PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	8/31/2021	**To:**	9/1/2021
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
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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:	Corey Price
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)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	El Paso Service Processing Center (EPSPC)		
Physical address:	8915 Montana Ave, El Paso, TX 79925		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	(915) 225-0700		
Facility type:	SPC		
PREA Incorporation Date:	9/22/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(915) 225-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(804) 418-

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 interview and documentation review portion of the Prison Rape Elimination Act (PREA) contingency audit of the El Paso Service Processing Center (EPSPC) was conducted by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Thomas Eisenschmidt and Douglas Sproat for Creative Corrections, LLC. The Auditors were provided guidance and review during the audit report writing and review process by the Immigration and Customs Enforcement (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 EPSPC is an ICE operated facility with security and support service supplied by Global Precision Systems/Asset Security Services (GPS) under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains male and female adult detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at EPSPC are from Ecuador, Mexico, and Guatemala. This was the second PREA audit for EPSPC. EPSPC is located in El Paso, Texas.

ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g., a health pandemic. The process is divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. During the Pre-Audit phase, the Auditor completes a review of the documentation, including detainee, staff, contractor, and volunteer files; investigative files; policy and procedures; and supplemental documentation needed to confirm the facility's compliance with the PREA regulations. The second phase, the Remote Interview phase, consists of interviews with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers (either through a virtual conference platform or conference line). The third phase, the On-site audit phase, is scheduled when the environment is safe for the ICE federal staff, facility staff, detainees, and Auditors. This phase mirrors a traditional PREA audit with a facility tour, observation of facility practices, and follow-up from the prior phases, as needed. Full compliance is contingent upon the on-site review of any additional documentation to determine all subparts of the standard were appropriately handled per the standard's requirement and upon the Auditor's review of notes and information gathered during the on-site visit.

The audit was originally scheduled for June 2020 and was converted to a contingency audit due to Covid-19 health pandemic. The audit period was expanded to cover the period of June 2019 through August 30, 2021. This expanded audit period allowed the Auditors to not only review the documentation submitted for the originally scheduled audit date, but also additional documentation submitted as part of the contingency audit process including the on-site visit. Approximately four weeks prior to the contingency audit, ERAU Team Lead, (b) (6), (b) (7)(C), provided the Auditors with the facility's PAQ, agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form in folders for ease of auditing. The main policy that provides facility direction for PREA is Policy 2.1.1, Sexual Abuse Assault Prevention and Intervention (SAAPI) Program. All the provided documentation, policies, and PAQ were reviewed by the Auditor. The Lead Auditor also reviewed the facility's website https://www.ice.gov/detention-facility/el-paso-processing-center.

At the beginning of the Remote Interview audit phase conducted on October 6-8, 2020, brief introductions were made and the detailed schedule for the remote interviews was covered. The Lead Auditor provided an overview of the contingency audit process and methodology used to demonstrate PREA compliance. The Lead Auditor explained the audit process is designed to assess compliance through written policies and procedures, and to determine whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Lead Auditor further explained compliance with the PREA standards would be determined based on a review of policy and procedures, observations made during the facility on-site visit, additional on-site documentation review, and staff and detainee interviews. It was shared that no correspondence was received by any detainees, staff, or other individual prior to the contingency audit phase. In the timeframe before the Remote Interview audit phase, the facility provided the requested information used for the random selection of detainees and staff to be interviewed including an alphabetic and housing listing of all detainees at the facility, lists of staff by duty position and shifts, and a list of volunteers and contractors on duty during the contingency audit.

There were 30 formal detainee interviews conducted (26 during the remote phase and an additional 4 during the on-site visit), randomly selected from the housing units. Interviews conducted during the Remote Interview phase were through Cisco WebEx. Nineteen detainees interviewed were limited English proficient (LEP) and required the use of Language Services Associates (LSA), a contract language interpretative service, provided through Creative Corrections. A total of 44 staff interviews were conducted. Interviews were conducted with ICE and GPS staff either randomly chosen or interviewed based on their specific title. Specifically, specialized staff interviewed included the Officer in Charge (OIC), Project Manager, Prevention of Sexual Abuse (PSA) Compliance Manager, three medical and mental health staff, the Administration/Human Resources staff, two non-security staff EPSPC Investigator, Training Administrator, Grievance Officer, the staff member responsible for Retaliation Monitoring, the Restricted Housing Unit (RHU) Supervisor, Classification Officer, Intake Captain, Supervisory Detention and Deportation Officer (SDDO), and four intake staff. There were no volunteers available to interview due to COVID-19, as volunteer services had been suspended.

At the conclusion of the Remote Interview audit phase on October 8, 2020, an exit briefing was held via teleconference. The Lead Auditor advised the facility that in addition to the Provisional Report being issued based on the results of the contingency audit phases, there will be an on-site tour of the facility scheduled at a later time. There will be no standard's determinations provided at the time of the Provisional Report. While on-site, more documentation review and interviews of staff/detainees may need to take place. In addition, Auditors will need to observe intake operations and other facility practices during the On-Site audit phase. During the site visit, four detainees were interviewed, seven investigative case files were reviewed, seven detainee medical records reviewed, seven detainee detention files were reviewed, five employee personnel files were reviewed, five employee training files were reviewed, and two contractor files were reviewed.

The third phase, the on-site audit phase, was scheduled when it was deemed the environment safe for the ICE federal staff, facility staff, detainees, and Auditors. Prior to the on-site audit phase, the Auditor requested updated facility information and received additional documentation from the ERAU Team Lead and facility staff which was provided to the Auditor. The on-site visit was conducted on August 31, 2021, through September 1, 2021, and consisted of a facility tour, interviews of staff and detainees, and review of follow-up documentation. The on-site visit was conducted by Lead Auditor and the Assistant Program Manager.

The count at EPSPC at the time of the on-site visit was 282 males and 38 females. There are 14 general population living units. During the on-site visit there were 3 open living units and 11 closed due to Covid-19 quarantine protocols. These general population units consist of multi-occupied detainee (8-20 person) dormitories. There is one RHU located in building [redacted]; there are two single cells and 36 double cells in the unit.

The facility utilizes trained GPS investigators to complete all allegations of sexual abuse. During the audit period, EPSPC reported 22 allegations of sexual assault. There were three open cases and 19 completed investigations. Of these completed investigations, 10 were allegations of detainee-on-detainee and 9 were allegations of staff-on-detainee. Regarding the detainee-on-detainee allegations, six were determined to be unsubstantiated and four were determined to be substantiated. The nine allegations of staff-on-detainee were determined to be: three unfounded, five unsubstantiated, and one substantiated. The open cases involved one staff-on-detainee and two detainee-on-detainee. The Lead Auditor reviewed 10 of these sexual abuse allegations. All 10 allegations were referred to ICE OPR. None were deemed criminal.

On August 31, 2021, an entrance briefing was held in the EPSPC staffing conference room. The ERAU ICE Section Chief, [redacted], opened the briefing and then turned it over to the Auditors. In attendance were:

GPS Staff

[redacted] - Assistant Project Manager
[redacted] - Detention Management Supervisor
[redacted] - PSA Compliance Manager
[redacted] - Compliance Department Operations Supervisor (CDOS)
[redacted] - CDOS
[redacted] - Assistant Quality Assurance Manager
[redacted] - American Correctional Association (ACA) Manager
[redacted] -ACA Manager
[redacted] - ACA Manager
[redacted] - Chief of Security
[redacted] - Assistant Safety Manager

ICE Staff

[redacted] - Office of Enforcement and Removal Operations (ERO), SDDO
Lieutenant Commander [redacted] -Immigration Health Services Corp (IHSC), Health Services Administrator (HSA)
[redacted], Section Chief, OPR, ERAU

Creative Corrections

Thomas Eisenschmidt-Certified PREA Auditor
[redacted], ICE PREA Assistant Program Manager

Auditor introductions were made, and then the Lead Auditor provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained that the audit process is designed to assess compliance through written policies and procedures and determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards would be determined based on the review of policy and procedures, observations made at the time of the facility tour, provided documentation review, and the results of interviews with both staff and detainees. The Auditor shared that he received no correspondence from any detainee or staff before the on-site visit. The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific categories) including an alphabetic and housing listing of all detainees detained at the facility, lists of staff by duty position and shifts, and a list of volunteers/contractors on duty.

On September 1, 2021, an exit briefing was held in the facility conference room. The ERAU ICE Section Chief, [redacted], opened the briefing and then turned it over to the Auditors.

In attendance were:

GPS Staff

[redacted] - Project Manager
[redacted] - Assistant Project Manager
[redacted] - Assistant Project Manager
[redacted] - Detention Management Supervisor
[redacted] - PSA Compliance Manager
[redacted] - CDOS

(b) (6), (b) (7)(C) - CDOS
(b) (6), (b) (7)(C) - Assistant Quality Assurance Manager
(b) (6), (b) (7)(C) - ACA Manager
(b) (6), (b) (7)(C) -ACA Manager
(b) (6), (b) (7)(C) - ACA Manager
(b) (6), (b) (7)(C) - Chief of Security
Stephanie Pugh- Assistant Safety Manager

ICE Staff

(b) (6), (b) (7)(C) - ERO, OIC
(b) (6), (b) (7)(C) - Contracting Officer's Representative (COR)
(b) (6), (b) (7)(C) - ERO, SDDO
Lieutenant Commander (b) (6), (b) (7)(C) -IHSC, HSA
(b) (6), (b) (7)(C) - Section Chief, OPR, ERAU

Creative Corrections

Thomas Eisenschmidt-Certified PREA Auditor
(b) (6), (b) (7)(C), ICE PREA Assistant Program Manager

The Auditors spoke briefly about the staff and detainee knowledge of the EPSPC PREA zero-tolerance policy. The Lead Auditor informed those present that it was too early in the process to formalize an outcome of the audit, and both Auditors would need to discuss their findings and review interviews conducted (staff and detainee). The Lead Auditor explained the audit report process, timeframes, and thanked all present for their cooperation.

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: 2

§115.31 Staff training
§115.35 Specialized training: Medical and Mental Health Care

Number of Standards Not Applicable: 2

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

Number of Standards Met: 31

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.15 Limits to cross-gender viewing and searches
§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
§115.43 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
§115.62 Criminal and administrative investigations
§115.72 Evidentiary standard for 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
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 6

§115.13 Detainee supervision and monitoring
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information

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 Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires, "EPSPC maintains a zero-tolerance policy for all forms of sexual abuse or assault. It is the policy of the EPSPC to provide a safe and secure environment for all detainees, employees, contractors, and volunteers free from the threat of sexual abuse or assault, by maintaining a Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program that ensures effective procedures for preventing, reporting, responding to, investigating, and tracking incidents or allegations of sexual abuse or assault. Sexual abuse or assault of detainees by other detainees or by employees, contractors, or volunteers is prohibited and subject to administrative, disciplinary, and criminal sanctions." The ICE Field Office Director (FOD) approved and signed the policy. The formal and informal interviews with detainees and staff confirmed their knowledge of this zero-tolerance policy toward all forms of sexual abuse.

(d): The Auditors determined compliance with this subpart of the standard based on Policy 2.1.1 that requires, "the PSA Compliance Manager is the point of contact for the local field office and ICE PSA Coordinator and must have sufficient time and authority to oversee facility efforts to comply with El Paso Service Processing Center [EPSPC] sexual abuse and assault prevention and intervention policies and procedures." EPSPC has designated a GPS employee as the PSA Compliance Manager to oversee the facility's compliance efforts with the implementation of PREA at EPSPC. The PSA Compliance Manager has been in his current position for approximately one year. During his interview, he confirmed he reports directly to the GPS Project Manager the ERO PREA Field Coordinator, and the OIC on all incidents relating to PREA. He also stated he has sufficient time and authority to perform all PREA-related responsibilities. The staff and detainee interviews confirmed their knowledge of who the PSA Compliance Manager is.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(c): The Auditors determined compliance with this subpart of the standard based on Policy 2.1.1 that requires "EPSPC ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. The OIC or designee shall determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, the EPSPC shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on EPSPC security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on EPSPC security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors." The PAQ and the interviews with the OIC and GPS Project Manager confirmed the staffing compliment of 545 staff, including male and female staff and is supplemented with a total of (b) (7)(E) video surveillance cameras strategically located throughout the facility. These video cameras operate 24 hours a day, 7 days a week. Most cameras are stationary; however, some cameras can pan, tilt, and/or zoom. A review of these cameras by the Auditors confirmed no privacy issues or concerns. According to the Project Manager and shift supervisors, GPS utilizes direct supervision of the detainees. If a detainee is in any area of the facility a staff member is present to supervise him/her. The facility never closes supervision posts. While conducting the facility tour, the Auditors observed this practice throughout the facility.

(b): Policy 2.1.1 requires "the facility determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, the facility shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee, the length of time detainees spend in agency custody, and any other relevant factors." The PSA Compliance Manager confirmed EPSPC did not conduct an annual review of the facility comprehensive guideline as required by this subpart.

DOES NOT MEET (b): EPSPC has not completed an annual review of the comprehensive detainee supervision guidelines required by the standard and the facility's policy. EPSPC must conduct an annual review of its' comprehensive supervision guidelines taking into account the need for video monitoring, consideration of generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee, the length of time detainees spend in agency custody, and any other relevant factors. The facility must provide documentation of the annual review of the comprehensive detainee supervision guidelines and the review that takes into consideration all elements outlined in subpart (c) for compliance review.

(d): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires "frequent unannounced security inspections be conducted to identify and deter sexual abuse of detainees. Inspections occur on night as well as day shifts. Staff are prohibited from alerting others that these security inspections are occurring, unless such announcement is related to the legitimate operational functions of the EPSPC." During the on-site tour, the Auditors reviewed log entries in different locations within the facility demonstrating unannounced rounds are occurring on day and night shifts. The Auditors interviewed shift supervisors from each shift who confirmed their requirement to visit each area of the facility where detainees have access during their shift. The line staff post orders were also reviewed requiring each makes periodic unannounced rounds during their shift. The Auditors noted these entries in the logbooks as well.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

Through the review of the Pre-Audit Questionnaire (PAQ) and interviews conducted with the OIC and PSA Compliance Manager, the Auditor confirmed EPSPC does not accept juveniles or family detainees. Therefore, this standard does not apply.

§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)(c)(d)(i): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 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. Pat-down searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All pat-down searches by staff of the opposite gender shall be documented. Staff are prohibited from searching or physically examining 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." The Assistant OIC (AOIC) indicated in a written statement and the PSA Compliance Manager confirmed during his interview that no cross-gender pat-searches were conducted at EPSPC within the audit period and that, if one was done, it would be documented as required by policy. Male and female random GPS security staff from each shift, 12 in total, were interviewed. Each of the security staff indicated proper pat-down search procedures are provided to them through their annual search training. Each described the conditions under which a pat-search may be performed, as outlined in policy, and required by the standard. Each also specifically stated that they are prohibited from searching any detainee for the sole purpose of determining their genital status and that if they were to conduct a cross-gender pat-search, it would be documented. The Auditors found no cross-gender pat-searches logged in the facility Search logbook conducted during the audit period.

(e)(f): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 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. All strip searches and visual body cavity searches shall be documented." The PAQ and the OIC and the Project Manager interviews confirmed juveniles are not housed at EPSPC. The PAQ and interviews with the OIC and PSA Compliance Manager indicated EPSPC conducted one same gender strip search (sexual assault investigation) which was authorized by the Captain during the audit period. The Auditors reviewed the Search Logbook and found this strip search was conducted under an exigent circumstance and documented per the standard's requirement. The PAQ and interviews with the OIC and PSA Compliance Manager also indicated there were no body cavity searches during the audit period. Interviews with the security staff indicated they were aware of the requirements of each type of search.

(g): Policy 2.1.1 that requires "detainees 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. Staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing. The officers and/or staff may proceed once the area is clear to enter." According to the Project Manager and PSA Compliance Manager interviews and the Auditors observations during the on-site visit, the housing units at the EPSPC are gender specific for supervision. Male GPS staff work on male living units and females GPS staff are assigned to the female living units. The Auditors were also told and observed if staff of the opposite gender need to enter one of the opposite gender living areas the unit officer announces to the detainees that they must clear the shower, allowing detainees 15 minutes to do so. After 15 minutes, the staff of the opposite gender may enter the unit. The Auditors interviewed random detainees and the majority of them confirmed staff of the opposite gender announce themselves prior to entering their living areas, or areas where they may be showering, performing bodily functions or in a state of undress.

(h): EPSPC is not a Family Residential Center; therefore, this subpart is not applicable.

(j): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires "all pat-down searches be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and policy, including officer safety. Security staff shall be trained in proper procedures for conducting pat-searches, including cross-gender pat-searches and searches of transgender and intersex detainees." During the 12 random security staff interviews, each staff confirmed their knowledge of the prohibition of searching transgender or intersex detainees to determine their genital status and their responsibility to perform all pat-down searches in a professional and respectful manner. The review of ten security staff training records provided demonstrated pat-down search training including proper procedures for conducting pat-down searches, cross-gender pat-down searches, and pat-searches of transgender and intersex detainees was completed and documented. The Auditors interviewed two transgender detainees who confirmed they believe they were never singled out to be searched and all searches they received were done professionally.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "EPSPC take appropriate steps to ensure that detainees with disabilities (including, for example, 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. Such steps shall include, when necessary, 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, 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. Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication. The Auditor was informed by the Intake Captain that when PPIPC intake staff are confronted with a detainee who may be hearing impaired or deaf, that orientation information is provided to them in writing or through use of their facility text telephone (TTY). She also stated that If staff is confronted with a detainee who is blind or has limited sight, he/she would be provided individualized service by a staff member to read information to him. Detainees with intellectual deficiencies would be referred to a supervisor, medical, or mental health staff based on the detainee limitation.

(b): Policy 2.1.1 requires. "The EPSPC shall take steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary." Interviews conducted with four intake staff indicated detainees arriving at EPSPC receive the El Paso Detainee Handbook, the DHS-prescribed ICE Sexual Assault Awareness Information pamphlet, and the ICE National Detainee Handbook. The El Paso Detainee Handbook is available in Spanish and English. The DHS-prescribed ICE Sexual Assault Awareness Information pamphlet is available in English, Spanish, French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic. 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).During the tour of the intake areas, the auditors were provided copies of some of these National Handbook languages with the other available to download, print and disseminate when needed. Two informational videos, PREA and Know your Rights, run continuously in the intake area in English and Spanish as well. During the audit, the Auditors interviewed 30 random detainees, 19 who were LEP. Each of these 19 men and women were Spanish speaking and provided orientation materials in their language. There were no detainees present during the Remote Interview phase or during the on-site visit from a country speaking a language currently not represented in the ICE National Detainee Handbook. When the Auditors questioned each of the four intake staff on what is provided to detainees from countries speaking a language not represented in the ICE National Detainee Handbook, the answers varied from reading the entire handbook to them to just providing what they felt was appropriate information. During these interviews and detainee file reviews, the facility could not demonstrate the use of a translation service specific for orientation purposes or produce documentation of the required PREA information being provided to detainees who spoke a language not addressed by the ICE National Detainee Handbook. The Auditors were not given the specifics of what information is provided to these detainees or provided proof that interpretive services were used specifically for orientation purposes.

DOES NOT MEET (b): The facility needs to ensure they provide the notification, orientation, and instruction in formats accessible to all detainees. The Auditor provided the facility with a manuscript of the relevant PREA information required under 115.33 to adopt using their facility-specific information. The facility started editing the manuscript while the Auditors were on-site. The facility needs to provide the completed manuscript, the updated policy to reflect the newly implemented process, five new intake detainee files, and documented staff training of the newly implemented policy for compliance review for detainee languages not covered through the ICE national Handbook.

(c): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "EPSPC in matters relating to allegations of sexual abuse the facility shall employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. EPSPC is required to provide detainees with disabilities and detainees with limited English proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. 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 Auditors interviewed 12 random GPS detention officers. Each officer confirmed that interpretation services for alleged detainee victims of sexual assault provides confidentiality and ensures that these services enable effective, accurate, and impartial interpretation. They were aware of the 2.1.1 policy restrictions on use of detainee interpreters, 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. A review of investigative files confirmed Spanish speaking detainees (LEP) were provided interpretation services by a staff member (typically the EPSPC Investigator). There was only one case involving the use of the ERO Language Service line, for a Mandarin speaking detainee, and it was documented accordingly.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(e)(f): The Auditors determined compliance with these subparts of the standard based on 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, and 6.8.0, ICE Suitability Screening Requirements for Contractor Personnel, and policy 2.11 that requires "the facility and agency, to the extent permitted by law, to refuse 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 been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard." The documents require all new hires, those staff awaiting promotions, and all staff on an annual basis to complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form. 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 Division Chief of the ICE OPR Personnel Security Unit (PSU), informed Auditors who attended remote training in October 2020, that candidate suitability for all employment 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. Applicants are questioned directly about any such previous misconduct both during their background check and during the job interview process and a positive response to any of those specific questions are grounds for unsuitability including material omissions or making false or misleading statements in the application. The GPS Human Resources (HR) Manager confirmed the facility would provide information on substantiated allegations of sexual abuse, involving former employees, upon the request from an institutional employer for which the employee has sought new employment. He also indicated, as part of the facility employment process, the facility would request information from prior institutions, where the prospective candidate was previously employed. He further stated that any employment candidate or staff member that provides false, misleading or incomplete information would be subject to dismissal from his/her employment or withdrawal of any offer for employment.

(b): This standard subpart requires, "An agency or facility considering hiring or promoting staff shall ask all applicants directly about previous misconduct described in paragraph (a) of this section, in written applications for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees." The interview with the Unit Chief from the ICE OPR Personnel Security Operations Unit confirmed that the hiring process and promotion application process are completed through USA Jobs. During this application process individuals are asked directly about misconduct outlined in subpart (a). He also confirmed that ICE employees, having contact with detainees, are not asked directly about

previous misconduct described in paragraph (a) of this section during employee performance reviews. Furthermore, the review of the 10 GPS employee files did not demonstrate employees are asked directly about this conduct during performance reviews either. Also, the review of a recent GPS promotion HR file did not demonstrate the staff person was questioned directly about previous misconduct described in paragraph (a) of this section prior to the promotion.

DOES NOT MEET (b): The facility and agency failed to ask about previous misconduct described in subpart (a) during any staff performance reviews or written self-evaluations conducted as part of reviews of current employees per the standard's requirement. GPS also failed to ask about this misconduct during a recent staff promotion as required. In accordance with subpart (b), the agency or facility considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct described in paragraph (a) of this section, 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.

(c)(d): The Auditors determined compliance with these subparts of the standard based on the Federal Statute 731.105 and ICE Directives 6, 7.0 and 6.8.0 that require" the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees prior to being allowed entrance into the facility. It further requires a background recheck be conducted every five years on all employees and unescorted contractors." The HR Manager for ICE stated ICE completes all background checks for all staff and contractors prior to hiring and then again, every five years. A review of documentation provided by the ICE OPR PSU confirmed that the 10 randomly selected employees' (5 GPS and 5 ICE) background checks were performed prior to being hired. Documentation also confirmed the due dates for the five-year background rechecks. The Auditor determined the provided background check documentation 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 PAQ and the interview with the EPSPC OIC who confirmed the facility has not expanded or modified the existing facility or updated video monitoring equipment since the previous audit or within the audit period.

§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)(b): ICE policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, requires "facilities secure and preserve the crime scene and safeguard information and evidence, consistent with ICE uniform evidence protocols and local evidence protocols in order to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." Policy 2.1.1, approved by DHS, states "local law enforcement agencies will not respond to this facility. Notification and criminal investigations are conducted by OIG or OPR." The PSA Compliance manager confirmed no local law enforcement responds to EPSPC. PREA allegations are investigated through OPR or DHS. The agency's policy 11062.2 further 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. The OPR will coordinate with the 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 then ERO would assign an administrative investigation to be conducted." The 2.1.1 policy states local law enforcement does not handle criminal cases arising at EPSPC. The Auditor interviewed a Supervisory Special Agent from OPR who confirmed if a crime was committed at the EPSPC, his office would handle the collection of evidence in the case, although additional information provided by the OPR indicated it has been established that the FBI would handle criminal investigations for EPSPC. There were no instances during the audit review period where the FBI actually collect evidence or conducted an investigation at the facility.

(c): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires "where evidentiary or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the OIC or designee shall arrange for an alleged victim to undergo a forensic medical examination by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel." The HSA confirmed EPSPC has a memorandum of understanding (MOU) with University Medical Center of El Paso (UMC), dated 2017 with no sunset date, confirming forensic examinations for sexual abuse allegations would be conducted under the hospital SANE program. The HSA also confirmed that all medical services are provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the allegation. She also stated that EPSPC has had no sexual abuse victims requiring a forensic examination within the last 12 months. There were no detainees, who alleged sexual abuse, present at the time of the site visit to interview.

(d): The Auditors determined compliance with these subparts of the standard based on the MOU with the Center Against Sexual and Family Violence (CASFV), dated 2017 with no sunset date, that requires the advocacy agency provide valuable expertise and support in the areas of crisis intervention and counseling, emotional support, and information to victims of sexual assault and accompany the victim through any forensic exam and investigative process. The facility reported 22 sexual abuse investigations during the audit period. In review of 10 closed investigative files, the Auditors determined the alleged victims were offered victim advocacy services as documented in the files. The Facility Investigator confirmed that when the detainee is first taken to medical, they are provided victim advocate information by both the investigator and medical staff after every report of an allegation. There were no detainees, who alleged sexual abuse, present at the time of the site visit to interview.

(e): EPSPC does not utilize local law enforcement. ICE policy 11062.2 requires its' investigators comply with subparts (a) through (d) of the standard; however, while there is no formal MOU with an external agency for conducting investigations of sexual abuse, the PSA Compliance Manager confirmed during his interview that the facility will request that the investigating agency follow the facility's evidence protocol. There were no criminal cases of sexual abuse reported at EPSPC during the audit period.

§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): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "EPSPC establish a protocol, to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority. This protocol shall be posted on the facility website, or otherwise made available to the public." The policy further requires "documentation of each investigation by written

report, that includes a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings with retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. All investigations are to be reported to the Joint Intake Center (JIC) who assesses allegations to determine which allegations 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 Inquiry Unit (AIU) for investigation. The AFOD would assign an administrative investigation to be completed. All investigations are closed with a report of investigation." The agency's policy 11062.2 outlines the evidence and investigation protocols. The interviews with the two GPS investigators and the PSA Compliance Manager confirmed every allegation of sexual abuse/assault is investigated with files being maintained for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. The facility reported 22 sexual abuse allegations during the audit period, with 2 cases still open. The Lead Auditor reviewed 10 investigative files and determined they were completed in accordance with the standard requirements.

(c): EPSPC maintains a website with protocols posted that is made available to the public. Members of the public are directed towards the agency website at: https://www.ice.gov/prea. A review of the ICE website confirms the sexual abuse investigation protocols are available.

(d)(e)(f): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "the OIC or designee promptly report all incidents of sexual abuse to the ICE FOD and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation." The interview with the OIC indicated that once she is notified of any incident of sexual abuse, regardless of who is involved, she immediately notifies the FOD, JIC, ICE OPR and DHS OIG. The documentation observed in the 10 investigative files reviewed demonstrated that ICE notifications were made.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 and the training curriculum "Understanding the Dynamic of Sexual Abuse and Assault" that require "training on the facility's SAAPI program be included in initial and annual refresher training for all employees. This policy and curriculum requires topics and discussion on the facility's zero-tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal sexual behavior; the right of detainees and staff to be free from sexual abuse and from retaliation from 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 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 policy also requires each staff member to pass a written or practical examination to ensure the subject matter has been mastered with this formal training fully documented in permanent training records. The Auditors reviewed 15 random staff training files and found each file contained a signed certification form acknowledging that each staff member had received and understood the training. The random 12 EPSPC staff and two ICE staff interviewed by Auditors confirmed each staff member had received PREA pre-service and annual refresher training. Staff interviewed discussed the PREA training each received, which included the subject matter required by the standard under subpart (a). The GPS Training Administrator confirmed all employees receive PREA training, prior to working with detainees. Except for employees on long term absence, everyone received required PREA training in 2020 with 75% of staff trained in PREA for 2021. The Auditors indicated the facility exceeds the requirement of the standard as PREA refresher training is provided annually instead of the standard requirement of bi-annually.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "all volunteers and other contractors who have contact with detainees to be trained on their responsibilities under the facility sexual abuse prevention, detection, intervention, and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of ICE and the EPSPC's zero-tolerance policy and informed how to report such incidents." Submitted with the facility PAQ was completed documentation for contractor training, to include signed acknowledgment forms. The Auditor interviewed the contracted maintenance supervisor, who discussed the PREA training he received, beginning with his initial hiring and the annual refresher PREA training. He indicated that he signed a document acknowledging the training received and that he understood the agency's zero-tolerance for sexual abuse. There were no volunteers at the facility to interview at the time of the site visit. The Auditors reviewed two volunteer training files and found the required signed PREA initial and annual refresher training acknowledgement.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 2.1.1 requires "upon admission to the EPSPC all detainees sign and date the Admission Checklist (EPC-PBNDS 0077) during the admission process to confirm that they were tendered the following: the National Detainee Handbook (includes information on Sexual Abuse and Assault Awareness, the local Detainee Handbook (includes information on Sexual Abuse and Assault), the orientation video (includes information on Sexual Abuse and assault), the Phone Access Card/ Free Phone Call, provided an opportunity to ask questions, the online Detainee Locator System (ODLS) form and the DHS Sexual Abuse & Assault Prevention Pamphlet." The Auditors reviewed these documents and found information to include 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; 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; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting a sexual 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. Policy 2.1.1 further requires "EPSPC provide the detainee notification, orientation, or instruction 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. During the intake process, detainees who are determined to be LEP or who may have a disability (i.e., hearing impaired, deaf, and blind, etc.) will receive interpretive services and/or medical and/or mental health assistance throughout the process." As noted in the 115.16 narrative section of this report and during the intake staff interviews, the facility could not demonstrate the use of a translation service specific for orientation purposes or produce documentation of the six subpart (a) requirements to detainees who spoke a language not addressed by the ICE National Detainee Handbook.

DOES NOT MEET (a)(b)(c): EPSPC does not comply with subparts (a)(b)(c) of this standard as the facility could not document it provides the six subpart (a) requirements, to every detainee in a language they understood as required in subpart (b) or demonstrate by documentation it was provided to those detainees where the language was not covered by the ICE National Handbook as required in (c). The Auditor provided the facility with a manuscript of the relevant PREA information required under subpart (a) to adopt using their facility-specific information. The facility started editing the manuscript while the Auditors were on-site. The facility needs to provide the completed manuscript, the updated policy to reflect the newly implemented process, five new intake detainee files, and documented staff training of the newly implemented policy for compliance review for detainee languages not covered through the ICE national Handbook.

(d): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires "EPSPC 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 (PREA Coordinator); 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 (including toll-free hotline numbers where available). If no such local organizations exist, the EPSPC shall make available the same information about national organizations." During the on-site visit, the Auditor observed the required DHS poster with the name of the PSA Compliance Manager in each area of the facility that detainees have access to, including in all housing units. These areas also contained the victim advocate contact information. The 30 detainees interviewed confirmed each of their housing units has the required information posted.

(e)(f): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires "upon admission to the EPSPC all detainees sign and date the Admission Checklist (EPC-PBNDS 0077) during the admission process to confirm that they were tendered the DHS Sexual Abuse & Assault Prevention Pamphlet." Information about reporting sexual abuse is included in the agency Detainee Handbook and made available to all immigration detention facility detainees. The ICE National Detainee Handbook is available in 14 languages and the DHS Sexual Abuse & Assault Prevention Pamphlet in 9 languages, while the other documents are available in Spanish and English only. When the Auditors questioned each of the four-intake staff on what is provided to detainees from countries speaking a language not represented in the ICE National Detainee Handbook, the answers varied from reading the entire handbook to them to just providing what they felt was appropriate information.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "in addition to the general training, all EPSPC staff responsible for conducting sexual abuse or assault investigations shall receive specialized training that covers, at a minimum, 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. The facility must maintain written documentation verifying specialized training provided to investigators pursuant to this requirement." 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." GPS Investigators received investigative training through the Agency Performance and Learning Management System (PALMS) and the National Institute of Corrections (NIC). The PALMS lesson plan for the GPS investigators is the "Investigating Incidents of Sexual Abuse and Assault" that covers investigative techniques, evidence collection, and all aspects to conducting an investigation of sexual abuse in a confinement setting. NIC training covered conducting sexual abuse investigations in confinement settings. The agency provided the training records of agency investigators to confirm compliance with subpart (b) of the standard. Interviews with the OIC, GPS Investigator, and GPS Training Administrator, indicated the two GPS investigators have received specialized training for conducting sexual abuse investigations, in accordance with the standard. EPSPC completed 22 investigations of sexual abuse within the last 12 months. Each investigation was completed by a trained investigator.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)
Notes:

(a)(b)(c): The Auditors determined compliance with these subparts of the standard based on IHSC Directive 03-01 (Sexual Abuse and Assault Prevention and Intervention) that requires "in addition to the general training provided to all employees, the agency shall provide specialized training to DHS or agency employees who serve as full and part-time medical practitioners or full and part-time mental health practitioners in immigration detention facilities where medical and mental health care is provided." The interview with the HSA confirmed all full- and part-time medical and mental health employees receive specialized training, provided by IHSC, covering all four elements outlined in subpart (b) of this standard: 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; and how and to whom to report allegations of sexual abuse. She also indicated medical staff at EPSPC are prohibited from conducting evidence or forensic examinations. If a forensic examination is required, the detainee is sent to UMC, where a SANE practitioner will examine the victim. Interviews with two medical and mental health staff confirmed they received this specialized training covering all four elements outlined in subpart (b) of this standard. The HSA confirmed that medical and mental health staff receive this training annually; and therefore, exceeds the standard's one-time requirement. The HSA also confirmed that the facility has not sent any detainees to UMC for a forensic examination, within the audit period. As noted earlier, the 2.1.1 policy was approved by the FOD.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(c)(d)(e)(f): Policy 2.1.1 requires "all detainees be screened upon arrival at the EPSPC 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. The initial classification process and initial housing assignment should be completed within twelve hours of admission to the EPC. 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 also 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." Policy 2.1.1 further requires "the facility reassess each detainee's risk of victimization or abusiveness between 60 and 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 Auditors interviewed four intake staff who complete the DHS Risk Classification Assessment (RCA) Worksheet to assess vulnerability and abusiveness of arriving detainees. They indicated that they believed medical staff conduct this assessment. The Auditors questioned medical staff and were informed that medical screens detainees upon admission. The Auditors reviewed the IHSC In-Processing Health Screening (Form I-794 or equivalent) which does not address all nine elements of subpart (c) nor does the RCA. The Auditors were provided and reviewed 15 random detainee detention files, none of which had an initial risk assessment included. Two of the detention files reviewed were detainees who were at EPSPC for longer than 90 days, requiring another vulnerability reassessment by policy and standard; however, there were no reassessments found in either file. The Auditors reviewed an additional five detention files while on site of detainees who alleged sexual abuse, but no reassessments were conducted after report of the allegations in all five cases was reported. Because the facility was unable to indicate how they assess detainees for risk of victimization or abusiveness, the Auditors could not determine a detainee being disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked as they are not being asked these questions.

DOES NOT MEET (a)(c)(d)(e)(f): The facility must develop a process in which they are able to assess all detainees on intake to comply with (a) to identify those at risk of victimization or abusiveness. The process must consider all aspects under (c) and (d), and the facility must share that process with the Auditor via documentation of 10 detainee files. The facility must also ensure detainees who are eligible for a reassessment receive one within 60-90 days or when otherwise warranted, in compliance with (e). Documentation to support this is occurring must also be provided to include initial review, 60-90-day review, and those making an allegation of sexual assault.

(b): Policy 2.1.1 and policy 2.2 Classification System requires" the facility segregate detainees from the general population pending receipt and processing of information needed for classification. The initial classification process and initial housing assignment shall be completed within 12 hours of admission to the facility. If the process takes longer, documentation shall be maintained to explain the cause of the delay and to indicate the detainee shall be housed appropriately." Interviews with two classification staff and the OIC confirmed that, due to the COVID-19 pandemic, all arriving detainees are currently being placed in housing together with other detainees, arriving on the same day, for a 14-day quarantine period. They also confirmed that after the 14th day, the detainee receives their classification. The policy and standard require the initial classification be concluded within 12 hours. The Auditors were also informed the initial classification is completed without a risk assessment.

DOES NOT MEET (b): The intake staff confirmed that arriving detainees do not receive a classification until their 15th day at the facility instead of within the first 12 hours as required per subpart (b). This classification practice was also confirmed by the OIC. The initial classification process and initial housing assignment should be completed within twelve hours of admission to the facility.

(g): The Auditors determined compliance with this subpart of the standard based on policy that requires "EPSPC implement appropriate protections on responses to questions asked pursuant to the vulnerability screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates." The PSA Compliance Manager did confirm that appropriate controls are placed on all detainee records and information, including RCA assessments, which are maintained in the detainee detention file and secured in the records room file cabinet, under lock and key.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Policy 2.2 requires "EPSPC ensure that detainees are housed according to their classification levels. After completion of the in-processing health screening form (IHSC-794 or equivalent), the classification officer assigned to intake processing shall review information provided by ICE/ERO and complete a custody classification worksheet. Upon completion of the classification process, the officer shall assign individual detainee's color-coded uniforms, wristbands, or other means of custody identification. During the classification process, staff shall reference facts and other objective, credible evidence documented in the detainee's A-file, work-folders, ICE automated records systems, criminal history checks, or other objective sources of information. Relevant considerations include any current criminal offense(s), past criminal offense(s), escape(s), institutional disciplinary history, documented violent episode(s) and/or incident(s), medical information or a history of victimization. Personal opinions, including opinions based on profiling, familiarity or personal experience, may not be considered in detainee classification. Special consideration shall be given to any factor that would raise the risk of vulnerability, victimization, or assault. Detainees who may be at risk of victimization or assault include, but are not limited to, persons with disabilities, persons who are transgender, elderly, pregnant, suffering from a serious medical or mental illness, and victims of torture, trafficking, abuse, or other crimes of violence. This process should incorporate the requirements in Policy 2.11 "Sexual Abuse and Assault Prevention and Intervention" regarding assessment of risk for victimization or perpetration of sexual abuse or assault." When the Auditors questioned the four classification officers, the Auditors were told they do not utilize a risk assessment but base the detainee's classification on information provided by ICE/ERO. Since the initial risk assessment and classification is not completed under the requirements of standard 115.41, the Auditors have concluded the housing determination made by the classification officers is not completed pursuant to subpart (a) of this standard.

DOES NOT MEET (a): The facility must develop and utilize an effective assessment process, in consultation with the classification document, and complete it within 12 hours in order to inform assignment of detainee housing, recreation and other activities as required by this subpart.

(b)(c): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "when making classification and housing decisions for a transgender or intersex detainees, EPSPC shall consider the detainee's gender self-identification and an assessment of the effects of placement on 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 of 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. The EPSPC's placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee. When operationally feasible, transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." The interview with the two classification officers indicated the facility has a Transgender Classification and Care Committee (TCCC) that reviews all transgender detainees assigned to EPSPC. The Auditors could not find any reference to this committee in policy 2.1.1 or policy 2.2. EPSPC received a transgender detainee on 8-28-2021 and the detainee was placed in a single cell in administrative segregation until seen by the TCCC on 8-30-2021 at which time the detainee was released to a general population bed under quarantine. The Auditors were unable to interview her, based on her quarantine status. A review of the detainee's file also confirmed she did not receive a risk assessment as required under 115.41.

RECOMMENDATION: The Auditors would recommend that the facility create a written document stating the purpose, makeup and responsibilities of the local TCCC or incorporate into Policy 2.1.1 or 2.2.

§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)(e)(f): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 and policy 2.12 (Special Management Units) that requires "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 EPSPC, the facility will consult with the 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 30 days. Detainees will receive the same privileges as are available to detainees in the general population, depending on any safety and security considerations for detainees, facility staff, and security. When space and resources are available, detainees in Administrative Segregation may be provided opportunities to spend time outside their cells (in addition to required recreation times), for such activities as socializing, watching television, and playing board games." The Auditor interviewed the CDOS who indicted that segregation is not normally used to house victims or potential victims of sexual assault, unless the detainee requests it. The OIC indicated, during her interview, that segregation would not be used to protect a vulnerable detainee and that alternative housing would be utilized, including the use of a medical bed. She also stated that if the use of segregation were ever used for any victim or vulnerable detainee, she would notify the FOD within 72 hours. She also stated that segregation has not been utilized within the last 12 months to house any victim or vulnerable detainee. When questioned about the recent transgender detainee placed in SHU, she indicated it was less than 72 hours to assess her safety concerns. While in administrative segregation she received all the privileges general population detainees receive. As noted earlier this policy was approved by the FOD.

(d): The Auditors determined compliance with this subpart of the standard based on Policy 2.12 that requires "the CDOS conduct a review within 72 hours of the detainee's placement in segregation to determine whether segregation is still warranted utilizing form I-885 (Administrative Segregation Review)." The policy further requires the CDOS to review, in person, the status of all detainees in segregation at least every 7 days for the first 30 days and every 10 days thereafter. The review authority will consider any alternatives available and what, if any, assistance could be provided the detainee to facilitate the return to the general population." During his interview, the CDOS confirmed this policy and practice. He also confirmed that segregation has not been utilized for this purpose. As noted earlier a transgenders detainee was placed in segregation pending review by the TCCC. EPSPC has two segregation buildings. A disciplinary unit and an administrative unit. The transgender detainee was placed in the administrative unit that allows outside cell access to television, vending machine and privileges except access to general population detainees.

§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 policy 2.1.1 that requires "detainees have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting." This policy, the El Paso Detainee Handbook, and the ICE National Detainee Handbook outline reporting means for detainees. EPSPC detainees can report allegations through verbal reports to any staff member (including the PSA Compliance Manager or medical staff); written informal or formal requests or grievances; telephone calls or written reports to the DHS/OIG, ICE/OPR; ICE Detention Reporting and Information Line (DRIL); and telephone calls or written reports to consular officials. EPSPC has a MOU with CASFV to not only provide support to all victims of sexual assault, but they also accept reports of sexual abuse. The Auditors observed contact information (telephone number and address) in each of the living areas for this advocate and the PSA Compliance Manager confirmed that all contact with CASFV is confidential and unmonitored. The Auditors observed the DHS posters in each of the living units which included information on reporting (anonymous and confidential) of sexual abuse allegations through the DHS OIG hotline telephone number. The two intake staff interviews indicated the consular office information and reporting information is provided to detainees in the orientation materials provided at intake and on posters throughout the facility. The Auditors tested the reporting telephone lines to both the DRIL and OIG without the use of a detainee PIN. The Auditors asked the person on the end of the call if the caller could remain anonymous and were told yes. The 30 random detainee interviews confirmed their consular office and reporting information is provided upon arrival and posted in their living areas.

(c): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires "staff shall take seriously all statements from detainees claiming to be victims of sexual abuse or assault and shall respond supportively and non-judgmentally. Staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." The facility's PAQ and interviews with both GPS investigators confirmed that of the 22 reported allegations of sexual assault, 2 were received from a third party (OIG helpline and victim advocate) and the remaining 20 allegations were reported to GPS staff. The random staff confirmed they are to accept and immediately report all 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. When the facility utilizes a contracted interpreter or a staff interpreter the individual who conducts the interview documents in writing the detainee allegation and comments.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "a formal grievances related to sexual abuse and assault may be filed at any time during, after, or in lieu of lodging an informal grievance or complaint and with no time limit imposed on when a grievance may be submitted." The policy further requires "written procedures must be implemented for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse or assault. Decisions on grievances shall be issued within 5 days of receipt and appeals shall be responded to within 30 days." Policy 6.2 (Grievance) requires "written procedures shall also cover urgent access to legal counsel and the law library. An emergency grievance involves an immediate threat to a detainee's health, safety or welfare. Medical emergencies will be brought to the immediate attention of proper medical personnel for further assessment. If it is determined that it is not a medical emergency, standard grievance procedures will apply." This policy further states, "detainees may obtain assistance from another detainee, the housing officer or other EPSPC staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties and all grievances related to sexual abuse and the facility's decision on any such grievance must be forwarded to the FOD." The Auditor interviewed the EPSPC Grievance Officer who confirmed that the PSA Compliance Manager and OIC are immediately notified of all allegations of sexual abuse made through the grievance office. They also stated allegations of sexual abuse are treated as an emergency grievance and that all medical emergencies are brought immediately to the proper medical personnel for assessment as required by policy. All emergency grievances are responded to within five days of receipt and responses to an appeal of the grievance decision are responded to within 30 days. The OIC confirmed that once notified of any allegation of sexual abuse, regardless of how it is received, she notifies the FOD. None of the 22 allegations, within the audit period, were made through the grievance program. The random staff interviews confirmed their knowledge of the policy of allowing the housing officer or other facility staff, family members, another detainee or legal representatives to assist the detainee with the grievance process if necessary.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "staff utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse and assault perpetrators to most appropriately address victims' needs." According to their website, CASFV is a safe haven for adults, youth, and children escaping domestic violence and sexual assault. They provide people with shelter, basic necessities, emergency assistance, therapeutic support, and other prevention and crisis intervention programs. EPSPC has a MOU with CASFV to not only provide support to all victims of sexual assault, but they also accept reports of sexual abuse. The Auditors observed contact information (telephone number and address) in each of the living areas for this advocate and the PSA Compliance Manager confirmed that all contact with CASFV is confidential and unmonitored. This contact information is also available in the El Paso Detainee Handbook. The Auditors made contact with the advocate service through the detainee telephone without the use of a detainee PIN. The PSA Compliance Manager also stated that each detainee alleging sexual assault is provided information about CASFV by either himself or the GPS investigator. The Auditor reviewed 10 investigative files and found notations, where the detainee was provided information about CASFV in the file.

§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 Auditors determined compliance with the standard based on Policy 2.1.1 that indicates "third-party reporting of sexual abuse can be made via DRIL Line, OIG, email, and a phone call to a supervisor or Deportation Officer." The ICE website, https://www.ice.gov/prea, is the main source for the public about information on reporting allegations at the EPSPC and provides contact telephone numbers. The ICE National Detainee Handbook and the El Paso Detainee Handbook provide reporting information by third parties for detainees as well. The ICE ERO DRIL is a toll-free service that provides a direct channel for agency stakeholders to communicate directly with ERO to answer questions and resolve concerns. The PSA Compliance Manager and investigator confirmed EPSPC had two allegations reported through a third-party within the audit period. The Auditor viewed the ICE website and found reporting information available to the public if needed.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "all staff immediately report any knowledge, suspicion, or information regarding an incident or allegation of sexual abuse occurring at the EPSPC; any retaliation against detainees or staff who reported or participated in an investigation about sexual abuse or assault; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." This policy also requires "information concerning the identity of a detainee victim reporting a sexual assault, and the facts of the report itself, shall be limited to those who have a need-to-know in order to make decisions concerning the victim's welfare, and for law enforcement/investigative purposes. Apart from such reporting, staff shall not reveal any information related to a sexual abuse and assault to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the EPSPC, or to make medical treatment, investigation, law enforcement, or other security and management decisions." Policy 2.1.1 also states "staff must also be able to report this information outside of their chain of command." This policy was reviewed and approved by the FOD. The 12 random security staff interviews confirmed their knowledge of the reporting requirements as outlined in policy and required by the standard including their ability to report sexual abuse outside their chain of command. The staff were all aware of keeping information they become aware of confidential. They also confirmed they could report sexual abuse allegations to the OIG, if necessary.

(d): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires, "if the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person's statute, the facility shall report that information to the FOD so that ICE can report the allegation to the designated State or local services agency under applicable mandatory reporting laws." There are no juveniles placed at EPSPC. The interviews with the OIC and PSA Compliance Manager confirmed there were no vulnerable adults housed at EPSPC within the last 12 months. The OIC indicated she would notify the FOD in all incidents of sexual abuse alleged to involve a vulnerable adult.

§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 determined compliance of the standard based on policy 2.1.1 that requires "all staff (employees, volunteers, and contractors) are responsible for being alert to signs of potential sexual abuse or assault, and to situations in which sexual abuses or assaults might occur. If an EPSPC staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." The Auditors interviewed 12 AGS security staff, the SDDO, the PSA Compliance Manager, and the OIC about this policy requirement. Each staff stated in any situation where a detainee appeared to be at substantial risk of imminent sexual abuse, their immediate and primary focus would be to provide immediate safety for the detainee. Their specific response and action would be predicated on the specific time, location of the detainee, and when they became aware of the situation but in any case, to safeguard the detainee. According to the OIC and the PSA Compliance Manager, EPSPC has had no known detainees at substantial risk of imminent sexual abuse within the audit period.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "upon receiving an allegation that a detainee was sexually abused or assaulted while confined at another facility, the OIC or designee shall notify the FOD and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation." EPSPC received a detainee report alleging he was sexually assaulted while in custody at another facility. The Auditor was informed by a GPS investigator and the PSA Compliance Manager that an alleged sexual abuse incident occurring at another facility (Luna County Jail). The Auditor was provided documentation from the ERO PREA Field Coordinator of the notification of this allegation being made to the Jail within 72 hours of the allegation being made. This policy further requires "any facility receiving notification of sexual abuse occurring at their facility shall ensure the allegation is referred for investigation and reported to the FOD." The PSA Compliance Manager and the GPS Investigator confirmed that EPSPC received and allegation from another facility (March 2021) that occurred at EPSPC. The Auditor was provided the investigative paperwork on this allegation and the overview and interview information that was provided to this facility.

§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 Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires, "staff take immediate action to separate any detainee who alleges that he/she has been sexually abused or assaulted from the alleged assailant and shall refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms." The policy further requires "the first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder shall request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating." During the random interviews with 12 GPS security staff, they detailed their responsibilities as responders to incidents of sexual abuse to include the subpart (a) requirements of this standard and policy. The review of the 10 investigative files confirmed in each of the cases where the alleged victim was responded to initially by a security staff member, and it appeared the security staff member followed the policy and standard responder requirements.

(b): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires, if the first staff responder is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." The OIC and a GPS investigator confirmed that there were no allegations at EPSPC reported to non-security staff. The Auditors interviewed two non-security staff who confirmed that any detainee informing them that they had been sexually assaulted would be secured and then immediately turned over to security staff.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 and IHSC Directive 3.01 (Sexual Abuse and Assault Prevention and Intervention) that require, "EPSPC use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a security staff member, and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise." The OIC and PSA Compliance Manager indicated that the 2.1.1 policy outlines the responsibilities and protocols for each discipline when responding to incidents of sexual abuse. After review of the 10 closed investigative files, the Auditors determined that the documentation in the files verified the multidisciplinary and coordinated responses taken by staff members at EPSPC when responding to allegations of sexual abuse.

(c)(d): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires, "if a victim of sexual abuse is transferred between detention 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 (unless the victim requests otherwise in the case of transfer to a non-ICE facility). If the receiving facility is unknown to the sending facility, the sending facility shall notify the FOD, so that he or she can notify the receiving facility." The OIC, PSA Compliance Manager, and the PAQ confirmed that EPSPC did not have a detainee who reported an allegation of sexual abuse being transferred to another facility by ICE requiring this notification. The OIC indicated that Medical would typically make these notifications to the medical unit at the receiving facility. Otherwise, she would contact that Facility Administrator.

§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 Auditors determined compliance with the standard based on policy 2.1.1 that requires, "staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." EPSPC had 10 allegations of sexual abuse made against staff within the audit period. The Auditors reviewed four investigative files where the allegation was made against a staff member. In each of

those files was documentation demonstrating that the staff, alleged in each case, was removed from detainee contact. The Interview with the OIC confirmed that staff, contractors, and volunteers under investigation would be removed from detainee contact until the conclusion 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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "staff, contractors, volunteers, and detainees not retaliate against any person, including a detainee, who reports, complains about, or partakes in an investigation into an accusation of sexual abuse, or for participating in sexual abuse as a result of, intimidation, threats, force, or fear of force." The policy further requires "EPSPC employ multiple protection measures, such as housing unit changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff that fear retaliation for reporting sexual abuse or for collaborating with investigations. For a minimum of 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. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The Auditors were not provided retaliation monitoring documentation for any of the 18 allegations made at EPSPC at the time of the provisional audit. Since the issuance of the provisional audit report, the facility has prepared a retaliation monitoring form and monitored those detainees who alleged sexual abuse. The PSA Compliance Manager is the designated staff person responsible for monitoring staff and detainee retaliation. During his interview, he confirmed retaliation monitoring starts the day the allegation is made and continues for at least 90 days or longer, if needed. He indicated that he personally meets with the detainee monthly, and documents the meeting on the Protection from Retaliation Log, Attachment B. He stated that detainee monitoring includes a review of the detainee's disciplinary reports and/or housing changes or program changes. He stated that staff monitoring is done for 90 days or more, if needed. He confirmed that monitoring includes a monthly in-person meeting with staff and includes monitoring negative performance reviews, time off refusals, and change of duties or reassignment requests. The Auditor found examples of retaliation monitoring in the completed investigative files reviewed.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 and 2.12 that require "victims of sexual assault and vulnerable detainees be housed in a supportive environment that represents the least restrictive housing option possible (e.g. in a different housing unit, transfer to another facility, medical housing, or protective custody), and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical or mental health needs of the victim." These policies further require "victims may not be held for longer than five days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim. The EPSPC shall notify the appropriate ICE FOD whenever a detainee victim, or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hours 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 reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault." The OIC indicated segregation would not be used to protect a victim of sexual abuse. She indicated that she would examine all alternative housing options, including the use of a medical bed. She also confirmed that, if administrative segregation was ever used for the placement of an alleged victim, she would notify the FOD within 72 hours and the placement would not exceed five days. The OIC and the PSA Compliance Manager confirmed no detainee alleging sexual abuse at EPSPC was placed in segregation during the audit period.

§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)(c)(d): The Auditors determined compliance with these subparts based on policy 2.1.1 requires "EPSPC coordinate with ICE and other appropriate investigative entities to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse. All investigations must be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators. The policy further requires administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity and should include preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and 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 years; and coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." The facility utilizes trained GPS investigators to complete all allegations of sexual abuse. During the audit period, EPSPC reported 22 allegations of sexual assault. The Lead Auditor reviewed 10 of these sexual abuse allegations. All 10 allegations were referred to ICE OPR. None were deemed criminal. There were three open cases and 19 completed investigations. Of these completed investigations, 10 were allegations of detainee-on-detainee and nine were allegations of staff-on-detainee. Regarding the detainee-on-detainee allegations, six were determined to be unsubstantiated and four were determined to be substantiated. The nine allegations of staff on detainee were determined to be: three unfounded, five unsubstantiated, and one substantiated. The open cases involved one staff-on-detainee and two detainee-on-detainee. Based on the 10 investigations reviewed it appeared, to the Auditors, that the investigations were prompt, thorough, conducted by trained investigators.

(e)(f): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "the departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." The interviews with both GPS investigators confirmed that they would continue their investigations regardless if the staff member or detainee left the control of ICE. They also confirmed that they cooperate to the fullest with any outside investigators if necessary and endeavor to remain informed about the progress of the investigation.

§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 Auditors determined compliance with the standard based on policy 2.1.1 that requires "the EPSPC uses no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated." Interviews with the two GPS investigators and PSA Compliance Manager verified that the facility utilizes the preponderance threshold when determining investigative outcomes. The review of the 10 investigative files appeared to the Auditors that a preponderance of the evidence was the standard used in determining the outcome of these investigations.

§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 Auditors determined compliance with the standard based on policy 2.1.1 that requires "following an investigation conducted by the EPSPC into a detainee's allegation of sexual abuse, the EPSPC shall notify the FOD of the results of the investigation and any responsive actions taken so that the information can be reported to ICE headquarters and to the detainee." During the provisional audit the Auditor did not find notifications being made to detainees at the completion of the investigation. However, during the on-site visit, the Auditors observed notifications or attempts to make notification in the investigative files that were reviewed.

§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): Policy 2.1.1 states "staff shall be subject to disciplinary or adverse action, up to and including removal from their position, for substantiated allegations of sexual abuse or for violating ICE or facility sexual abuse rules, policies, or standards. Removal from their position is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse." The OIC confirmed this policy was approved by the agency. There were 10 allegations of sexual abuse involving staff within the audit period. Two of the allegations were determined unfounded, five were determined unsubstantiated, one was substantiated; the other two allegations were open investigations.

(c)(d): Policy 2.1.1 requires "EPSPC report all incidents of substantiated sexual abuse by staff, and all removals of staff, or resignations in lieu of removal for violations of sexual abuse policies, to appropriate law enforcement agencies unless the activity was clearly not criminal. The EPSPC shall also report all such incidents of substantiated abuse, removals, or resignations in lieu of removal to the FOD, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known." The OIC confirmed that all allegations of sexual abuse or assault are reported to her and forwarded to the FOD and to OPR, regardless of the investigation outcome. The investigative files indicated the OIC was notified in each of the files reviewed. She also stated that no staff has been terminated or disciplined during the audit period for violation of the zero-tolerance policy. The one substantiated allegation against staff resulted in a resignation during the investigation by OPR, and based on the investigative findings, the individual was not prosecuted.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires, "contractors and volunteers suspected of perpetrating sexual abuse or assault 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 EPSPC 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." This policy further requires "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 EPSPC 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." The OIC confirmed that all allegations of sexual abuse or assault are reported to her and forwarded to the FOD and to OPR. She indicated, where applicable, contractors and volunteers would be reported to relevant licensing bodies. The 10 investigative files reviewed, indicated that the OIC was notified. The OIC also stated that no contractor or volunteer has been terminated or disciplined during the audit period for violation of the zero-tolerance policy.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires, "detainees be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault." The EPSPC detainee disciplinary process is outlined in the Disciplinary Review Document. This document outlines the detainee discipline system and review process for rule violations. The document outlines the specific levels of reviews, appeals, procedures, and documentation procedures. The policy 2.1.1 also requires, "the disciplinary process 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. The facility will not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact." The facility had 4 allegations of detainee-on-detainee sexual abuse substantiated within the last 12 months. The Disciplinary Officer (CDOS) confirmed disciplinary hearings were completed on each of the four substantiated cases and according to the PSA Compliance Manager the detainee perpetrators were disciplined. The Auditors reviewed two of these cases, randomly chosen, and found each was disciplined for the violation. The Auditors were also provided the disciplinary disposition sheets in all four cases. The Auditor interviewed the CDOS, who also serves as the hearing officer, who confirmed a report of sexual abuse made in good faith, based upon a reasonable belief that the alleged conduct occurred, would not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. He also indicated sanctions imposed are commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future and that he verifies the mental health of the detainee, prior to initiating the hearing.

§115.81 - Medical and mental health assessment; 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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "if the screening required in standard 115.41 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 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 72 hours after the referral." The IHSC HSA confirmed that medical does ask each arriving detainee at EPSPC about prior victimization. She indicated that if they respond in the affirmative, a referral for medical or mental health follow-up is automatically initiated within the system. She also indicated the detainee is typically seen on the same day the referral is made, but always within 24 hours for medical and 72 hours for mental health. There were no detainees alleging prior victimization upon intake at the facility during the site visit for the Auditors to interview.

§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 Auditors determined compliance with these subparts of the standard based on policy 2.1.1 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 with all treatment services, both emergency and ongoing, be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." The Auditors reviewed 10 investigative files and their medical files. All alleged victims were seen on the day the allegation became known to the facility. The HSA indicated victims of sexual abuse at EPSPC would have access to medical examinations and crisis services, in accordance with professionally accepted standards of care, and at no cost to the detainee regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. There were no detainees alleging sexual assault at the facility to interview at the time of the site visit. The screening conducted by medical asks about prior victimization upon the detainee admission. If the detainee responds in the affirmative a scheduled visit for mental health is automatically scheduled. The HSA did show the Auditor the system and referral. The Auditors confirmed the appointment process with the Mental Health practitioner as well.

§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)(f): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "EPSPC 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. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate." The policy also states, "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 10 investigative case files the Auditors reviewed demonstrated that each alleged victim was seen by medical staff on the day the allegation became known to the facility. The HSA indicated victims of sexual abuse at EPSPC would have access to medical examinations and crisis services, consistent with community standards, and at no cost to the detainee regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. She also stated detainee victims of sexual abuse are provided, when indicated, tests and medication for sexually transmitted diseases and lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. As noted earlier, detainee victims of sexual assault needing a forensic exam would be taken to University Medical Center of El Paso. There were no detainees at the facility who alleged sexual abuse for the Auditors to interview. The HSA also confirmed all medical services are provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the allegation. She also stated that EPSPC has had no sexual abuse victims requiring forensic examination sent to the hospital within the last 12 months.

(g) The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires, "EPSPC 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 Mental Health Administrator confirmed staff in mental health would and has offered evaluations in all confirmed sexual abuse incidents. In the four cases where the allegations were substantiated and reviewed by the Auditor, the detainee perpetrator was offered services to each of the detainees.

§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): The Auditors determined compliance with this subpart of the standard based on policy 2.1.1 that requires, "the facility conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For any substantiated or unsubstantiated allegation, the facility shall prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and assault. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the FOD, or his or her designee, for transmission to the ICE PSA Coordinator. The facility shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator." The PSA Compliance Manager confirmed incident reviews are conducted and documented for every allegation of sexual abuse. The Auditors reviewed 10 investigative files and found an incident review in each of the files. Two of the incident reviews had the same date as the incident. The Auditor discussed it with the facility and recommended that the facility pay attention to documenting their incident review with the accurate date.

(b): The Auditors determined compliance with these subparts of the standard based on the DHS Sexual Abuse or Assault Incident Review form that requires the team to examine and determine if the assault or abuse was motivated by race; ethnicity; gender identity; LGBTI identification; status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The incident reviews completed on this form, included the review of each of these considerations.

(c): The Auditors determined compliance with these subparts of the standard based on policy 2.1.1 that requires "the facility 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 OIC or designee and FOD or his or her designee, for transmission to the ICE PSA Coordinator." The Auditors was provided a copy of the 2020 annual review with copies to the ICE PSA Coordinator, OIC and the FOD.

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 Auditors determined compliance with the standard based on the Policy 2.1.1 requires "the facility maintain in a secure area all case records associated with claims of sexual abuse or assault, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary." The PSA Compliance Manager confirmed that data collected for any investigation of sexual abuse is securely maintained in his office under double lock and key, with access restricted to only staff with a need to review. He indicated the records are retained for at least five years, after the date of the initial collection, unless federal, state, or local law requires otherwise. The Auditors viewed this secure location during the site visit.

§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 was allowed access to the entire facility and able to interview staff and detainees about sexual safety during the on-site visit.
(e): The Auditor was 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 Auditor 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:	2
Number of standards met:	31
Number of standards not met:	6
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 11/1/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 11/2/2021

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 11/2/2021

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-(b) (6), (b)
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-(b) (6), (b)
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:	Corey Price		
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:	El Paso Service Processing Center (EPSPC)		
Physical address:	8915 Montana Ave, El Paso, TX 79925		
Mailing address: *(if different from above)*			
Telephone number:	(915) 225-0700		
Facility type:	SPC		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge
Email address:	(b) (6), (b) (7)(C)	**Telephone**	(915) 225-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(804) 418-(b) (6), (b)

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 U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the El Paso Service Processing Center (EPSPC) was conducted on August 31, 2021, through September 1, 2021, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager, (b) (6), (b) (7)(C), and Assistant Program Manager (APM), (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The PM'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 EPSPC is an ICE operated facility with security and support service supplied by Global Precision Systems/Asset Security Services (GPS) under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains male and female adult detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at EPSPC are from Ecuador, Mexico, and Guatemala. This was the second PREA audit for EPSPC. EPSPC is located in El Paso, Texas.

During the audit, the Auditor found the EPSPC met 31 standards, had two standards (115.31 and 115.35) that exceeded, had two standards (115.14, 115.18) that were non-applicable, and six non-compliant standards (115.13, 115.16, 115.17 115.33, 115.41 and 115.42).

Based on the non-compliant standards identified during the audit, the facility was placed in a 180-day corrective action period, beginning on November 4, 2021, and ending May 3, 2022. On January 6, 2022, April 28, 2022, and May 3, 2022, the Auditor was provided the ICE PREA Corrective Action Plan (CAP) from the External Reviews and Analysis Unit (ERAU) that was reviewed and approved by the auditor to determine compliance with the six standards that did not meet compliance during the PREA audit site visit and documentation review. The final supplied documentation was reviewed by the Auditor on May 4, 2022, and the Auditor determined that the facility demonstrated compliance with four standards (115.13, 115.16, 115.17, 115.33) but remained non-compliant with two standards (115.41, 115.42).

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. 13 - Detainee supervision and monitoring

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

Notes:

(b): Policy 2.1.1 requires, "the facility determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, the facility shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee, the length of time detainees spend in agency custody, and any other relevant factors." The PSA Compliance Manager confirmed EPSPC did not conduct an annual review of the facility comprehensive guideline as required by this subpart.

Does Not Meet (b): EPSPC has not completed an annual review of the comprehensive detainee supervision guidelines required by the standard and the facility's policy. EPSPC must conduct an annual review of its' comprehensive supervision guidelines taking into account the need for video monitoring, consideration of generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee, the length of time detainees spend in agency custody, and any other relevant factors. The facility must provide documentation of the annual review of the comprehensive detainee supervision guidelines and the review that takes into consideration all elements outlined in subpart (c) for compliance review.

Corrective Action Taken (b): On January 6, 2022, the Auditor was provided the CAP stating EPSPC would conduct an annual review of its comprehensive supervision guidelines taking into account the need for video monitoring, consideration of generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee, the length of time detainees spend in agency custody, and any other relevant factors. The CAP provided on May 3, 2022, contained an annual review, that considered all the requirements of this standard as well as the facility policy requirements. EPSPC has demonstrated full compliance with subpart (b) of this standard in all material ways.

§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 2.1.1 requires, "The EPSPC shall take steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary." Interviews conducted with four intake staff indicated detainees arriving at EPSPC receive the El Paso Detainee Handbook, the DHS-prescribed ICE Sexual Assault Awareness Information pamphlet, and the ICE National Detainee Handbook. The El Paso Detainee Handbook is available in Spanish and English. The DHS-prescribed ICE Sexual Assault Awareness Information pamphlet is available in English, Spanish, French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic. 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). During the tour of the intake areas, the auditors were provided copies of some of these National Handbook languages with the others available to download, print and disseminate when needed. Two informational videos, PREA and Know your Rights, run continuously in the intake area in English and Spanish as well. During the audit, the Auditors interviewed 30 random detainees, 19 who were LEP. Each of these 19 men and women were Spanish speaking and were provided orientation materials in their language. There were no detainees present during the Remote Interview phase or during the on-site visit from a country speaking a language currently not represented in the ICE National Detainee Handbook. When the Auditors questioned each of the four intake staff on what is provided to detainees from countries speaking a language not represented in the ICE National Detainee

Handbook, the answers varied from reading the entire handbook to them to just providing what they felt was appropriate information. During these interviews and detainee file reviews, the facility could not demonstrate the use of a translation service specific for orientation purposes or produce documentation of the required PREA information being provided to detainees who spoke a language not addressed by the ICE National Detainee Handbook. The Auditors were not given the specifics of what information is provided to these detainees or provided proof that interpretive services were used specifically for orientation purposes.

Does Not Meet (b): The facility needs to ensure they provide the notification, orientation, and instruction in formats accessible to all detainees. The Auditor provided the facility with a manuscript of the relevant PREA information required under 115.33 to adopt using their facility-specific information. The facility started editing the manuscript while the Auditors were on-site. The facility needs to provide the completed manuscript, the updated policy to reflect the newly implemented process, five new intake detainee files, and documented staff training of the newly implemented policy for compliance review for detainee languages not covered through the ICE National Detainee Handbook.

Corrective Action Taken (b): The January 6, 2022, CAP required the facility and agency to provide a completed manuscript addressing meaningful access to all aspects of the facility's efforts to prevent, detect and respond to sexual abuse to detainees, an update to the facility policy to reflect the newly implemented process, five new intake detainee files, and documented staff training of the newly implemented policy. The CAP documentation submitted on May 3, 2022 included the updated 2.1 policy; policy approval by the OIC; the training curriculum provided to staff and attendance sheets of intake staff members for this new orientation procedure; the manuscript addressing meaningful access to all aspects of the facility's efforts to prevent, detect and respond to sexual abuse to detainees whose language is not provided in the ICE National Detainee Handbook; the addition of the interpreter ID number line to be provided when utilizing the manuscript for staff to designate during intake when used; and 10 examples of detainees receiving this information via individual Admission Checklists, which were signed by each of the 10 detainee. This documentation demonstrates compliance with the standard subpart (b) in all material ways.

§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:

(b): This standard subpart requires, "An agency or facility considering hiring or promoting staff shall ask all applicants directly about previous misconduct described in paragraph (a) of this section, in written applications for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees." The interview with the Unit Chief from the ICE OPR Personnel Security Operations Unit confirmed that the hiring process and promotion application process are completed through USA Jobs. During this application process individuals are asked directly about misconduct outlined in subpart (a). He also confirmed that ICE employees, having contact with detainees, are not asked directly about previous misconduct described in paragraph (a) of this section during employee performance reviews. Furthermore, the review of the 10 GPS employee files did not demonstrate employees are asked directly about this conduct during performance reviews either. Also, the review of a recent GPS promotion HR file did not demonstrate the staff person was questioned directly about previous misconduct described in paragraph (a) of this section prior to the promotion.

Does Not Meet (b): The facility and agency failed to ask about previous misconduct described in subpart (a) during any staff performance reviews or written self-evaluations conducted as part of reviews of current employees per the standard's requirement. GPS also failed to ask about this misconduct during a recent staff promotion as required. In accordance with subpart (b), the agency or facility considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct described in paragraph (a) of this section, 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.

Corrective Action Taken (b): The January 6, 2022, CAP required the facility and agency to develop a process in which all staff are asked to disclose, during annual performance reviews or written self-evaluations, any such misconduct outlined in subpart (a) of the standard. The facility was also required to develop a process in which all staff receiving a promotion, who may have contact with detainees, are directly asked questions about previous misconduct as described in paragraph (a) of this section. The May 3, 2022, CAP documentation provided the Auditor with 10 examples of staff utilizing the Department of Homeland Security, 6 Code of Federal Regulations (CFR), Part 115 document that addresses the subpart (a) requirement for annual reporting. EPSPC had no promotions during the CAP but informed the Auditor that the Department of Homeland Security, 6 Code of Federal Regulations, Part 115 document would be used for future promotions. The Auditor was also provided training sign-in sheets from the HR staff demonstrating the use of Department of Homeland Security 6 Code of Federal Regulations Part 115 document. The provided documentation demonstrates compliance with the standard 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): Policy 2.1.1 requires, "upon admission to the EPSPC all detainees sign and date the Admission Checklist (EPC-PBNDS 0077) during the admission process to confirm that they were tendered the following: the National Detainee Handbook (includes information on Sexual Abuse and Assault Awareness, the local Detainee Handbook (includes information on Sexual Abuse and Assault), the orientation video (includes information on Sexual Abuse and assault), the Phone Access Card/ Free Phone Call, provided an opportunity to ask questions, the online Detainee Locator System (ODLS) form and the DHS Sexual Abuse & Assault Prevention Pamphlet." The Auditors reviewed these documents and found information to include 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; 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; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting a sexual 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. Policy 2.1.1 further requires "EPSPC provide the detainee notification, orientation, or instruction 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. During the intake process, detainees who are determined to be LEP or who may have a disability (i.e., hearing impaired, deaf, and blind, etc.) will receive interpretive services and/or medical and/or mental health assistance throughout the process." As noted in the 115.16 narrative section of this report and during the intake staff interviews, the facility could not demonstrate the use of a translation service specific for orientation purposes or produce documentation of the six subpart (a) requirements to detainees who spoke a language not addressed by the ICE National Detainee Handbook.

Does Not Meet (a)(b)(c): EPSPC does not comply with subparts (a)(b)(c) of this standard as the facility could not document it provides the six subpart (a) requirements, to every detainee in a language they understood as required in subpart (b) or demonstrate by documentation it was provided to those detainees where the language was not covered by the ICE National Handbook as required in (c). The Auditor provided the facility with a manuscript of the relevant PREA information required under subpart (a) to adopt using their facility-specific information. The facility started editing the manuscript while the Auditors were on-site. The facility needs to provide the completed manuscript, the updated policy to reflect the newly implemented process, five new intake detainee files, and documented staff training of the newly implemented policy for compliance review for detainee languages not covered through the ICE National Detainee Handbook.

Corrective Action Taken (a)(b)(c): The January 6, 2022, CAP required the facility to provide an orientation manuscript that provides the detainee orientation, or instruction in formats accessible to all, including those who are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. The CAP also required EPSPC provide 10 detainee orientation documents from detainees who were non-Spanish/English speaking, hard of hearing, blind, visually impaired, or intellectually impaired to demonstrate use of the new manuscript. Finally, the facility was required to train Intake staff on the new procedure and provide the Auditor with documentation of the training. The CAP documentation submitted on May 3, 2022 included the updated 2.1 policy; policy approval by the Officer In Charge (OIC); the training curriculum provided to staff and attendance sheets of intake staff members for the new orientation procedure; the manuscript addressing meaningful access to all aspects of the facility's efforts to prevent, detect and respond to sexual abuse to detainees; evidence of delivery of the orientation to detainees in a language of their understanding; the addition of the interpreter ID number line for documenting use of an interpreter during intake when used; and 10 examples of detainees receiving this information. This documentation demonstrates compliance with the standard subparts (a)(b)(c) in all material ways.

§115. 41 - Assessment for risk of victimization and abusiveness
Outcome: Does not Meet Standard
Notes:

(a)(c)(d)(e)(f): Policy 2.1.1 requires "all detainees be screened upon arrival at the EPSPC 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. The initial classification process and initial housing assignment should be completed within twelve hours of admission to the EPC. 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 also 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." Policy 2.1.1 further requires "the facility reassess each detainee's risk of victimization or abusiveness between 60 and 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 Auditors interviewed four intake staff who complete the DHS Risk Classification Assessment (RCA) Worksheet to assess vulnerability and abusiveness of arriving detainees. They indicated that they believed medical staff conduct this assessment. The Auditors questioned medical staff and were informed that medical screens detainees upon admission. The Auditors reviewed the IHSC In-Processing Health Screening (Form I-794 or equivalent) which does not address all nine elements of subpart (c) nor does the RCA. The Auditors were provided and reviewed 15 random detainee detention files, none of which had an initial risk assessment included. Two of the detention files reviewed were detainees who were at EPSPC for longer than 90 days, requiring another vulnerability reassessment by policy and standard; however, there were no reassessments found in either file. The Auditors reviewed an additional five detention files while on site of detainees who alleged sexual abuse, but no reassessments were conducted after report of the allegations in all five cases was reported. Because the facility was unable to indicate how they assess detainees for risk of victimization or abusiveness, the Auditors could not determine a detainee being disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked as they are not being asked these questions.

Does Not Meet (a)(c)(d)(e)(f): The facility must develop a process in which they are able to assess all detainees on intake to comply with (a) to identify those at risk of victimization or abusiveness. The process must consider all aspects under (c) and (d), and the facility must share that process with the Auditor via documentation of 10 detainee files. The facility must also ensure detainees who are eligible for a reassessment receive one within 60-90 days or when otherwise warranted, in compliance with (e). Documentation to support this is occurring must also be provided to include initial review, 60-90-day review, and those making an allegation of sexual assault.

Corrective Action Taken (a)(c)(d)(e)(f): The CAP required the facility develop a process in which they are able to assess all detainees on intake to comply with the subpart (a) requirements to identify those at risk of victimization or abusiveness. The process must consider all aspects under subparts (c) and (d), and the facility must provide documentation of 10 detainee files after the date of the audit. The facility provided the Auditor with a 2.2.A ICE Custody Classification Worksheet conducted by intake staff, and the RCA document conducted by classification as the documents to meet these two subparts (c)(d) requirements. Neither of these documents address the consideration of the build and appearance of the detainee, previous incarcerations, or sex offense convictions against a child or adult. The facility provided the ICE Custody Classification Worksheet for 10 detainees on May 3, 2022, indicating a "reclassification" as evidence of the 60–90-day reassessments; however, this does not constitute a risk reassessment since all elements required in subparts (c) and (d) are not taken into consideration, as found deficient with the initial assessment requirement. Additionally, the facility did not provide documentation to demonstrate that detainees were reassessed after an incident of a sexual abuse allegation; nor was documentation provided indicating staff have been retrained on the requirements of this standard. The subparts of this standard remain non-compliant.

(b): Policy 2.1.1 and policy 2.2 Classification System requires" the facility segregate detainees from the general population pending receipt and processing of information needed for classification. The initial classification process and initial housing assignment shall be completed within 12 hours of admission to the facility. If the process takes longer, documentation shall be maintained to explain the cause of the delay and to indicate the detainee shall be housed appropriately." Interviews with two classification staff and the OIC confirmed that, due to the COVID-19 pandemic, all arriving detainees are currently being placed in housing together with other detainees, arriving on the same day, for a 14-day quarantine period. They also confirmed that after the 14th day, the detainee receives their classification. The policy and standard require the initial classification be concluded within 12 hours. The Auditors were also informed the initial classification is completed without a risk assessment.

Does Not Meet (b): The intake staff confirmed that arriving detainees do not receive a classification until their 15th day at the facility instead of within the first 12 hours as required per subpart (b). This classification practice was also confirmed by the OIC. The initial classification process and initial housing assignment should be completed within twelve hours of admission to the facility.

Corrective Action Taken (b): The facility was required to demonstrate that the classification process and initial housing assignment is being performed within 12 hours of the detainee's arrival at the facility. The intake staff, at the time of the site visit, confirmed that arriving detainees do not receive their classification until day 15 due to COVID-19. This classification practice was also confirmed by the OIC. The initial classification process and initial housing assignment must be completed within 12 hours of admission to the facility. The facility provided the ICE Custody Classification Worksheet for 10 detainees on May 3, 2022, but there is no date stamp or documentation on the worksheet that indicated the date and

time of arrival to support that the classification is occurring within 12 hours in accordance with standard subpart (b) requirements. This standard subpart remains non-compliant.

§115. 42 - Use of assessment information
Outcome: Does not Meet Standard
Notes:

(a) Policy 2.2 requires "EPSPC ensure that detainees are housed according to their classification levels. After completion of the in-processing health screening form (IHSC-794 or equivalent), the classification officer assigned to intake processing shall review information provided by ICE/ERO and complete a custody classification worksheet. Upon completion of the classification process, the officer shall assign individual detainee's color-coded uniforms, wristbands, or other means of custody identification. During the classification process, staff shall reference facts and other objectives, credible evidence documented in the detainee's A-file, work-folders, ICE automated records systems, criminal history checks, or other objective sources of information. Relevant considerations include any current criminal offense(s), past criminal offense(s), escape(s), institutional disciplinary history, documented violent episode(s) and/or incident(s), medical information or a history of victimization. Personal opinions, including opinions based on profiling, familiarity or personal experience, may not be considered in detainee classification. Special consideration shall be given to any factor that would raise the risk of vulnerability, victimization, or assault. Detainees who may be at risk of victimization or assault include, but are not limited to, persons with disabilities, persons who are transgender, elderly, pregnant, suffering from a serious medical or mental illness, and victims of torture, trafficking, abuse, or other crimes of violence. This process should incorporate the requirements in Policy 2.11 "Sexual Abuse and Assault Prevention and Intervention" regarding assessment of risk for victimization or perpetration of sexual abuse or assault." When the Auditors questioned the four classification officers, the Auditor was told they do not utilize a risk assessment but base the detainee's classification on information provided by ICE/ERO. Since the initial risk assessment and classification is not completed under the requirements of standard 115.41, the Auditor concluded the housing determinations made by the classification officers were not completed pursuant to subpart (a) of this standard.

Does Not Meet (a): The facility must develop and utilize an effective assessment process, in consultation with the classification document, and complete it within 12 hours in order to inform assignment of detainee housing, recreation and other activities as required by this subpart.

Corrective Action Taken (a): The standard requires that all information from the risk assessment under 115.41 be utilized to inform assignment of detainees housing recreation and other activities. According to the supplied documentation the vulnerability assessment is completed in part by ICE ERO on admission and in part later by the medical department without demonstrating how this information is shared with the Classification Supervisor or PSA Compliance Manager. On May 6, 2022, the facility provided five exhibits demonstrating email communication between health services and other staff responsible for making detainee assignments to housing, recreation, and other activities is occurring. However, the facility could not demonstrate when the information is shared and if it was being shared prior to the housing assignment. The Auditor concurs that this demonstrates partial compliance with this standard. However, until the requirements of 115.41 are satisfied, all information required to be taken into consideration is not captured; and therefore, this standard remains non-compliant.

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 12, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) June 23, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) June 24, 2022
Program Manager's Signature & Date