2-DHS that requires, "If a victim of sexual abuse is transferred between facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." The Warden, HSA, PSA Compliance Manager and the PAQ confirmed that CCCC had no instances of victim transfers between DHS or non-DHS facilities within the previous 12 months or for the audit period that were available. The Warden and HSA further stated that, if they were to transfer a victim of sexual abuse, all proper notifications would be made in accordance with the policy and the standard.

§115.66 - Protection of detainees from contact with alleged abusers.

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

Notes:

The Auditor determined compliance with this standard after review of policy 14-2-DHS that requires, "Staff suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Contractors and civilians [volunteers] suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault, but have violated other sexual abuse policies." The Warden confirmed that if any staff member, volunteer, or contractor was alleged to have perpetrated sexual abuse, they would be removed from all detainee contact pending the results of the investigative process. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that

occurred since the facility's last audit. There was one allegation made against a staff member during the adjusted audit cycle. The Auditor was provided documentation reflecting the staff member was restricted from working with detainees until the completion of the investigation.

§115.67 - Agency protection against retaliation.

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

Notes:

(a)(b)(c) The Auditor determined compliance on these subparts of the standard after review of policy 14-2-DHS that requires, "Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least ninety (90) days following a report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond ninety (90) days if the initial monitoring indicates a need to continuing. The PSA Compliance Manager shall ensure that thirty/sixty/ninety (30/60/90) day retaliation monitoring is conducted by the designated staff, following a report of sexual abuse, to protect against potential retaliation against detainees or employees. This shall include periodic status checks of detainees and review of relevant documentation. Monitoring is documented on the 14-2D PREA Retaliation Monitoring Report (30/60/90) form. Monitoring shall continue beyond ninety (90) days if the initial monitoring indicates a continuing need." The Grievance Supervisor conducts retaliation monitoring at CCCC. She confirmed retaliation monitoring for retaliation begins the day an allegation is made and continues for a minimum period of 90 days or longer, if necessary. She indicated retaliation monitoring includes monthly face to face contact with the detainee and a review of disciplinary reports and/or housing or program changes or requests. When monitoring staff retaliation, she indicated the monitoring would include negative performance reviews, time off refusals, or reassignment requests. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor thoroughly reviewed 5 sexual abuse allegation case investigative files, for the adjusted audit cycle, and found a 90-day retaliation monitoring conducted and documented in the case files as outlined in the 14-2-DHS policy. The Auditor also confirmed through the Warden and PSA Compliance Manager that CCCC the had no reported instances of alleged retaliation occurring during the last twelve months.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d) The Auditor based compliance on these subparts of the standard after review of policy 14-2-DHS requiring," The facility shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. Detainee victims shall not be held for longer than five days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment." The PSA Compliance Manager and the Warden both indicated that placing a detainee victim in involuntary administrative segregation would be the last option that would be utilized at CCCC. In a case where a detainee victim needed to be temporarily housed, the use of one of the medical beds would be used. They also both confirmed, during the audit period, segregation was not used to house a victim of sexual abuse. The Warden also confirmed any detainee victim placed in administrative segregation would require a notification be made to the FOD within 72 hours. He also stated, prior to the detainee returning to general population, a vulnerability reassessment would be completed. The Warden and Segregation Supervisor confirmed they cannot remember segregation being used to place any alleged detainee victim of sexual assault. The Auditor's review of five randomly selected investigative case files did not indicate any alleged detainee victim being placed in segregation post-allegation.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b) The Auditor based compliance on these subparts of the standard after review of policy 14-2-DHS requiring, "" the Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, where appropriate, are completed for all allegations of sexual abuse." The current Investigator confirmed he is required to conduct an administrative investigation on all allegations of sexual abuse, regardless of whether the allegation is referred for criminal investigation. He indicated in accordance with policy 14-2-DHS, he is required to coordinate his investigation with any agency conducting the criminal investigation. He indicated his duties as an investigator, as described in his job position description, require his investigations to be thorough, prompt and objective. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor completed a review of five randomly selected sexual abuse investigative files for the adjusted audit cycle, and found the investigation was completed promptly by a trained investigator and appeared to be thorough and objective.

(c)(e)(f) The Auditor based compliance on these subparts of the standard after review of policy 14-2-DHS requiring, " Administrative investigation procedures include: preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, an witnesses; reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five (5) years; coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." The criminal investigations at CCCC are conducted by the Milan Police Department. The Warden confirmed the facility notifies this department upon every allegation of sexual abuse and waits to conduct the administrative investigation after consultation with the appropriate investigative offices within DHS. The Investigator indicated he would cooperate with any outside agency conducting the criminal investigation to include providing documents or other potential evidence they would need and endeavor to remain informed about the investigation's progress. The CCCC Investigator is a certified law enforcement member and indicated by policy and experience his protocols and determinations for administrative investigations are based on direct and circumstantial evidence; available physical DNA evidence; available electronic monitoring data; interviews note from alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator. He also confirmed that by policy and practice the departure of the alleged abuser or victim from the facility or agency's employment or control would not provide a basis for terminating an investigation. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the

audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor reviewed five randomly selected sexual abuse investigative files from the adjusted audit cycle and found the file contents demonstrated compliance with the subpart (c) and policy 14-2-DHS protocol requirements.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with this standard after review of policy 14-2-DHS that requires, "In any sexual abuse investigation in which the facility is the primary investigating entity, the facility shall utilize a preponderance of the evidence standard for determining whether sexual abuse has taken place." The CCCC Investigator confirmed the evidence standard utilized when determining the outcome of a sexual abuse case is the preponderance of evidence. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor conducted a file review of five randomly selected sexual abuse allegation investigative files from the adjusted audit cycle, and it appeared that all the outcomes of the investigations were based on this standard of evidence.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with this standard after review of policy 14-2-DHS that requires, "When the detainee is still in immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken. If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee. All detainee notifications or attempted notifications shall be documented [and] signed for on the 14-2E Detainee Allegation Status Notification, verifying that such notification has been received. The signed 14-2E Detainee Allegation Status Notification shall be filed in the detainee's file." The CCCC Warden, who as previously mentioned could serve as an emergency investigator, PSA Compliance Manager and SDDO confirmed this detainee notification process at the facility is performed by ICE. The interview with the SDDO confirmed that she or a Deportation Officer (DO) typically handle these notifications and then provide the Investigator with the completed 14-2E document. She also stated that if the detainee is moved to another ICE facility, the SDDO at that facility is contacted to facilitate signing form 14-2E and returning it to her or the DO. If the detainee is released to an address in this country, ICE forwards the document requesting his signature and asks it to be returned to the facility, again becoming part of the investigative file. If the detainee has been deported, she indicated ICE typically has no forwarding address and an unsigned 14-2E is sent to the investigative file. The Auditor feels the notification requirement is met as the SDDO attempt is feasible under the circumstances. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor reviewed five randomly selected sexual abuse allegation investigative files from the adjusted audit cycle, and found two files with this signed form and three files with the form but no signature as the detainee had left the custody of the facility and ICE.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS requiring, "Employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse." The Warden and the HR Manager interviews confirmed removal of staff from their position at Cibola and from the Federal service, is the presumptive disciplinary sanction for any staff member who has engaged in or attempted or threatened to engage in sexual abuse or failed to follow the zero-tolerance policy. As noted in standard 115.11, the CCCC policy regarding dismissal from service for violations with the zero-tolerance policy was approved by the AFOD.

(c)(d) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS that requires, "All terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal and to any relevant licensing bodies, to the extent known." The Warden confirmed during his interview that all allegations of sexual abuse are immediately reported to the Milan Police Department, regardless of the employment status of the individual. He also indicated he would report violations of the CCCC sexual abuse policy, by licensed staff to any licensing bodies as known. There were no substantiated allegations of sexual abuse involving staff during the extended audit period requiring this notification.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS that requires, "Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall also report such incidents to the FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known. Contractors and civilians suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation." The Warden informed the Auditor that any contractors and volunteers would face removal from the facility for any violation of the zero-tolerance policy. The facility would report such violations to local police, licensing bodies and the FOD through the AFOD. He further stated that there were no reported incidents requiring the removal of a contractor or volunteer within the audit period.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS and policy 15-100 (Resident Rules and Discipline) that require, "Detainees shall be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an

administrative or criminal finding that the detainee engaged in sexual abuse, consistent with the requirements of ICE PBNDS 3.1 Disciplinary System. Sanctions shall be commensurate with the nature and circumstances other abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories. The disciplinary process shall consider whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. For the purpose of disciplinary action, a report of sexual abuse or assault made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. A detainee shall have the right to due process, which includes the right: to present statements and evidence, including witness testimony on his/her own behalf; and appeal the committee's determination through the detainee grievance process." The Warden and PSA Compliance Manager both confirmed the CCCC disciplinary system allows for progressive levels of reviews, appeals, procedures, and documentation procedures. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. There was one substantiated allegation of sexual abuse involving detainee on detainee during the adjusted audit cycle. Because of the custody level of the facility, the detainee was immediately moved to another facility before a disciplinary hearing was conducted. The receiving facility was notified of the substantiated incident by CCCC, but due to the transfer, the Auditor was unable to determine if a hearing was conducted on the incident.

§115.81 - Medical and mental health assessments; history of sexual abuse.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS that requires, "If the screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than seventy-two (72) hours after the referral." The two intake officers interviewed confirmed that any detainee disclosure of prior victimization, during intake, requires the detainee be immediately referred to medical. The vulnerability assessment is entered electronically into the Offender Management System (OMS) and if a checkmark is made on the document a referral email is immediately forwarded to medical and mental health for follow up. The HSA confirmed when this medical follow-up/referral is initiated, the detainee receives a health evaluation typically the same or next day and no later than two working days from the date of the assessment. When a referral for mental health is initiated, the detainee receives a mental health evaluation no later than 72 hours after the referral. Although the 14-2-DHS policy makes the same notification requirement for any detainee arriving at CCCC with sexually abusive behavior, the Classification Supervisor indicated the detainee would be held in the hold area until moved from CCCC. As noted earlier, detainees with this type of disclosure on their record would not be maintained at CCCC as the custody level for the facility is low; and therefore, they do not accept detainees with this type of history. She further stated any detainee found to have perpetrated sexual assault/abuse would be moved to another facility.

§115.82 - Access to emergency medical and mental health services.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS that requires, "Detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All treatment services, both emergency and ongoing, 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." Interviews with the CCCC HSA confirmed that a detainee requiring a forensic examination is sent to the University of New Mexico Hospital and all treatment services, to include emergency medical treatment and crisis intervention services, including sexually transmitted infections prophylaxis, are provided without cost and with professionally accepted standards of care. CCCC had no detainees sent out for a forensic examination or medical treatment for sexual abuse during the audit period. The Auditor's review of five randomly selected investigative files and the associated medical files reviewed confirmed detainees were immediately seen by medical staff at the time the facility became aware of the allegation. The interview with the HSA confirmed victims of sexual abuse would be transported to the Albuquerque SANE Collaborative for treatment as outlined in the MOU dated February 2021 with no sunset date.

§115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 14-2-DHS that requires, "The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. 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 facility shall provide victims with medical and mental health services consistent with the community level of care. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services." The HSA confirmed all detainees, who experience sexual abuse while in detention, receive medical and mental health services consistent with the community-level of care, evaluation, and treatment without cost, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. The HSA also confirmed the medical and mental health departments at CCCC provide on-site crisis intervention services, if necessary, to include, sexually transmitted infections and other infectious diseases testing, and prophylactic treatment to victims, if necessary. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor reviewed five randomly selected sexual abuse allegation investigative files and documentation from their medical files from the adjusted audit cycle and found the detainees in each case were immediately seen by medical upon reporting the allegation.

(g) The Auditor determined compliance with this subpart of the standard after review of policy 14-2-DHS that requires, "The facility shall attempt to conduct a mental health evaluation of all known Detainee-on-Detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." The interview with the PSA Compliance Manager and HSA, who oversees Mental Health,

confirmed that all known abusers would be offered services consistent with the policy and standard. They also indicated that violent detainees are not placed or housed at CCCC because of the facility only supports housing detainees with certain custody determinations (low). Accordingly, there were no known abusers at CCCC. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. There was one allegation of substantiated sexual abuse during the adjusted audit cycle. The detainee was immediately transferred prior to any mental health referral. According to the PSA Compliance Manager and HSA, the receiving facility was notified.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) Policy 14-2-DHS requires," the Facility Administrator ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation. In addition to the Facility Administrator, the incident review team shall include upper-level facility management and the facility SART, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall: consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; and examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. All findings and recommendations for improvement will be documented on the 14-2F-DHS Sexual Abuse Incident Review Report. Completed 14-2F-DHS forms will be forwarded to the Facility Administrator, the PSA Compliance Manager, and the FSC PREA Coordinator. The facility shall implement the recommendations for improvement or shall document reasons for not doing so. Both the report and response shall be forwarded to the FSC PREA Coordinator and the ICE Prevention of Sexual Assault Coordinator." The Auditor interviewed a member of the incident review team who detailed what the team reviews during every incident and their review included the requirements in the policy and the standard. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor conducted a review of five randomly selected sexual abuse investigative files from the adjusted audit period and found a completed incident review in each of the files. However, the incident review form had no date to signify when the review was completed.

Does Not Meet (a)(b): The documentation provided was not dated; and therefore, the Auditor could not confirm compliance with the standard that requires the review to be completed within 30 days of the conclusion of the investigation**.** To confirm compliance the facility must develop a practice that requires dating form 14-2F-DHS to confirm the review is being conducted within 30 days of the conclusion of the investigation.

(c) The Auditor determined compliance with this subpart of the standard after review of policy 14-2-DHS that requires, "The facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the Facility Administrator and ICE Field Office Director, or his or her designee, for transmission to the ICE PSA Coordinator." The interview with the PSA Compliance Manager indicated he provided the SDDO with a copy of the negative report for 2020, which the Auditor reviewed.

§115.87 - Data collection.

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

Notes:

(a) The Auditor determined compliance on this subpart of the standard after review of policy 14-2-DHS that requires, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be retained in accordance with CoreCivic Policy 1-15 Retention of Records." The Auditor observed the case record storage room and found the documents were secured under a double lock and restricted key.

§115.201 - Scope of audits.

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

Notes:

(d) The Auditor were allowed access to the entire facility and able to interview staff and detainees about sexual safety during the on-site visit.
(e) The Auditor were able to revisit areas of the facility and to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j) Audit notices were posted and observed throughout the facility in English and Spanish. The Auditors received no staff or detainee correspondence.

AUDITOR CERTIFICATION

Update Audit Findings Outcome Counts by Clicking Button: **Update Outcome Summary**

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	1
Number of standards met:	35
Number of standards not met:	3
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

I certify that the contents of the report are accurate to the best of my knowledge and no conflict of interest exists with respect to my ability to conduct an audit of the agency under review. I have not included any personally identified information (PII) about any detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.

Thomas Eisenschmidt 1/17/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 1/18/2022

PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 1/18/2022

PREA Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Corrective Action Plan Final Determination

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-[redacted]
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	772-579-[redacted]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	El Paso Field Office		
Field Office Director:	Kenneth Genalo		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	11541 Montana Ave. Suite E., El Paso, Tx 79936		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Cibola County Correctional Center (CCCC)		
Physical address:	2000 Cibola Loop, Milan, NM 87021		
Mailing address: *(if different from above)*			
Telephone number:	915-225-1901		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-285-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Assistant Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	505-285-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

Directions: Please provide summary of audit findings to include the number of provisions with which the facility has achieved compliance at each level after implementation of corrective actions: Exceeds Standard, Meets Standard, and Does Not Meet Standard.

The Prison Rape Elimination Act (PREA) audit of the Cibola County Correctional Center (CCCC) was conducted on November 16-18, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt for Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Managers (APM), (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) all DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards during the audit period of December 7, 2018, through November 18, 2021. The CCCC is privately owned by CoreCivic and operates under contract with the DHS, Immigration and Customs Enforcement (ICE), Office of Enforcement and Removal Operations (ERO). The facility processes adult male detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the CCCC are from Nicaragua, Senegal, and Turkey. The facility does not house juveniles, females, or family detainees. This was the second PREA audit for the CCCC and the facility is located in Milan, New Mexico.

During the audit, the Auditor found CCCC met 35 standards, had one standard (115.31) that exceeded, two standards (115.14. 115,18) that were non-applicable, and three non-compliant standards (115.16, 115.33, and 115.86). As a result, the facility was placed under a Corrective Action Period that began January 17, 2022, and ended July 17, 2022, to address the non-compliant standards. The final supplied documentation was reviewed by the Auditor on June 8, 2022. The CAP has been completed and accepted by the Auditor and the facility is found compliant with all standards.

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence replied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable.

§115. 16 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(b) Policy 14-2-DHS requires, "The facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." The Auditor interviewed two intake staff. Both these individuals indicated that when they encounter a detainee who is LEP they would utilize their interpretive language service to assist them with interviews if a staff interpreter was unavailable. They also indicated when providing information on the efforts to prevent, detect, and respond to sexual abuse, in a language not covered by ICE National Detainee Handbook (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) that already provides this information, they utilize their interpretive language contract to provide the detainee with this meaningful access information to prevent, detect, and respond to sexual abuse. At the time of the audit, the facility only had the DHS-prescribed Sexual Abuse and Awareness information pamphlet available in English and Spanish, although the pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. Based on a follow-up interview with the PSA Compliance Manager after the onsite visit, the facility now has the pamphlet in all nine languages available for dissemination. The Auditor questioned both of them on what specific information is provided to the detainee. Both of these individuals were not specific and could not detail any specific information that is provided. They were also unable to demonstrate what is specifically provided to each detainee. The Auditor also interviewed two detainees who indicated they spoke a language not covered by the ICE National Detainee Handbook. The review of these two detainee's files only contained a signed English form with no notation of interpreter use. During the site visit, the PSA Compliance Manager explained he was developing a manuscript with the information requirements of this subpart and the orientation requirements of 115.33 to be provided to detainees who are LEP.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. To become compliant, the facility needs to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are LEP. The facility needs to provide evidence of the new process implementation that was being developed by the PSA Compliance Manager at the time of the audit, and evidence that the process is being complied with; documentation of the interpretation service use to deliver the script and signature of detainee's participation for five detainees who speak languages other than English and Spanish and particularly any who speak a language that is not covered by the ICE National Detainee Handbook. In order for the facility to be fully compliant, equal access to all information aspects of the Sexual Abuse and Assault Prevention and Intervention (SAAPI) program, the facility needs to demonstrate how the information from the facility's handbook is conveyed to LEP detainees if they speak a language other than English or Spanish.

Corrective Action Taken (b): The Auditor received the initial CAP on March 2, 2022 and concurred with the proposed corrective action. Upon arrival at the facility, the language spoken by each new detainee will be determined by facility staff based on their country of origin and use of the Language Line Solutions Language Identification Guide, a pamphlet that includes the most common languages encountered in North America that are offered through the service; The guide is be offered to the detainee to determine which language they speak. The staff member will locate the geographical region where the detainee is from, then show the detainee the languages listed for that region. Underneath each language is the translation of the statement: "Point to your language. An interpreter will be called. The interpreter is provided at no cost to you." The DHS-prescribed Sexual Abuse and Assault Awareness (SAA) information pamphlet will be distributed to each new detainee to be used as the informational document to demonstrate compliance with the sexual safety education requirement of subpart (b), which are available in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. The detainee will sign the Intake SAAPI Education Acknowledgement form which acknowledges receipt of the DHS-prescribed SAA information pamphlet and the ICE National Detainee Handbook. This document also indicates when a Language Line interpreter is used and the language. The Auditor reviewed the documents provided by the facility which included the Language Line Solutions Language Identification Guide; DHS-prescribed SAA information pamphlet; Intake SAAPI Education Acknowledgement form; and ICE National Detainee Handbook and concurred that they meet the subpart (b) requirements. On June 8, 2022, the facility provided six examples of detainees who speak languages other than English and Spanish receiving the required SAAPI information in a language that they understood. Four of the six spoke languages

that were not covered by the DHS-prescribed SAA information pamphlet and the form was documented that they received the SAAPI information using a Language Line interpreter. CCCC has demonstrated compliance with the subpart (b) requirements in all material ways.

§115. 33 - Detainee education

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

Notes:

(a)(b)(c)(e)(f) Policy 14-2-DHS requires, "Upon admission, all detainees shall be notified of the facility's zero tolerance policy on sexual abuse and assault through the orientation program and detainee handbook. Detainees will be provided with information (orally and in writing) about the facility's SAAPI Program. Such information shall include, at a minimum: the facility's zero-tolerance policy for all forms of sexual abuse or assault; the name of the facility PSA Compliance Manager, and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the OHS/Office of Inspector General (OIG) and the ICE/Office of Professional Responsibility (OPR) investigation processes; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling." The standard requires this information be provided as well. As noted in standard 115.16, the Auditor interviewed two intake staff who indicated all detainees arriving at CCCC receive the CoreCivic Handbook, only available in Spanish and English, the DHS-prescribed ICE Sexual Abuse and Assault Awareness Information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed ICE Sexual Abuse Awareness Information pamphlet is available in English and Spanish only at CCCC. The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The intake staff indicated to the Auditor that when intake staff is confronted with a detainee that may be hearing impaired or deaf, most CCCC orientation information is provided to them in writing or if that is not successful information would be provided through the use of the text telephone (TTY). When staff encounters a detainee who is blind or with limited sight the staff member would attempt to provide individualized service to the detainee to include reading information if needed. These two intake staff also confirmed that when dealing with a detainee with low intellect or limited reading skills would typically involve assistance of a supervisor, medical or mental health staff based on the degree of limitation of the detainee. Both these individuals indicated that when they encounter a detainee who is LEP and not covered by any of the languages the ICE National Detainee handbook is available in, they utilize their interpretive language contract when dealing with the detainee. However, when the Auditor questioned both of them on what information is specifically provided to the LEP detainee to ensure all aspects of the facility's efforts to prevent, detect and respond to sexual abuse, both were not specific with what information is provided and unable to demonstrate what is specifically told each detainee. The Auditor also interviewed two detainees who indicated they spoke a language not covered with the ICE National Detainee handbook. The review of these two detainee's files only contained a signed English form with no notation of interpreter use. The facility was unable to demonstrate the required information outlined in subpart (a) in this standard was provided to these two detainees not speaking a language covered by the ICE National Handbook. During the site visit, the PSA Compliance Manager informed the Auditor that he was finishing a manuscript with the information outlined in this standard subpart (a), information required in standard 115.16 and additional orientation information to be provided to detainees whose language is not covered by the ICE National Detainee handbook.

Does Not Meet (a)(b): The facility has not demonstrated that they provide subpart (a) and (b) requirements to all detainees, which requires notification, orientation, and instruction be provided in formats accessible to all detainees, including those who are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. This information must include instruction on prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; Explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of-contact line officer, the DHS Office of Inspector General, and the Joint Intake Center; Information about self-protection and indicators of sexual abuse; Prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and The right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. To become compliant, the facility needs to demonstrate they provide meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainee who are LEP. The facility needs to provide evidence of the new process implementation that the PSA Compliance Manager stated he was developing at the time of the audit, and evidence that the process is being complied with. Over the next 60 days, documentation of the interpretation service used to deliver the script and signature of detainee's participation for five detainees who speak languages other than English and Spanish and particularly any who speak a language that is not covered by the ICE National Detainee handbook should be presented for compliance review.

Corrective Action Taken (a)(b): The Auditor received the initial CAP on March 2, 2022, and concurred with the proposed corrective action. Upon arrival at the facility, the language spoken by each new detainee will be determined by facility staff based on their country of origin and use of the Language Line Solutions Language Identification Guide, a pamphlet that includes the most common languages encountered in North America that are offered through the service; The guide is be offered to the detainee to determine which language they speak. The staff member will locate the geographical region where the detainee is from, then show the detainee the languages listed for that region. Underneath each language is the translation of the statement: "Point to your language. An interpreter will be called. The interpreter is provided at no cost to you." The DHS-prescribed SAA information pamphlet will be distributed to each new detainee to be used as the informational document to demonstrate compliance with the sexual safety education requirement of subparts (a)(b), which are available in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. The detainee will sign the Intake SAAPI Education Acknowledgement form which acknowledges receipt of the DHS-prescribed SAA information pamphlet and the ICE National Detainee Handbook. This document also indicates when a Language Line interpreter is used and the language. The Auditor reviewed the documents provided by the facility which included the Language Line Solutions Language Identification Guide; DHS DHS-prescribed SAA information pamphlet; Intake SAAPI Education Acknowledgement form; and ICE National Detainee Handbook and concurred that they meet the subpart (b) requirements. On June 8, 2022, the facility provided six examples of detainees who speak languages other than English and Spanish receiving the required SAAPI information in a language that they understood. Four of the six spoke languages that were not covered by the DHS-prescribed SAA information pamphlet and the form was documented that they received the SAAPI information using a Language Line interpreter. CCCC has demonstrated compliance with the subparts (a) and (b) requirements in all material ways.

§115. 86 - Sexual abuse incident reviews

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

Notes:

(a)(b) Policy 14-2-DHS requires "the Facility Administrator ensure that a post-investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation. In addition to the Facility Administrator, the incident review team shall include upper-level facility management and the facility SART, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall: consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; and examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. All findings and recommendations for improvement will be documented on the 14-2F-DHS Sexual Abuse Incident Review Report. Completed 14-2F-DHS forms will be forwarded to the Facility Administrator, the PSA Compliance Manager, and the FSC PREA Coordinator. The facility shall implement the recommendations for improvement or shall document reasons for not doing so. Both the report and response shall be forwarded to the FSC PREA Coordinator and the ICE Prevention of Sexual Assault Coordinator." The Auditor interviewed a member of the incident review team who detailed what the team reviews during every incident and their review included the requirements in the policy and the standard. As there were zero allegations of sexual abuse reported at CCCC for the prior 12-months period, the audit period was extended to capture closed investigations that occurred since the facility's last audit. The Auditor conducted a review of five randomly selected sexual abuse investigative files from the adjusted audit period and found a completed incident review in each of the files. However, the incident review form had no date to signify when the review was completed.

Does Not Meet (a)(b): The documentation provided was not dated; and therefore, the Auditor could not confirm compliance with the standard that requires the review to be completed within 30 days of the conclusion of the investigation. To confirm compliance, the facility must develop a practice that requires dating form 14-2F-DHS to confirm the review is being conducted within 30 days of the conclusion of the investigation.

Corrective Action Taken (a)(b): The Auditor received the initial CAP on March 2, 2022, and concurred with the corrective action proposed which included revising the ICE/ERO Sexual Abuse or Assault Incident Review Form to include a report date. The facility was awaiting approval from ICE on the document change since the form is an Agency form. On April 27, 2022, the facility provided the Auditor with the revised ICE/ERO Sexual Abuse or Assault Incident Review Form that includes a line for the report date to be entered. CCCC has demonstrated full compliance with subparts (a)(b) in all material ways.

§115. **Choose an item.**
Outcome: Choose an item.
Notes:

§115. **Choose an item.**
Outcome: Choose an item.
Notes:

§115. **Choose an item.**
Outcome: Choose an item.
Notes:

AUDITOR CERTIFICATION:
I certify that the contents of the report are accurate to the best of my knowledge and no conflict of interest exists with respect to my ability to conduct an audit of the agency under review. I have not included any personally identified information (PII) about any detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.

Thomas Eisenschmidt June 29, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) July 18, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) July 19, 2022
Program Manager's Signature & Date