PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	8/24/2021	**To:**	8/25/2021
AUDITOR INFORMATION			
Name of auditor:	Sabina Kaplan	**Organization:**	Creative Corrections, LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Phoenix Field Office
Field Office Director:	(Interim) Simona Flores-Lund
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	2035 North Central Avenue, Phoenix, Arizona 85004
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:	La Palma Correctional Center		
Physical address:	5501 North La Palma Road, Eloy, Arizona 85131		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	520-464-3200		
Facility type:	D-IGSA		
PREA Incorporation Date:	7/24/2018		
Facility Leadership			
Name of Officer in Charge:	Christopher Howard	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-464-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Chief of Unit Management
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-464-

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

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the La Palma Correctional Center (LPCC) was conducted by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Sabina Kaplan and Valerie Wolfe-Mahfood for Creative Corrections, LLC. This is the first DHS ICE PREA audit of the facility. The Lead Auditor was provided guidance and review during the audit report writing and review process by the Immigration Customs and Enforcement (ICE) PREA Program Manager (b) (6), (b) (7)(C) and Assistant ICE PREA 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 External Review and Analysis Unit (ERAU) during the audit report review process.

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 April 2020 but was converted to a contingency audit due to the COVID-19 health pandemic. The audit period was expanded to cover the period of April 2019 through August 25, 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 Auditor with the facility's PAQ (Pre-Audit Questionnaire), agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation were 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 CoreCivic 14-02-DHS, Sexual Abuse Prevention and Response. All the provided documentation, policies, and PAQ were reviewed by the Auditor. A tentative daily time schedule was provided by the Lead Auditor for the interviews with staff and detainees. The Auditor also reviewed the facility's website, (www.corecivic.com/facilities/la-palma-correctional-center).

At the beginning of the Remote Interview audit phase conducted on October 27-29, 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 32 formal detainee interviews (24 during the remote phase and an additional 8 during the on-site visit), randomly selected from the housing units; interviews conducted during the Remote Interview phase were through Cisco WebEx. Seventeen 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. The remaining detainees interviewed consisted of randomly selected detainees (10), detainees who reported sexual abuse (1), transgender detainees (2), and detainees who reported a history of sexual abuse (2). A total of 26 staff/contractor interviews were conducted. Interviews were conducted with CoreCivic staff either randomly chosen or interviewed based on their specific title. Specifically, specialized staff interviewed included the Warden, Prevention of Sexual Assault (PSA) Compliance Manager, first line supervisors (3), a medical staff member, Administration/Human Resources, non-security contractors (2), facility investigator, Training Supervisor (Assistant Warden), and intake staff (2), a community advocate, and a Safe/Sane Nurse. Due to the pandemic, there was a lack of volunteers on site; and therefore, the Second Auditor was only able to interview two volunteers.

At the conclusion of the Remote Interview audit phase on October 29, 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 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.

The third phase, the On-site audit phase, was scheduled when the environment was deemed safe for the ICE federal staff, facility staff, detainees, and Auditors. Prior to the On-site audit phase, the Lead 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 24-25, 2021, and consisted of a facility tour, interviews of staff and detainees, and review of follow-up documentation.

The count at the time of the on-site visit was 1,808 males. The physical plant consists of eighteen buildings sitting on approximately 87 acres. There are 1,620 double occupancy cells. The only single cells are in the Medical Unit where there are seven. The facility is divided into three autonomous Compounds. Compound One consists of Navajo, Cocopah, and Apache Units. Compound Two consists of Yuma, Tewa, and Pima Units. Compound Three consists of Zuni, Mohave, and Hopi Units. Each compound houses general population detainees with the exception of (b) (7)(E) [redacted]. Each compound includes a program area and a medical area. To the front of the facility, outside the secure perimeter, is a gatehouse where staff and visitors are cleared prior to entering the facility. The Administration area is also

located in the gatehouse. Just inside the secure perimeter are the visitation area, maintenance, intake and discharge, food service/dining, and central control.

The facility uses three investigators to complete all allegations of sexual abuse. Of the three named investigators, only two were trained prior to the contingency portion of the audit. During the on-site audit, the facility documented the training of the third investigator. There were 25 sexual abuse allegations reported during the audit period. Eighteen allegations involved detainee upon detainee and seven allegations were staff/contractor on detainee. Twenty-two were closed and three were actively being investigated by ICE OPR (Office of Professional Responsibility). All 25 investigations were referred to ICE OPR. All the allegations by policy were reported to the Eloy Police Department. Of the 25 allegations, two detainee-on-detainee cases were substantiated, nine detainee-on-detainee cases were unsubstantiated, five detainee-on-detainee cases were unfounded, five staff/contractor-on-detainee cases were unfounded, and one staff/contractor-on-detainee case was unsubstantiated. Two detainee-on-detainee cases and one staff/contractor-on-detainee case remain open.

The entry briefing was held in the LPCC Conference room at 8:15 am on Tuesday, August 24, 2021. In attendance were:

- (b) (6), (b) (7)(C), ICE/OPR/Inspections and Compliance Specialist (ICS)
- (b) (6), (b) (7)(C), ICE/Office of Enforcement and Removal Operations (ERO)/Supervisory Detention and Deportation Officer (SDDO)/PREA Coordinator
- Christopher Howard, Warden, LPCC
- (b) (6), (b) (7)(C), Assistant Warden/PSA Compliance Manager, LPCC
- (b) (6), (b) (7)(C), Assistant Warden, LPCC
- (b) (6), (b) (7)(C), Assistant Chief of Unit Management (ACOUM), LPCC
- (b) (6), (b) (7)(C), Chief of Security, LPCC
- (b) (6), (b) (7)(C), Assistant Chief of Security, LPCC
- (b) (6), (b) (7)(C), Manager Quality Assurance, LPCC
- (b) (6), (b) (7)(C), Investigator, LPCC
- (b) (6), (b) (7)(C), Health Services Administrator (HSA), LPCC
- (b) (6), (b) (7)(C), ICE/Deportation Officer (DO)
- Valerie Wolf-Mahfood, Certified DOJ/DHS Auditor, Creative Corrections, LLC
- Sabina Kaplain, Certified DOJ/DHS Auditor, Creative Corrections, LLC

Brief introductions were made and the detailed schedule for the audit was covered. The Lead Auditor provided an overview of the 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 tour, additional on-site documentation review, and staff and detainee interviews. It was shared that no correspondence was received by any detainee prior to the on-site visit. 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, a full list of detainees for specific categories to be interviewed, lists of staff/contractors by duty position and shifts, and a list of contractors on duty. The Lead Auditor was informed detainees housed in Pods Apache/Alpha, Apache/Delta, Navaho/Alpha, Navaho/Bravo, Navaho/Charlie, Cocopah/Alpha, Cocopah/Bravo, Cocopah/Charlie/ Yuma/Alpha, Yuma/Charlie, Zuni/Delta, Tewa/Alpha, Tewa/Charlie, and Pima/Alpha would not be available to interview due to positive COVID-19 related issues. The Lead Auditor further explained that while the interviews had been conducted during Phase II, observations would be made during the facility tour and the Auditors would conduct conversations with staff randomly to further assist with determining compliance.

On August 25, 2021, an exit briefing was conducted by the Lead Auditor in the Compound Chow Hall. In attendance were:

- (b) (6), (b) (7)(C), ICE/OPR/ICS
- (b) (6), (b) (7)(C), ICE/SDDO/PREA Coordinator
- (b) (6), (b) (7)(C), ICE/Officer in Charge (OIC)
- Christopher Howard, Warden, LPCC
- (b) (6), (b) (7)(C), Assistant Warden/PSA Compliance Manager, LPCC
- (b) (6), (b) (7)(C), Assistant Warden, LPCC
- (b) (6), (b) (7)(C), ACOUM, LPCC
- (b) (6), (b) (7)(C), Chief of Security, LPCC
- (b) (6), (b) (7)(C), Assistant Chief of Security, LPCC
- (b) (6), (b) (7)(C), Manager Quality Assurance, LPCC
- (b) (6), (b) (7)(C), Investigator, LPCC
- (b) (6), (b) (7)(C), HSA, LPCC
- (b) (6), (b) (7)(C), Quality Assurance Coordinator, LPCC
- (b) (6), (b) (7)(C), Chaplain, LPCC
- (b) (6), (b) (7)(C), Unit Manager, LPCC
- (b) (6), (b) (7)(C), Unit Manager, LPCC
- (b) (6), (b) (7)(C), Unit Manager, LPCC
- (b) (6), (b) (7)(C), Unit Manager, LPCC

- (b) (6), (b) (7)(C), Unit Manager, LPCC
- (b) (6), (b) (7)(C), Learning and Development Manager, LPCC
- (b) (6), (b) (7)(C), ICE/DO
- Valerie Wolf-Mahfood, Certified DOJ/DHS Auditor Creative Corrections, LLC
- Sabina Kaplain, Certified DOJ/DHS Auditor, Creative Corrections, LLC

The Lead Auditor spoke briefly about the staff and detainee knowledge of the LPCC 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 that she would need to discuss their findings and review interview notes conducted with (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: 0

Number of Standards Not Applicable: 1

§115.14 Juvenile and family detainees

Number of Standards Met: 33

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.71 Criminal and Administrative Investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of Audits

Number of Standards Not Met: 7

§115.13 Detainee supervision and monitoring
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.31 Staff Training
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.63 Reporting to other confinement facilities
§115.66 Protection of detainees from contact with alleged abusers

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 facility has a written policy 14-02-DHS, Sexual Abuse Prevention and Response, mandating zero-tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment. The policy provides definitions of sexual abuse and general PREA definitions. In an interview with the facility Warden, it was confirmed that the policy is reviewed and approved by ICE as required by the standard.

The zero-tolerance policy is publicly posted on the LPCC's website (www.corecivic.com/facilities/la-palma-correctional-center). During the on-site visit, the Auditors observed on the housing unit bulletin boards, and in other locations throughout the facility, signage that included the ICE Zero-Tolerance posters. The Auditors also reviewed the facility handbook, ICE National Detainee Handbooks, and the DHS-prescribed Sexual Assault Awareness Information pamphlet handed out at intake. Further informal interviews with staff and formal interviews with detainees further confirmed LPCC's commitment to zero tolerance of sexual abuse.

(d): The facility's Warden appointed a PSA Compliance Manager at the supervisory level who oversees the facility's compliance efforts with the implementation of PREA. The Lead Auditor determined compliance through the review of the facility's policy 14-02-DHS and an interview with the PSA Compliance Manager, who is also the Assistant Warden. A review of the organizational chart confirms that the PSA Compliance Manager reports to the Warden. The PSA Compliance Manager, during the interview, confirmed she has sufficient time and authority to oversee facility efforts to comply with the sexual abuse prevention and intervention policy. Per policy 14-2-DHS, the facility's PSA Compliance Manager is "responsible to assist with the development of written policies and procedures for the Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program, to assist with the development of initial and ongoing PREA training protocols, to serve as a PREA liaison with other agencies, to coordinate the gathering of statistics and reports on allegations of sexual abuse or assault, to review the results of investigations of sexual abuse and assist in conducting an annual review of all investigations to assess and improve prevention and response efforts, and to review facility practices to ensure required levels of confidentiality are maintained."

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(c): A review of the updated PAQ indicated the facility's staffing level is 347 staff with 259 security staff, 179 males and 80 females, that may have recurring contact with detainees. This is a significant change from the staffing level noted during the contingency audit phase of 373. The remaining staff consists of medical and mental health contracted employees. During the audit period, LPCC line staff went from working two 12-hour shifts to working three 8-hour shifts in March of 2021. The PREA staffing plan assessment, dated 6/10/21, indicated the factors taken into account for the staffing levels at LPCC included generally accepted detention and correctional practices, any judicial finding of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and other relative factors, including but not limited to, the length of time detainees spend in agency custody; however, a review of the annual PREA staffing plan assessment, dated 6/10/21, noted that "there have not been any changes since the last annual PREA Staffing Assessment," even though in March 2021, line staff/contractors started working three 8-hour shifts. During the post on-site audit phase, the Lead Auditor requested, via email, further documentation to support that the facility took into consideration all elements of the standard prior to making the change in shifts. The facility could not provide any documentation that could confirm that during the modification of on-site supervision, the facility took into consideration the required elements of subsection (c) of the standard. The Warden indicated that the number of staff is determined by an established staff to detainee ratio, the physical layout and size of the facility, and the composition of the detainee population. The Auditor was supplied with shift rosters prior to the onset of the Remote Interview phase of the audit and during the on-site visit. While on-site, the Lead Auditor observed posted overtime sign-up sheets available for staff to sign up for overtime as needed. In addition, the Lead Auditor observed staffing levels during the on-site audit and determined they were adequate. . (b) (7)(E) [redacted]

Does Not Meet (c): Per sub paragraph (c) of standard 115.13, 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, or the findings and recommendations of sexual abuse incident review reports, and any other relevant findings, including the length of time detainees spend in agency custody. LPCC changed their staffing pattern from two 12-hour shifts to three 8-hour shifts in March of 2021. The Lead Auditor requested documentation needed to confirm that the facility utilized all elements of the standard prior to altering their staffing pattern but this could not be provided by the facility. Therefore, the Lead Auditor could not confirm that during the last reorganization of line supervision the facility took into consideration any judicial findings of inadequacy, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, or the findings and recommendations of sexual abuse incident review reports in evaluating whether the change in supervision will affect the facilitates efforts to prevent sexual abuse. The facility must document that the standard elements of (c) are taken into consideration during the review of supervision guidelines for compliance.

(b)(d): Policy 14-2-DHS, and facility post orders, outline the comprehensive detainee supervision guidelines to meet detainee supervision needs. Policy 14-2-DHS "requires staff, including supervisors, to conduct frequent unannounced security inspection rounds to identify and deter sexual abuse of

detainees." Policy 14-2-DHS further requires "that the occurrence of such rounds shall be documented in the applicable log as "PREA Rounds" and will be conducted on all shifts (to include night, as well as day) in all areas where detainees are permitted, and employees shall be prohibited from alerting other employees that supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the facility." The post orders outline the responsibilities of detainee supervision including the requirement to make frequent but irregular patrols of the unit that are not regular and routine. The Auditor interviewed random supervisory security staff and reviewed PREA unannounced rounds by supervisors during the on-site visit and determined compliance. The Lead Auditor reviewed supervision guidelines (post orders) on-site and confirmed the annual formal review was conducted on the LPCC Policies and Post Orders for 2021 in April 2021. The supervision guidelines (post orders) are reviewed by the Chief of Security and distributed on an annual basis. During the review of 17 sexual abuse incident reviews, the incident review team reviewed staffing supervision requirements in 15 incidents. As for the remaining investigations reviewed, one incident did not have a completed incident review submitted with the packet and one investigation was still pending. The 15 incidents that were reviewed indicated no staffing deficiencies.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The LPCC does not house juvenile and family detainees. Review of the PAQ and an interview with the PSA Compliance Manager confirmed the facility does not house juveniles nor family detainee units.

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

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

Notes:

(b)(d): Policy 14-2-DHS states, "Pat searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required, or, in exigent circumstances." All cross-gender pat searches shall be documented. Staff interviewed indicated that cross-gender pat-down searches are not conducted on the detainees at LPCC. They further indicated that they had not conducted or were aware of any cross-gender pat-down searches conducted during the audit period. This was further supported by a memo to file and the PAQ.

(c): LPCC does not house female detainees; therefore, provision (c) is not applicable.

(e)(f): Policy 14-2-DHS states, "Strip searches of detainees by staff of the opposite gender shall not be conducted except in exigent circumstances, or when performed by medical practitioners." All strip searches shall be documented. Policy 14-2-DHS further states that "body-cavity searches will be conducted by a medical professional and must take place in an area that affords privacy." Interviews with line staff confirmed staff are aware of the facility's policy for conducting strip or body-cavity searches, and that if performed shall be approved by a supervisor and documented on an incident report. During the audit period, no cross-gender strip or body-cavity searches were conducted. This was documented through a memo to file and interviews with security supervisors and line staff.

(g): Policy 14-2-DHS states, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement." Policy 14-02-DHS also states, "Employees of the opposite gender must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." Interviews with staff also confirmed the detainees have privacy for these functions. However, during interviews, detainees felt that they did not have privacy to use the restroom due to windows in the cells. During the on-site visit, the Lead Auditor, determined through observation that the detainees were able to shower, perform bodily functions, and change their clothing as dictated by the standard. In addition, the Auditors observed one blind spot located in the kitchen next to the ovens. The Auditors recommend that a mirror be installed for better site vision of the area. The facility installed the recommended mirror prior to the exit briefing. No other site issues or crossed gender viewing issues were noted. During the interviews, female staff indicated they announce themselves when entering an area by announcing "female on deck." Many of the detainees interviewed indicated they recalled opposite gender staff announcing themselves on a regular basis and this practice was further confirmed through observation by the Auditors during the on-site visit. Although the policy language allows potential cross-gender viewing of monitored bowel movements and during medical exams, an interview with the Warden during the on-site visit confirmed that female staff/contractors would not be utilized during these instances.

(i): Policy 14-2-DHS states, "The facility shall not search or physically exam a transgender or intersex detainee for the sole purpose of determining a detainee's genital status." It further states, "If a detainee's gender is unknown, it may be determined during conversation with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private, by a medical practitioner." No searches, for the sole purpose of determining a detainee's genital status, have occurred in the audit period per memo submitted with the PAQ documentation memo and interviews with line and medical staff. Informal interviews with staff during the on-site visit confirmed compliance with this section of the standard.

(j): A review of LPCC's training curriculum "Search Procedures" confirms that security staff are trained to conduct all pat searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs, including consideration of officer safety. Interviews with the Training Supervisor and security staff, the review of the training lesson plans, which reinforce these policies in the annual training, and the review of security staff training records, confirmed that training is conducted as required by the standard. When security staff were randomly asked how a transgender pat down search would be completed, they indicated that the transgender/intersex detainee could request the gender of the security officer to conduct the pat-down search. Informal interviews with staff during the on-site portion of the audit confirmed compliance with this section of the standard.

(h) LPCC is not designated as a Family Residential Center; therefore, provision (h) is not applicable.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 14-2-DHS dictates that "detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facilities efforts to prevent, detect, and respond to sexual abuse." Policy 14-2-DHS further dictates that "when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall attempt to accommodate the detainee by providing access to in-person, telephonic, or video interpretive services, access to written materials related to sexual abuse in formats or through methods that ensure effective communication; and auxiliary aids such as readers, materials in Braille (if available), audio recordings telephone handset amplifiers, telephone telecommunications devices for deaf persons (TTY's), interpreters, and note takers." In addition, policy 14-2-DHS states, 'That the facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its program and activities." There were zero intakes during the on-site visit; and therefore, the Auditors toured intake processing with the guidance of the Intake Supervisor who narrated step by step the intake process. The Auditors were advised that upon intake, detainees are provided with the LPCC facility handbook. It was unclear, however, if the facility provided the detainee with the ICE National Detainee Handbook in the detainee's preferred language as LPCC does not request this information from the detainee upon arrival. In an interview with the Intake Supervisor, the Lead Auditor was advised that should a detainee request an ICE Handbook in a language that is not covered by the hard cover handbooks on site, specifically English, Spanish, Punjabi, Portuguese, and Spanish, another language one would be printed out for him and pointed out a few hand printed copies in other languages. She could not however, pull up the link needed to print the various languages not available on-site. 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, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. Although the LPCC facility handbook provides detainees with information on the agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse, as well as information on detainees' rights and responsibilities, available programs and services, and facility rules, it was only available in English, Spanish, and Punjabi. The facility also made available to the Auditor, the DHS-prescribed Sexual Assault Awareness Information pamphlet. The pamphlet is handed out at intake and is available in English and Spanish, which provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault. The pamphlet was not available in other languages the agency has available; the pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. A video, available in English, Spanish, Chinese, and Punjabi, is only played on DVD, as needed, in a small holding area that through observation could not accommodate a large intake of detainees. The video is also played in the housing unit, in English and Spanish daily. This is logged into the unit logbook. There is no accommodation, however, for detainees who do not speak the languages offered in the video. The medical staff advised if a detainee coming through intake spoke a language that was not available in a written format, they will utilize the interpretive service, Language Line Associates. The Intake Supervisor interviewed also stated that if staff encountered detainees who spoke a language not available during intake, they would utilize a language line (Voice Interpretation Services). A review of the logbook while on site revealed that the language line had only been utilized 11 times from 12/8/20 – 8/21/21. In the 16 investigative files reviewed, the Lead Auditor determined the facility did not utilize another detainee to interpret during the investigations. The Auditors also reviewed 17 randomly chosen detainee detention files. Although the detainees signed a document indicating they received PREA materials, the files did not provide documentation confirming the use of the language line and/or interpreters for those detainees who did not speak English or Spanish. Interviews with the 17 detainees who were LEP reported they did not receive information in a language they understand and that detainees were advised to call the "number" indicated on the English version of the DHS-prescribed Sexual Assault Awareness Information pamphlet. During the on-site visit, the Intake Supervisor confirmed that the practice was to hand the detainee the DHS-prescribed Sexual Assault Awareness Information pamphlet and advise them to call the number should they have any questions. The Intake Supervisor further confirmed that there is no practice in place to provide 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 with access to information regarding sexual abuse as required by the standard.

Does Not Meet (a)(b): The Audit Team toured intake processing during the on-site visit and discussed the process with the Intake Supervisor. During the tour the Auditors observed a simulated practice and confirmed that LEP detainees were not provided with PREA information in a language they could understand as required by the standard. The Auditors confirmed that the facility only had available the DHS-prescribed Sexual Assault Awareness Information pamphlet in English and Spanish and staff could not readily provide the Audit Team with the link to print the pamphlets in French, Chinese, Punjabi, Portuguese, Hindi, Haitian Creole, and Arabic. In addition, there was no available documentation to confirm that LEP detainees received the ICE Handbook in a language they could understand. The detainees reported, which was confirmed by staff interviews, they do not receive PREA information at intake, but are advised to call the Hotline number on the pamphlet should they have any questions. During the on-site the Auditors informally interviewed random detainees while touring the pods, who confirmed that they did not receive the ICE National Detainee Handbook. A video, available in English, Spanish, Chinese, and Punjabi, is only played on DVD, as needed, in a small holding area that through observation could not accommodate a large intake of detainees and although the video is played daily on the housing unit, it is only available in English and Spanish. The log verifying the use of the language line only confirmed 11 uses between 12/8/20 and 8/21/21. The Intake Supervisor further confirmed that there is no practice in place to provide 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 with access to information regarding sexual abuse as required by the standard. For compliance, the facility must demonstrate how LEP detainees are provided the PREA information in a manner they understand, and all detainees receive an ICE National Detainee Handbook in a language they understand, if available, or document how the information is provided to them in another method. In addition, the facility must demonstrate how they provide the PREA information to those 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 with access to information regarding sexual abuse as required by the standard. The facility must provide 10 LEP detainee intake files documenting the PREA information provided to the detainee in a manner they understand; the documentation must demonstrate a variety of languages, other than English and Spanish over a month period. In addition, if available, the facility must provide an additional 10 detainee intake files of those 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 to confirm that there is a practice in place that provides detainees with disabilities access to information regarding sexual abuse as required by the standard.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(e)(f): Policy 14-2-DHS, requires the facility, to the extent permitted by law, to decline "to hire or promote any individual, 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. This policy requires new hires, staff awaiting promotions, and staff on an annual basis complete and submit the Self-Declaration of Sexual Abuse/Sexual Harassment form 14-02-A. The individual directly responds to questions about misconduct as required in the standard, and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. This form is retained in the employee's personnel file as required by policy 14-2-DHS. The Lead Auditor reviewed 10 employee personnel files and found that all files lacked the Self-Declaration of Sexual Abuse/Sexual Harassment form 14-2-A. The Lead Auditor requested five forms from the reviewed personnel files and the facility could not produce the forms. During the on-site portion of the audit the Lead Auditor reviewed an additional five randomly selected staff/contractor personnel files and determined that the facility was now in compliance with this section of the standard. The interview with the Human Resources (HR) staff confirmed that all new hires and current staff are required by policy to disclose all misconduct noted above and have a continuing affirmative duty to disclose any sexual misconduct. She further stated that material omissions regarding conduct as outlined in subpart (a) of this standard or giving false information is grounds for termination or withdrawal of an offer for employment and that, unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer.

(c)(d) Policy 14-2-DHS requires LPCC "prior to hiring any employees who may have contact with detainees, perform a criminal background records check consistent with federal, state, and local law and make its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse as defined by this policy." The interview with the HR staff confirmed that individuals seeking employment, which includes contractors and employees, receive a background check prior to contact with any detainee. She further stated that background checks are conducted by ICE on all LPCC employees. These checks include credit history, motor vehicle history, all police contacts, and National Crime Information Center (NCIC) checks. Further, all employees receive a five-year background recheck. A review of 10 employee personnel files revealed that five-year background checks are not up to date. The Lead Auditor requested two five-year background rechecks, due in 2019, and the facility could not produce the background rechecks. During the on-site portion of the audit, it was disclosed to the Lead Auditor that the facility's contract with ICE was not established until the year 2018 and therefore, 5-year background checks will be due in 2022. The Auditor reviewed background checks for three ICE employees and found pre-hire background checks completed and current five-year checks completed. In addition, the Lead Auditor reviewed the personnel file of one contractor and determined the background check was completed as required by subpart (d) of the standard.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a)(b): Policy 14-2-DHS states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of the existing facilities, CoreCivic shall consider the effect of the design, acquisition, expansion, or modification upon the company's ability to protect detainees from sexual abuse. Policy 14-02-DHS further states, "When installing or updating video monitoring system, electronic surveillance system or other monitoring technology CoreCivic shall consider how such technology may enhance their ability to protect detainees from sexual abuse." Documentation submitted with the PAQ indicated LPCC determined during the annual PREA staffing assessment that the facility camera system needed upgrading. All analog cameras, wiring, Matrix, DVRs, monitors, etc. were removed and replaced. The upgrade, requested to improve visibility, was approved and the cameras were installed the same year. An interview with the Warden confirmed these changes. In addition, during the on-site visit, the PSA Compliance Manager confirmed that there have been no substantial expansions or modifications of the existing facility, it's video monitoring systems, its electronic surveillance system, or other monitoring technology during the timeframe following the contingency portion of the audit.

§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)(e): Policy 14-2-DHS requires sexual abuse investigations "follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocols must be developmentally appropriate, be adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, 'A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,' or similarly comprehensive and authoritative protocols developed after 2011." In the interview with the Warden, it was confirmed that this policy was developed in coordination with DHS as required by the standard. The facility has a memorandum of understanding (MOU) with the Eloy Police Department to conduct criminal investigations at LPCC and requiring they adhere to the requirements of subparts a-e of the standard. The MOU was initiated in February 2020 and is continuous unless either party gives 30 days' notice to end the MOU.

(b)(d): Policy 14-2-DHS requires "the investigating entity attempt to make available to the victim a victim advocate from a rape crisis center. The investigating entity may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services." LPCC has an MOU with the Southern Arizona Center Against Sexual Assault (SACASA). The agreement in the MOU is for SACASA to provide amongst other services, emotional support, crisis information, information, and referrals. The MOU was entered into in January 2017 and is continuous unless either party gives 30 days' notice to end the MOU. During the on-site visit, the second Auditor contacted SACASA via telephone from one of the housing units. The staff member contacted confirmed SACASA's commitment to provide services to the detainees at LPCC as required by the standard. The Lead Auditor's review of 17 investigative files confirmed that all alleged detainee victims were offered victim advocacy services after an allegation of sexual abuse.

(c) Policy 14-2-DHS requires "victims of sexual abuse have access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate. A Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) shall perform such examinations where possible. If SAFEs or SANEs cannot be made available, other qualified medical practitioners can perform the examination. The investigating entity shall document its efforts to provide SAFEs or SANEs." LPCC does not perform forensic exams at the facility. Detainees needing this type of exam are sent to HonorHealth Hospital in Scottsdale, Arizona. LPCC has an MOU with HonorHealth Hospital. The agreement in the MOU is to provide a SANE for comprehensive care in sexual assault cases for facility detainees. The agreement was entered into April

2018 and is continuous unless either party gives 30 days' notice to end the MOU. The Auditor interviewed the facility HSA who confirmed detainees are sent to the hospital and are seen by a SANE practitioner. The HSA at LPCC also confirmed detainee victims would never be charged for medical services related to victimization. In addition, during the on-site portion of the audit, the second Auditor contacted staff at HonorHealth Hospital and was able to further confirm that the hospital will provide SAFE/SANE services as required by the standard. The Lead Auditor's review of 17 investigative files confirmed that there were no incidents of sexual abuse at the facility that required a forensic medical examination.

§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): Policy 14-2-DHS requires that "the facility administrator ensures that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault." Policy 14-02-DHS further requires that "all criminal investigations be referred to a law enforcement agency with legal authority to conduct criminal investigations and that administrative investigations shall be conducted after consultation with the appropriate investigative office within ICE/DHS, and the assigned criminal investigative entity." This protocol is also outlined in the MOU with the Eloy Police Department, detailing the roles and responsibilities of both the facility and the investigating entity in performing sexual abuse investigations. 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 and/or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Investigative 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 Warden and facility investigator confirmed that every allegation of sexual abuse made must be investigated. The facility lead investigator confirmed in an interview that an administrative investigation is conducted on all allegations of sexual abuse after consultation with the investigative office within DHS and the Eloy Police Department. The facility had 25 allegations within the audit period that were referred for investigation; 22 were closed and 3 were actively being investigated by ICE OPR. In addition, policy 14-02-DHS dictates that the facility shall retain reports of allegations in accordance with Policy 1-15 Retention of Records which states, "PREA records shall be retained for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five years." Interviews with the Warden, PSA Compliance Manager, and facility investigators corroborated the above-mentioned policy.

(c): The Lead Auditor reviewed CoreCivic's website, (www.corecivic.com/facilities/la-palma-correctional-center) and the ICE website, (https://www.ice.gov/prea). Both websites provide the public with the investigative protocols.

(d)(e)(f): Policy 14-2-DHS requires that "when a detainee, or staff member, contractor, or volunteer, is alleged to be the perpetrator of sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility (ICE OPR) or the DHS Office of Inspector General (DHS OIG), as well as the appropriate ICE Field Office Director/designee." Both the Warden, and SDDO, who is also the assigned PREA Coordinator, confirmed this procedure and stated that the Warden would immediately report any sexual abuse incidents immediately to the ICE SDDO who would notify the JIC, the ICE OPR and/or the DHS OIG. There were 25 sexual abuse allegations reported during the audit period. All cases were referred to ICE OPR and the Eloy Police Department. Twenty-two cases were closed and three were actively being investigated by ICE OPR. The Auditor reviewed 15 of the reported allegations in their entirety and found them to be well organized, allowing for ease of auditing.

§115.31 - Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 14-2-DHS outlines how the facility trains all employees who may have contact with detainees, and for all facility staff/contractors to be able to fulfill their responsibilities and includes each element of the standard. "Training on the facility's Sexual Abuse or Assault Prevention and Intervention SAAPI Program shall be included in training for all new employees and shall also be included in annual refresher/in-service training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards." During the Pre-Audit phase of documentation review, the Lead Auditor reviewed the LPCC PREA training curriculum and determined it to be compliant with the standard in all material ways. The Lead Auditor randomly selected 10 employee/contractor files and reviewed training documentation of the employee/contractors for proof of completion and determined the training was compliant per the standard's requirement. Staff/contractor training documentation is maintained within the employee/contractors' training files. Interviews with the Training Supervisor confirmed staff/contractors receive the required PREA training and refresher training as required by the standard. Facility staff, in conjunction with policy 14-2-DHS, receive PREA training annually. However, although compliant with the standard to provide refresher training every two years, the facility was not in compliance with facility policy that mandates annual refresher training, as five staff did not receive refresher training in 2020. In addition, during the on-site portion of the audit, the Lead Auditor reviewed the training records of four ICE employees, who had contact with detainees at LPCC, and determined that none of the four were compliant with the requirement to have refresher training every two years. Specifically, two ICE staff received their last training in 2015, one received his last training in 2016, one received her last training in 2017.

Recommendation: Based on documentation reviewed, not all facility staff has received refresher training in the year 2020 as required by facility policy 14-2-DHS that requires all staff/contractors receive annual training on the facility's SAPPI program. The Lead Auditor recommends that the facility come into compliance and provide annual training as required. I

Does Not Meet (b)(c): The Lead Auditor was provided with the PREA training records on four ICE employees who have contact with detainees. Upon review, the Lead Auditor determined that the documentation provided confirmed that ICE staff did not meet the two-year refresher requirement of the standard. Specifically, the training records confirmed that two ICE staff received their last training in 2015, one received his last training in 2016, one received her last training in 2017. In a follow up email with the ICE SDDO it was confirmed that the documentation provided was the most recent training received by the four ICE staff. To come into compliance LPCC must provide the Lead Auditor with documentation to show that a sample of ICE employees have received refresher training every two years as required.

§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): Policy 14-2-DHS outlines how the facility shall train, or require the training of, all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard. Per the policy, LPCC will "ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures." The policy further states, "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 the facility's zero-tolerance policy and informed on how to report such incidents." In review of the training curriculum, the Lead Auditor determined all the required elements of this standard is covered and the curriculum meets the level and type of training required for volunteers and contractors who may have contact with detainees. Submitted with the facility PAQ was supporting documentation of completed training for volunteers and contractors, e.g., signed acknowledgments of training received and training session sign in sheets. The Lead Auditor interviewed the facility's Training Supervisor, who is responsible for conducting volunteer and contractor training. In addition, the Lead Auditor requested training documentation for one contractor and training sign in sheets for both contractors and volunteers. The Lead Auditor determined that contractors and volunteers received the required training. In addition, the Lead Auditor confirmed, through copies of the PREA training documents provided with the PAQ and through an interview with the Training Supervisor, that contractors and volunteers receive the same level of PREA training that is provided to staff.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f): Policy 14-2-DHS indicates that "during the intake process, all detainees shall be notified of the facility's zero-tolerance policy on sexual abuse and assault." The policy further indicates that "the facility will provide the information (orally and in writing) about the facility's SAAPI program." Documentation submitted with the PAQ indicates that PREA information was provided to detainees through the ICE Sexual Assault Awareness Information pamphlets, DHS posted signage "ICE Zero-Tolerance," the ICE National Detainee Handbook, and the LPCC facility handbook. The Auditors reviewed 17 randomly chosen detainee files which contained signed documentation indicating the distribution of the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the LPCC facility handbook. The Lead Auditor's review of the receipt of handbook(s) signed by the detainee is in English and doesn't provide confirmation that the handbooks were distributed in a language the detainee understands. In addition, 12 interviewed indicated that they either did not receive either handbook or that the handbook they received was not in a language they understand. There were zero intakes during the on-site visit; and therefore, the Auditors toured intake processing with the guidance of the Intake Supervisor who narrated step by step the intake process. The Auditors were advised that upon intake, detainees are provided with the LPCC facility handbook. It was unclear, however, if the facility provided the detainee with the ICE National Detainee Handbook in the detainee's preferred language as LPCC does not request this information from the detainee upon arrival. In an interview with the Intake Supervisor, the Lead Auditor was advised that should a detainee request an ICE Handbook in another language, one would be printed out for him and pointed out a few hand printed copies in other languages. She could not however, pull up the link needed to print the various languages not available on-site. The LPCC facility handbook provides detainees with information on the agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse, as well as information on detainees' rights and responsibilities, available programs and services, and facility rules but it was only available in English, Spanish, and Punjabi. The facility also made available to the Auditors, the DHS-prescribed Sexual Assault Awareness Information pamphlet. The pamphlet is handed out at intake and is available in English and Spanish, which provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault; however, the pamphlet was not available in the other languages which are provided through ICE: Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. In an interview with the Intake Supervisor, the Lead Auditor was informed that the detainee is handed the pamphlet in English with the number to the OIG circled and is advised to call the number should they have any PREA-related questions. During the on-site visit, the Auditors were advised by the Intake Supervisor that a video, available in English, Spanish, Chinese, and Punjabi, is only played on DVD, as needed, in a small holding area that through observation could not accommodate a large intake of detainees. The video is also played on the housing unit, in English and Spanish daily, which is logged into the unit logbook when played. There is no accommodation, however, for detainees who do not speak the languages offered in the video. Policy 14-2-DHS states, "Detainee orientation and instruction must be in a language, or manner that the detainee understands, including for those who are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills." Interviews with line staff confirmed that a PREA video is presented in four languages: English, Spanish, Chinese, and Punjabi. However, staff could not account for the detainees who spoke a language not covered by the video, or if the detainee was deaf, visually impaired, or otherwise disabled. Of the 32 detainees interviewed by the Second Auditor, the majority indicated that they did not see the PREA video and indicated that "staff told them to look at the number on the poster and call it

Does Not Meet (a)(b)(c)(e)(f): The Lead Auditor, through both interviews and on-site observation, determined that the PREA intake information is not provided to detainees as required by subparts (a, b, c, e, and f) of the standard. Although the facility has the detainee sign a Detainee Summary Form as required by subpart (c) of the standard, the form does not reflect what actually occurs during the intake process nor if the detainee received the handbooks in a language they understand. While touring detainee intake processing, the Audit Team confirmed that the facility did not have readily available copies of ICE National Detainee Handbooks, and/or, the DHS-prescribed Sexual Assault Awareness Information pamphlet in languages the agency had available to ensure all detainees were given access to information in a language they could understand. In an interview with the Intake Supervisor, the Lead Auditor was informed that the detainee is handed the pamphlet in English with the number to the OIG circled and advised to call the number should they have any PREA related questions. The facility must ensure that detainees are informed about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse that addresses standard elements in (a) and document the process properly. The PREA orientation must be provided in a language or manner the detainee understands that is documented in a manner for compliance review. The Auditor will request intake lists from various days to select random detainee files for compliance review on the PREA orientation process.

(d) Policy 14-2-DHS states, "the facility shall post on all housing unit bulletin boards the following notices: The DHS-prescribed sexual abuse and assault awareness notice; The name of the facility PSA Compliance Manager; and information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available). If no such local organizations exist, the facility shall make available the same information about national organizations. The facility did provide the Auditor with an exhibit containing the aforementioned documentation for review." During the on-site visit the Auditors did observe posting of related informational signage on the housing unit bulletin boards, the posting of the name of the current PSA Compliance Manager, and the contact information for the local rape crisis center that can assist detainees who have been victims of sexual abuse.

§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): Policy 14-2-DHS states, "The facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilitates." It further states, "The training will cover interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action of prosecutorial referral, and information about effective cross-agency coordination in the investigation process." The training curriculum, (PREA) Investigating Sexual Abuse in Confinement Setting, was provided on-site through the National Institute of Corrections (NIC). This training covers the unique nature of investigating sexual abuse in confinement, the techniques for interviewing sexual abuse victims, the proper uses of Miranda and Garrity warnings, the proper techniques for the collection of physical evidence, understanding best practices for reaching investigative conclusions, information about effective cross-agency coordination in the investigation process, and describing the level of evidence needed to substantiate both administrative and criminal findings. LPCC has three investigative staff and all three investigators have received specialized training for conducting sexual abuse investigations. The Lead Auditor was provided with certificates of completion for the three staff who completed the training. The Auditor determined the training curriculum meets this standard's requirements in all material ways. LPCC reported 25 incidents of sexual abuse during the audit period. The investigator responsible for 18 investigations was interviewed and verified that he received the training and was knowledgeable of the requirements needed to conduct sexual abuse investigations within a confinement setting. In review of the remaining seven cases, one case was investigated by a second trained facility investigator, and six cases were investigated by two trained ICE investigators.

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

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

Notes:

(a)(b): ICE Health Services Corps (IHSC) does not provide medical care or mental health services at this facility; therefore, these subparts are not applicable. However, the facility's contracted medical and mental health staff provide medical and mental health services to the ICE detainees.

(c): Policy 14-2-DHS dictates that "all full and part-time Qualified Health Care Professionals and Qualified Mental Health Professionals, who work in the facility, shall receive specialized medical training on how to detect and assess signs of sexual abuse, how to preserve evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, how and to whom to report allegations of sexual abuse, and how to preserve physical evidence of sexual abuse." Interviews with the facility medical staff confirmed that medical staff is required to receive the training and described the training as required in subpart (a) of the standard. The interview with the Training Supervisor and review of training records for medical staff confirmed all medical staff currently working at LPCC have received this training (PREA Medical and Mental Health Specialty Training – (E-Learning)). The Lead Auditor reviewed the training curriculum and confirmed that the PREA Medical and Mental Health Specialty Training covered all requirements of the standard. The Lead Auditor also confirmed by review of Policy 14-2-DHS that the agency has reviewed and approved the policy. CoreCivic requires medical and mental health staff take the specialized training annually. The Lead Auditor reviewed three medical staff training records. During the audit period, five mental health staff were added to the LPCC roster since October 2020. Following the on-site visit, the Lead Auditor requested documentation of specialized training for the newly hired mental health staff. The facility provided the Lead Auditor with two training certificates for PREA Medical and Mental Health Specialty Training – (E-Learning).

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): Policy 14-2-DHS states, "All detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexual abusive behavior and shall be housed to prevent sexual abuse or assault, to assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger." The policy further states, "Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility. The screening involves the use of the Sexual Abuse Screening Tool (Form 14-2B-DHS) taking into account 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 been previously incarcerated or detained, the nature of the detainee's criminal history, whether the detainee has self-identified as LGBTI or gender nonconforming, whether the detainee has any convictions for sex offenses against an adult or child, whether the detainee has self-identified as having previously experienced sexual victimization, and the detainee's own concerns about his or her physical safety." The second Auditor reviewed 10 detainee files and determined the files contained the completed documentation needed to meet this standard. The interview with the classification and intake staff confirmed most detainees are assessed within four to five hours of their arrival, for potential risk of sexual victimization or sexually abusive behavior and stated the assessment considers prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault in assessing detainees for risk of being sexually abusive. Of the 32 detainee interviews, 12 detainees indicated that their risk assessment was completed on the day they arrived. The other 20 detainees indicated that they did not receive a risk assessment or did not remember. These detainees were no longer at the facility during the on-site visit and therefore the Audit team could not follow up with further interviews. During the on-site visit of the facility the intake staff provided the Auditors with copies of the PREA questions located on the Sexual Abuse Screening Tool asked during intake. The questions were translated into 17 different languages, including Nepali, Gujarati, Chinese, Punjabi, Hindi, Spanish, Russian, Urdu, Bangla, Vietnamese, Tamil, Korean, Portuguese, Turkish, Persian, Armenian, and Romanian. Intake staff were interviewed and stated that when a detainee arrives speaking one of these languages, they are provided the questions to read and answer. They further stated that if the detainee didn't speak one of these languages, or English, they were provided with the use of a translator via Voyce Interpretation Services.

(e): Policy 14-2-DHS requires that "each detainee's risk of victimization or abusiveness is reassessed between sixty (60) and ninety (90) days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." According to the Lead Auditor's interview with the Classification Supervisor, reassessment of a detainee's risk level for victimization or abusiveness is conducted by the appropriate case manager utilizing the Sexual Abuse Screening Tool. This was verified by the Lead Auditor's review of seven detainee investigative files during the on-site visit which were found to have a reclassification completed. Interviews during the on-site portion of the audit with the Classification Supervisor and facility investigator and based on the Lead Auditor's review of seven detainee investigative files, it was further confirmed that although the facility completes a reclassification of the detainee following an incident of sexual abuse, it does not complete the reclassification within 24 hours of the abuse allegation as required by the PBNDS 2011.

Does Not Meet (e): According to the Lead Auditor's interviews with the Classification Supervisor and Lead Investigator, although reassessment of a detainee's risk level for victimization or abusiveness is conducted by the appropriate case manager following an incident of sexual abuse, utilizing the Sexual Abuse Screening Tool, it is not completed within the requirement of 24 hours as dictated by PBNDS 2011. In addition, the Lead Auditor reviewed seven investigative files while on-site and further confirmed that the completion of the reassessments following an incident of sexual abuse are in fact untimely. Therefore, section (e) of the standard is non-compliant. To become compliant the facility must provide, if available, a sample of sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse. In addition, the facility must provide confirmation that both the classification staff and investigators have received training regarding the requirement to completed the reassessment within 24 hours following the incident.

(f): Policy 14-2-DHS states. "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked during the intake process." Interviews with the PSA Compliance Manager, intake staff, and Classification Supervisor indicated detainees are not disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to the standard.

(g): Policy 14-2-DHS requires the "facility implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees." Interviews with the PSA Compliance Manager, intake staff, and Classification Supervisor confirmed that appropriate controls on the dissemination within the facility of the information obtained during the intake process is in place. According to intake staff the facility uses a controlled computerized electronic file that is available only to staff that need to know and is password protected.

§115.42 - Use of assessment information.

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

Notes:

(a): Policy 14-2-DHS requires that the facility use the information obtained through the risk assessment (Form 14-28-DHS) at initial screening when considering detainee housing, recreation, voluntary work programs and other activities. In review of 10 detainee files, the Auditor determined that the facility is utilizing the data collected from the Form 14-28-DHS to determine initial housing, recreation, work, and other activity decisions. Interviews with the classification and intake staff further confirmed the facility utilizes the information as required in the standard to determine initial housing, recreation, work, and other activity decisions.

(b): Policy 14-2-DHS states, "In making assessments and housing decisions for transgender or intersex detainees, the facility will consider the detainee's gender and self-identification, and 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 policy further indicates, "Transgender and intersex detainees shall be reassessed at least twice a year to determine whether any threats to safety were experienced by the detainee. During the Remote Interview phase of the audit, two specialized interviews with transgender detainees were conducted by the second Auditor. Neither detainee interviewed indicated that they were reassessed, and one reported they were not seen by medical. The Lead Auditor reviewed the medical and mental health files of the two transgender detainees. One detainee's file confirmed that the detainee was seen by medical and mental health staff upon intake. The other detainee's file did not. In the medical and mental health files provided, neither file indicated that the detainee was transgender upon intake. There were no additional records provided to confirm whether the detainee was referred to medical and/or mental health upon the detainee disclosing transgender status on January 7, 2020. The documentation provided also could not confirm whether the transgender detainees were reassessed at least twice a year due to the transgender detainee being released prior to that time. Interviews with intake and medical staff indicated that a medical and mental health professional will be consulted on a case-by-case basis, to determine whether the placement of transgender detainees would present management or security concerns. The Lead Auditor had planned to interview transgender detainees during the on-site portion of the interview; however, there were no transgender detainees housed at the facility during the visit.

(c): Policy 14-2-DHS states, "That when operationally feasible, transgender and intersex individuals shall be given an opportunity to shower separately from other detainees." Interviews with intake staff, the Classification Supervisor, and line staff confirmed that transgender or intersex detainees can shower separately from other detainees. Both transgender detainees interviewed by the second Auditor confirmed that they were able to shower separately during count time.

§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)(d)(e): Policy 14-2-DHS prohibits the use of administrative segregation to protect detainees at high risk for sexual abuse and assault except in those instances where reasonable efforts have been made to provide appropriate housing. The policy further states, "Such detainees shall be assigned to Administrative Segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of thirty (30) days." In addition, "the facility will consult with the ICE FOD to determine if a less restrictive housing or custodial option is appropriate and available or whether transfer may be appropriate to a hospital or another facility where the detainee can be housed in general population or in an environment better suited to the needs of the detainee." Policy 14-2-DHS dictates, "If segregated housing is warranted, the facility will take the following actions: a supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted; a supervisory staff member will conduct an identical review after the detainee has spent 7 days in administrative segregation, and weekly after for the first 30 days and every 10 days thereafter." The Warden confirmed to the Lead Auditor that policy 14-02-DHS was reviewed and approved by ICE. The Lead Auditor accepted the Warden's confirmation for documentation of the policy review. He further stated that any high-risk detainee placements in segregation must be reported to the ICE FOD within 72 hours and if appropriate custodial options are not available at the facility, the facility will consult with the ICE FOD to determine if ICE can provide additional assistance. He also confirmed that should a detainee be placed in administrative segregation for protective custody they would be provided access to programs, visitation, counsel, and other services available to the general population detainees to the extent possible. The Segregation Supervisor also indicated detainees would be provided access to programs, visitation, counsel, and other services available to the general population or document the reason it was not provided. The Lead Auditor confirmed through interviews, documentation submitted with the PAQ, and during the on-site visit that no detainees identified for high risk for sexual abuse and assault were placed in segregation for protection during the audit period.

§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): Policy 14-2-DHS encourages detainees "to immediately report pressure, threats, or incidents of sexual abuse and assault, as well as possible retaliation by other detainees or employees for reporting sexual abuse and staff neglect, or violation of responsibilities that may have contributed to such incidents." Policy 14-2-DHS outlines procedures for staff to accept reports made verbally, in writing, anonymously, and from third parties, to promptly document any verbal reports, and requires the facility to provide instructions on how detainees may contact their consular official, the DHS OIG, and the ICE Detention and Reporting Information Line (DRIL) Hotline. The policy further dictates that "the reporting will be confidential, and if desired, anonymous." Interviews with random detainees indicated that the majority are aware of the processes in place to report incidents of sexual misconduct, e.g., report to a staff member, file a grievance, place a phone call, contact their consular official, the DHS OIG or, as appropriate, another designated office to anonymously report. During intake, detainee's sign that they received a copy of both the LPCC facility handbook and the ICE National Detainee Handbook. During the on-site visit, the Auditors were able to view copies of both handbooks provided by the facility. Documentation provided, however, is not clear as to whether the detainees received either handbook in a language that they could understand, as explained in 115.16 and 115.33. Both handbooks include the process for detainees to report allegations of sexual misconduct including placing anonymous calls to the DHS OIG Hotline number. During the on-site visit, the Second Auditor attempted two separate times to contact the DRIL line to confirm that the detainee was able to report an incident of sexual abuse anonymously. After waiting on hold for 30 minutes each time she hung up and attempted to call the local crisis hotline SACASA. The Second Auditor was able to speak with a staff member and confirm that they will take an anonymous report of sexual abuse.

(c): Policy 14-02-DHS requires "staff to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible and that staff shall promptly document any verbal reports." Each of the 10 random staff interviewed confirmed they must immediately report any allegation they become aware of and put in writing any allegation verbally received. Of the 17 allegations reviewed by the Lead Auditor, 13were reported to staff, one was made through the PREA Hotline, one was reported through internal email, one was reported through the grievance procedure, and one was filed via an email from ICE. The Lead Auditor further determined that the detainees were aware of the multiple ways to report sexual abuse.

§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): Policy 14-2-DHS states, "Formal grievances filed by detainees involving allegations of an immediate threat to a detainee's health, safety, or welfare, related to sexual abuse will be removed from the grievance process and will be forwarded immediately to the facility investigator or Administrative Duty Officer." In addition, the LPCC Detainee Handbook states, "Alleged PREA incidents will not be processed through the CoreCivic facility Grievance Process. Should a report be submitted and received as a detainee grievance, it will be immediately referred to the facility investigator or administrative duty officer." Subparts (a) through (f) of the standard require: "The facility shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint and shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. The facility shall implement written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. The facility shall issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. Facilities shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE FOD at the end of the grievance process. To prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties." Both facility policy and the LPCC facility handbook dictate that a sexual abuse grievance will be removed from the grievance process and will be forwarded immediately to the facility investigator or Administrative Duty Officer. During the on-site visit, the Lead Auditor further interviewed the Grievance Coordinator regarding the grievance procedure at LPCC. She indicated that the facility would process a sexual abuse grievance immediately by notifying the Sexual Abuse Response Team (SART) and then close the grievance. In addition, the Lead Auditor, while on-site informally interviewed line staff/contractors and determined that thy were knowledgeable in the grievance process which included grievance boxes, located throughout the facility, to enhance detainee confidentiality. Staff indicated that the contents of the boxes were picked up daily. There was one sexual abuse grievance during the audit period. The Lead Auditor reviewed the investigative file and determined that LPCC's grievance process was compliant with the standard.

§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): Policy 14-2-DHS requires CoreCivic to "maintain, or attempt to enter into, a MOU, or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support for immigrant victims of crimes. In addition, as requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews." Documentation submitted with the PAQ confirms LPCC has an MOU with SACASA to provide support in areas of crisis intervention, counseling, and support during the investigation and prosecution. The MOU was entered into January 2017 and is continuous unless one of the parties gives a 30-day notice of intent to terminate the agreement. The LPCC facility handbook, provided to each detainee, and signage located on the housing units, informs detainees of the mailing address and the 24-hour crisis line telephone number. It also informs them that communication with this advocacy group is not monitored, however, in phone directions handed out at intake, the detainee is advised that "CoreCivic reserves the right to monitor (this includes recording) conversations on any telephone located within its institutions." The second Auditor's interviews with detainees indicated that of the 10 random detainees interviewed, four were aware of the availability of a confidential emotional support service for victim of sexual abuse. In addition, of the 17 LEP detainees interviewed, 2 were aware of the availability of a confidential emotional support service for victims of sexual abuse. During the on-site visit, the second Auditor contacted SACASA staff and confirmed that they would provide services as mandated by the standard.

§115.54 - Third-party reporting.

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

Notes:

Policy 14-2-DHS requires the facility "to establish a method to receive third-party reports of sexual abuse and shall post this information on the facility PREA link found on their website." The Lead Auditor reviewed the LPCC web page (www.corecivic.com/facilities/la-palma-correctional-center) and the ICE web page (www.ICE.gov/PREA). CoreCivic home page has an email address and phone number to report an allegation or suspected incident of sexual and the ICE home page has reporting links to both their office and OIG. During the detainee interviews, when asked if someone else could report for you either inside or outside the facility, 18 of the 24 detainees interviewed indicated they did not know or could not have someone to report for them. They did, however, know that they could use the telephone system to report to outside resources including ICE and the OIG.

§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): Policy 14-2-DHS requires "all employees to immediately report: any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility in accordance with this policy, whether or not the area is under CoreCivic's management authority; retaliation against detainees or employees who have reported such an incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation." Policy 14-2-DHS provides staff a means to privately report without going through their chain of command by allowing them to forward a letter, sealed and marked "Confidential," to the Facility Administrator, or, to the CoreCivic Ethics Hotline at www.CoreCivic.ethicspoint.com. The Auditor interviewed 10 random staff members, and each confirmed their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Staff was also aware of their ability to write directly to the Warden if it became necessary. Staff interviewed indicated reporting obligations and maintaining confidentiality are presented in the annual PREA training they receive.

(c): Policy 14-2-DHS requires staff "not reveal any information related to a sexual abuse to anyone other than to the extent necessary, and as specified to make treatment, investigation, and other security and management decisions." Interviews with 10 random staff confirmed that information they become aware of is to remain confidential, except when disclosing to a supervisor or during the investigation to an investigator.

(d): As previously noted, LPCC is an adult male facility and does not accept juveniles. Policy 14-02-DHS 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 allegation shall be reported to the designated state or local services agency under applicable mandatory reporting laws." The Warden confirmed that, although it has not yet happened at LPCC, if an alleged victim was designated as a vulnerable adult, he would be the person responsible for the necessary reporting and would contact the Arizona agency where he is mandated to report the sexual abuse allegation.

§115.62 - Protection duties.

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

Notes:

Policy 14-2-DHS requires that "when staff become aware a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee. The random staff interviewed confirmed if they become aware a detainee is at substantial risk of sexual abuse, their first response would be the safety of the detainee at risk. Their first course of action would be to seek out the detainee, isolate him, and notify their supervisor." The Warden confirmed detainee safety would be his paramount concern. He confirmed his options would depend on the situation, but he would make sure the detainee is placed in the least restrictive housing available and would immediately ensure an investigation was conducted. In review of investigative files, the Lead Auditor determined the facility took the appropriate action required to protect detainee victims.

§115.63 - Report to other confinement facilities.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 14-2-DHS requires "when facility staff becomes aware of any allegation of sexual abuse that took place while the alleged victim was at another facility, the facility is to contact the facility head or appropriate office of the facility where the alleged abuse took place as soon as possible, but no later than 72 hours after receiving the allegation information. All such contacts and notifications shall be documented on the 5-1 B Notice to Administration (NTA)." Out of the 17 detainee files reviewed, the Lead Auditor discovered 5 intake screenings in which the detainee alleged sexual abuse at another facility. Upon review, four out of five investigation files confirmed the facility failed to document the allegations as required. During the on-site visit, the facility presented the Lead Auditor with a Continuous Improvement Plan of Action dated 7/18/19 covering the standard deficiency; however, all four incidents occurred post training.

Does Not Meet (a)(b)(c): Although the facility noted that a Continuous Improvement Plan of Action, dated 7/18/19, was needed to bring staff/contractors into compliance with sections (a)(b)(c) of the standard, they continued to show non-compliance with these subsections of the standard. Four out of five investigative files reviewed where a detainee reported a history of sexual abuse at another facility did not contain the required documentation. To come into compliance, the facility must further train its staff/contractors on the importance of notifying the facility where there is a sexual assault allegation reported to LPCC. In addition, if available, the facility must provide any investigative files that occurred following the on-site portion of the audit for compliance review.

(d): Policy 14-2-DHS requires, "If an allegation is received from another facility, alleging to have occurred at LPCC, the facility must ensure the allegation is investigated." The Warden confirmed that as with any allegation of sexual assault, he would immediately report the alleged incident to the SDDO, the facility lead investigator who reports the allegation to the Eloy Police Department and ensure that the facility investigates the allegation as required by policy.

§115.64 - Responder duties.

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

Notes:

(a)(b): Policy 14-2-DHS requires, "The first security staff member to respond to the report, or his or her supervisor, shall ensure that the alleged victim and perpetrator are separated." In addition, "The responder shall, to the greatest extent possible, preserve and protect the crime scene until appropriate steps can be taken to collect evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall, request the alleged victim and abuser do not to take any actions that could destroy physical evidence." The policy further requires "if the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." The random security staff interviewed detailed their responsibilities as required under subpart (a) of this standard. The staff also carry a small card outlining their specific responsibilities as required by this standard. The Auditor also interviewed two contractors and two volunteers, and all confirmed if a detainee reported an allegation to them, they would request the detainee victim not take any actions that could destroy physical evidence and would contact the closest security staff member.

§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): Policy 14-2-DHS establishes a SART at LPCC comprised of the PSA Compliance Manager, medical representative, security representative, mental health representative, and a victim services coordinator. The SART, outlined in policy 14-2-DHS, "is LPCCs' institutional plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to any incident of sexual abuse." The 14-02-DHS policy provides a checklist, 14-2C: Sexual Abuse Incident Check Sheet, that is completed after an alleged incident, documenting whether the policy and SART plan was followed by staff. The Auditor interviewed the PSA Compliance Manager, the facility lead investigator, and medical staff, who described their responsibilities as a team member when responding to incidents of sexual abuse. The Auditor reviewed 17 investigative files and found a completed Form 14-C - Sexual Abuse Incident Check Sheet in each file.

(c)(d): Policy 14-2-DHS requires, "If a victim of sexual abuse is transferred between any types of facility, 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." In a memo submitted by LPCC with the PAQ the Warden noted that "The transfer of detainees between LPCC and other facilities is coordinated through ICE ERO staff. To ensure appropriate information is transmitted to the receiving facility, including any involvement PREA incident, ERO staff include this information in the data (case comment) in the Enforce Alien Removal Module (EARM)." This practice was confirmed by the Warden during his interview. The Auditor reviewed two investigative files where the detainee was transferred to another facility; the information from EARM was inputted in the files that were reviewed on-site.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Policy 14-2-DHS requires "any staff, contractor, or volunteer suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of an investigation." The Warden confirmed he would remove anyone suspected of sexual abuse from the facility and from contact with any detainee. Of the 17 investigative files reviewed by the Lead Auditor, 7 files were determined to be staff/contractor-on- detainee. A review of six detainee investigative files indicated that the staff/contractors were removed of all duties requiring detainee contact; however, all staff/contractors were returned to duty once the facility determined the outcome of the investigation, and not when the outcome was determined by ICE OPR. Interviews with the Warden and Investigator confirmed that the staff/contractor is separated, following the allegation, and returned to duties requiring detainee contact, after consultation with the ERO OIC while the investigation is still officially an open investigation with the agency.

Does Not Meet: Through review of seven investigative files that involved staff/contractors and interviews with the Warden and Facility Investigator, it was confirmed that the facility returned staff/contractors to duties requiring detainee contact prior to the official outcome of the investigation. To come into compliance, the facility must change the current practice of returning the staff/contractor to duties requiring detainee contact from clearance by the OIC to official outcome determined by ICE OPR. To confirm practice, the Lead Auditor will review all available staff/contractor-on-detainee allegations that occur following the on-site visit.

§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): Policy 14-2-DHS "prohibits staff, contractors, and volunteers, and other detainees, from retaliating against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. For at least 90 days following any report of sexual abuse, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews, or reassignments of staff. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The policy designates the PSA Compliance Manager to ensure the designated staff conducts retaliation monitoring, following a report of sexual abuse, to protect against potential retaliation against detainees or employees. Interviews with PSA Compliance Manager and the facility lead investigator confirmed that the facility monitors both staff retaliation and detainee retaliation and that each monitoring responsibility is assigned to appropriate staff at the time an allegation of sexual abuse is made. In addition, the facility lead investigator advised that there were no instances where staff retaliation monitoring was needed. The classification staff monitors detainee retaliation. The facility lead investigator confirmed the monitoring includes periodic status checks, at least monthly, of the detainee and review of relevant documentation, including any disciplinary reports and housing or program changes. Monitoring for both staff and detainees is documented on form 14-2D-DHS: Retaliation Monitoring Report (30/60/90) form. The facility lead investigator indicated that monitoring for both staff and detainees will continue beyond 90 days if the initial monitoring indicates a continuing need. Any instances of staff and/or detainees' retaliation would be brought to the attention of the PSA Compliance Manager who would report it to the Warden. Of the 17 sexual abuse investigative files reviewed by the Lead Auditor, monitoring was conducted on all of the detainees as required by the standard. There were zero monitoring requests initiated for staff during the audit period.

§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): Policy 14-2-DHS requires "the facility take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. The Warden confirmed that he would notify the ICE FOD whenever a detainee victim has been held in administrative segregation. The Lead Auditor reviewed 17 investigative files and confirmed that two detainees were housed in protective custody due to their own request

(b)(c)(d): Policy 14-2-DHS requires "a detainee victim who is in protective custody after having been subjected to sexual abuse not be held longer than five (5) days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee and that the detainee victim will not be returned to the general population until completion of a re-assessment taking into consideration any increased vulnerability of the detainee as a result from the sexual abuse." The policy further ensures LPCC shall notify the appropriate ICE Field Office Director (FOD) whenever a detainee victim has been held in administrative segregation for seventy-two (72) hours." The Warden confirmed that he would house a detainee victim of sexual abuse in the least restrictive housing option possible. The Lead Auditor reviewed 17 investigative files and confirmed that two detainees were housed in protective custody due to their own request. There were no detainees placed in protective custody following an incident of sexual abuse who did not request placement into the unit. There were no detainee medical reassessments to review prior to placement in general population. In addition, there were no detainees placed in protective custody following an incident of sexual abuse during the on-site visit.

§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): The standard requires if the facility has responsibility for investigating allegations of sexual abuse, all investigations into alleged sexual abuse must be prompt, thorough, objective, and conducted by specially trained, qualified investigators. The facility has three investigators. Documentation submitted to the Lead Auditor confirmed that all are specially trained. The facility lead investigator confirmed in an interview that all investigations into sexual abuse are prompt, objective, and thorough. All 17 investigative files reviewed by the Lead Auditor further confirmed that the investigations are prompt, objective, and thorough.

(b): The standard requires upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity, the Eloy Police Department. The facility lead investigator confirmed in an interview that an administrative investigation is conducted on all allegations of sexual abuse after consultation with the investigative office within DHS and the Eloy Police Department. In addition, all 17 investigative files reviewed by the Lead Auditor further confirmed that an administrative investigation is completed on all sexual abuse allegations and that the investigative office within ICE and the Eloy Police Department was consulted.

(c): Policy 14-2-DHS states, "Administrative investigations 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 all reports and referrals of allegations for as long as the alleged abuser is detained or employed by the agency or facility, plus five (5) years; and Coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." A review of 17 investigative files for the audit period demonstrated the investigation addresses the requirements (i-vii) of this standard subpart and as required by policy. Interviews with the PSA Compliance Manager and Warden confirmed that investigative files are retained in accordance with the standard.

(e)(f): Policy 14-2-DHS states, "The departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." Interviews with the Warden, PSA Compliance Manager, and investigator confirmed an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. Per Policy 14-2-DHS, "When outside agencies conduct investigations of sexual abuse and assault, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." The review of 17 sexual abuse investigations confirmed that all allegations, whether criminal or not, were referred to the Eloy Police Department for 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:

Policy 14-2-DHS requires that "when an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse and assault are substantiated and that "any sexual abuse administrative investigation in which the facility is the primary investigating entity, the facility shall utilize a preponderance of the evidence standard for determining whether sexual abuse has taken place." Upon review of 17 investigative files, the Lead Auditor determined investigations are completed in accordance with the standard. The facility lead investigator, during an interview, verified that the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated.

§115.73 - Reporting to detainees.

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

Notes:

Policy 14-2-DHS requires, "Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken." The policy further requires, "If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee." The facility lead investigator confirmed detainees are informed of investigation outcomes regardless of the entity that completes the investigation. The detainee is provided the decision, in person by the facility investigator and provided a written response utilizing Form 14-2E Detainee Allegation Status Notification, which is signed and filed in the detainee's file. The Auditor reviewed 17 investigative files and determined, by viewing Form 14-2E, notifications are given to the detainee upon the completion of an investigation as required by the standard.

§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)(c)(d): Policy 14-2-DHS requires, "Employees be subject to disciplinary sanctions up to and including termination for staff violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff that have engaged in, attempted, or threatened to engage in sexual abuse." Policy 14-2-DHS further states that "it is subject to the review and approval of ICE." The interview with the Warden confirmed the facility's policies and procedures regarding disciplinary or adverse actions for staff were provided to the agency for review and approval. In addition, Policy 14-2-DHS states, "All terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the act was clearly not criminal, and any relevant licensing bodies, to the extent known." During the past 12 months, the facility has not had a substantiated allegation involving staff sexual misconduct. Therefore, files demonstrating termination, resignation, or other disciplinary actions were not available for review. An interview with the AFOD confirmed staff are subject to discipline for violations of the department's sexual abuse policies and termination is the presumptive disciplinary sanction for a staff member who has engaged in sexual abuse. The Warden confirmed the lead facility investigator is responsible for reporting such incidents to the facility personnel investigator for follow through and that the facility would also follow the Federal Security Clearance Process who determines denial or revocation of government security clearance.

According to a memo from the Warden submitted with the PAQ, and on-site interviews with the Warden, PSA Compliance Manager, and facility lead investigator, LPCC did not have any staff who violated CoreCivic's sexual abuse policies during this audit period.

§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): Policy 14-2-DHS requires "contractors and volunteers suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of an investigation." It further requires any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures; and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault; but have violated other provisions within these standards. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies, unless the activity was clearly not criminal. In addition, policy requires the facility report such incidents to the ICE 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 Warden confirmed that any contractor or volunteer suspected of perpetrating sexual abuse would be removed from all duties involving detainee contact, and that if the allegation was substantiated, the incident would be reported to the contractor's employer, who would have the responsibility of reporting the incident to licensing bodies, if applicable. The Lead Auditor spoke with two contractors and two volunteers who confirmed they were aware of the corrective action for violation of the facility zero tolerance policy. The facility did not have any allegations involving a contractor or volunteer during this audit period.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, "In addition to the forms of sexual abuse and/or assault defined in the definition section of 14-02-DHS, all other sexual conduct - including consensual sexual conduct - between detainees is prohibited and subject to disciplinary sanctions. Detainees shall be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault." Policy 14-02-DHS further requires, "Sanctions be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories." Interviews with the facilty Warden and PSA Compliance Manager confirmed compliance with sections (a) and (b) of the standard.

(c): Policy 15-100, Resident Rules and Discipline, details the LPCC disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure.

(d): Policy 14-2-DHS requires "If a detainee is mentally disabled or mentally ill but competent, the disciplinary process shall consider whether the 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 Warden confirmed that contributing factors in the case would become evident in the investigative process. These mitigating factors would be discussed prior to a misconduct report being issued.

(e): Policy 14-2-DHS prohibits a detainee from being disciplined for sexual conduct with an employee unless the employee did not consent to such contact.

(f): Policy 14-2-DHS requires, "A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation."

The Lead Auditor interviewed both the Warden and PSA Compliance Manager about sanctions for detainees. Both confirmed any sexual contact, including consensual sexual conduct between detainees, will subject the detainee to a misconduct report and the progressive levels of sanctions within

the discipline process. Both also indicated the detainee's mental disabilities, or any mental illness, would factor into the disciplinary outcome and detainees making a report in good faith would not be disciplined. According to a memo submitted with the PAQ, and confirmation during the on-site visit, only one detainee at LPCC was placed in segregation due to a substantiated case of sexual abuse, during the audit period, and disciplinary sanctions were imposed.

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

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

Notes:

(a)(b)(c): Policy 14-02-DHS requires "if the risk screening 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. If the detainee is referred to medical, the detainee must be seen within two working days from the assessment. If the detainee is referred to mental health the follow-up must be no later than 72 hours from the assessment." Medical staff, during the interview, indicated that they consult with intake staff and would refer the detainee to mental health for follow-up. Medical and mental health records submitted during the on-site audit confirmed that both the detainee who experienced prior sexual victimization and the detainee who perpetrated sexual abuse were referred to medical and mental health staff for evaluation. In addition, two detainees who experienced a history of sexual victimization indicated that they were referred to both medical and mental Health upon intake A review of their medical files confirmed they were referred to both medical and mental health as required by the standard.

§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): Policy 14-02-DHS requires "Detainee victims of sexual abuse and assault shall be provided 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." Policy 14-02-DHS further requires, "Emergency medical treatment 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 HSA interview confirmed that detainees receive medical/mental health services immediately upon an allegation being made in accordance with professional standards of care, at no charge regardless if the victim participates in the investigation. The Lead Auditor reviewed one investigative file in which the detainee was sent to an emergency room due to a sexual abuse allegation. Based on the review, it was determined that the facility is in compliance with the standard.

§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): Policy 14-02-DHS requires, "The facility to offer a medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse or assault while in immigration detention." The policy also requires, "The evaluation and treatment of the victim; including follow-up services, treatment plans, and, when necessary, referrals for continued care consistent with the community level of care." The policy also states, "The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody." The medical staff interviews confirmed that detainee treatment is immediate, based on their professional opinion, and consistent with community level of care, including additional follow up if necessary. In addition, interviews with medical staff confirmed that referrals for continued care following a detainee's transfer to, placement in another facility, or their release from custody would be made. A review of one detainee file, in which the detainee was sent to the emergency room due to a sexual abuse allegation, further confirmed compliance.

(d): LPCC is an adult male facility. This subpart does not apply.

(e): Policy 14-02-DHS requires, "Detainee victims of sexual abuse shall be offered tests for sexually transmitted infections as medically appropriate." The facility medical practitioner confirmed that the facility could perform these blood tests, but they are typically performed upon transfer to the outside hospital. A review of one detainee file, in which the detainee was sent to the emergency room due to a sexual abuse allegation, further confirmed that the detainee was offered tests for sexually transmitted infections.

(f): Policy 14-02-DHS requires, "Medical treatment services 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." This policy was confirmed by an interview with the HSA. A review of one detainee file, in which the detainee was sent to the emergency room due to a sexual abuse allegation, further confirmed compliance.

(g): Policy 14-02-DHS requires, LPCC "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". Medical and Mental Health records submitted during the on-site audit confirmed that both the detainee who made the allegation of sexual abuse, and the alleged perpetrator were afforded the opportunity to meet with both medical and mental health staff for evaluation. In addition, two detainees who experienced a history of sexual victimization indicated that they were referred to both medical and mental health upon intake. A review of their medical files confirmed they were referred to medical and mental health as required by the standard.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b)(c): Policy 14-02-DHS states, "The facility administrator will ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation." Policy 14-02-DHS further states, "The incident review team shall include upper-level facility management and the facility SART with input from line supervisors, investigators, and medical or mental health practitioners and will consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. The review team will also consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or gender non-conforming identification, status; or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility shall

implement the recommendations 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." Policy further states and was corroborated by the Lead Auditor's review of the facilities annual review report that "the facility conducts an annual review of all investigative files, and resulting incident reviews, to assess and improve sexual abuse intervention, prevention and response efforts, including preparation of a negative report if the facility does not have any reports of sexual abuse during the reporting year." Interviews with the Warden and PSA Compliance Manager corroborated this policy. A review of 16 investigative files for the audit period demonstrated the facility reviews all allegations of sexual abuse, including cases that were determined to be unfounded, and completes a written incident review on all substantiated and unsubstantiated determinations as required by the standard.

§115.87 - Data collection.

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

Notes:

(a): Policy 14-02-DHS requires, "All case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling be retained in accordance with Policy 1-15 Retention of Records." The Warden confirmed the facility maintains these documents in a secure filing area under the control of the lead investigator and that access is only on a need-to-know basis. In addition, during the on-site visit, the Lead Auditor was provided the opportunity to observe the secure filing of records as required by the standard.

§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)(e)(i)(j): During all stages of the audit, including the Pre-Audit, Remote Interview phase, and on-site visit, the Auditors were able to review all policies, memos, and other documents required to make assessments on PREA compliance. Interviews with detainees were conducted in private both remotely through WebEx and on-site and remained confidential. Interviews with the staff were conducted in private both on a conference line and on-site. The Auditors received no detainee correspondence prior to either the Remote Interview phase or the on-site visit.

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:	0
Number of standards met:	33
Number of standards not met:	7
Number of standards N/A:	1
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.

Sabina Kaplan 10/19/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C) 10/1/2021

PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 10/19/2021

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:	Sabina Kaplan	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	914-474-[redacted]
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Phoenix Field Office		
Field Office Director:	(Interim) Simona Flores-Lund		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	2035 North Central Avenue, Phoenix, Arizona 85004		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	La Palma Correctional Center		
Physical address:	5501 North La Palma Road, Eloy, Arizona 85131		
Mailing address: *(if different from above)*			
Telephone number:	520-464-3200		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	Christopher Howard	**Title:**	Warden
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(520) 464-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Chief of Unit Management
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(520) 464-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) audit of La Palma Correctional Center (LPCC) was conducted on August 24 - August 25, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors, Sabina Kaplan and Valerie Wolfe-Mahfood for Creative Corrections, LLC. The Lead Auditor was provided guidance and review during the audit report writing and review process by the Immigration Customs and Enforcement (ICE) PREA Program Manager (PM) (b) (6), (b) (7)(C) and Assistant ICE PREA Program Manager, (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. This facility is operated by CoreCivic.

The purpose of the August 2021, audit was to determine compliance with DHS PREA Standards. The PREA Incorporation date was July, 24, 2018. This was the first DHS PREA audit for LPCC. The audit was originally scheduled for April 2020 but was converted to a contingency audit due to the COVID-19 health pandemic. The audit period was expanded to cover the period of April 2019 through August 25, 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. The facility's Corrective Action Period (CAP) began October 18, 2021, and ended April 17, 2022.

The agency provided the Auditor the CAP in November 2021. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The facility submitted documentation for the corrective action process on February 11, 2022, through April 11, 2022. The Auditor reviewed the final documentation submitted on April 11, 2022. The review of this documentation confirmed that all seven standards are compliant in all material ways.

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:

(a)(c): A review of the updated PAQ indicated the facility's staffing level is 347 staff with 259 security staff, 179 males and 80 females, that may have recurring contact with detainees. This is a significant change from the staffing level noted during the contingency audit phase of 373. The remaining staff consists of medical and mental health contracted employees. During the audit period, LPCC line staff went from working two 12-hour shifts to working three 8-hour shifts in March of 2021. The PREA staffing plan assessment, dated 6/10/21, indicated the factors taken into account for the staffing levels at LPCC included generally accepted detention and correctional practices, any judicial finding of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and other relative factors, including but not limited to, the length of time detainees spend in agency custody; however, a review of the annual PREA staffing plan assessment, dated 6/10/21, noted that "there have not been any changes since the last annual PREA Staffing Assessment," even though in March 2021, line staff/contractors started working three 8-hour shifts. During the post on-site audit phase, the Lead Auditor requested, via email, further documentation to support that the facility took into consideration all elements of the standard prior to making the change in shifts. The facility could not provide any documentation that could confirm that during the modification of on-site supervision, the facility took into consideration the required elements of subsection (c) of the standard. The Warden indicated that the number of staff is determined by an established staff to detainee ratio, the physical layout and size of the facility, and the composition of the detainee population. The Auditor was supplied with shift rosters prior to the onset of the Remote Interview phase of the audit and during the on-site visit. While on-site, the Lead Auditor observed posted overtime sign-up sheets available for staff to sign up for overtime as needed. In addition, the Lead Auditor observed staffing levels during the on-site audit and determined they were adequate. . (b) (7)(E)

[redacted]

Does Not Meet (c): Per sub paragraph (c) of standard 115.13, 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, or the findings and recommendations of sexual abuse incident review reports, and any other relevant findings, including the length of time detainees spend in agency custody. LPCC changed their staffing pattern from two 12-hour shifts to three 8-hour shifts in March of 2021. The Lead Auditor requested documentation needed to confirm that the facility utilized all elements of the standard prior to altering their staffing pattern but this could not be provided by the facility. Therefore, the Lead Auditor could not confirm that during the last reorganization of line supervision the facility took into consideration any judicial findings of inadequacy, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, or the findings and recommendations of sexual abuse incident review reports in evaluating whether the change in supervision will affect the facilitates efforts to prevent sexual abuse. The facility must document that the standard elements of (c) are taken into consideration during the review of supervision guidelines for compliance.

Corrective Action Taken (c): The facility submitted a staffing plan dated 6/11/21 that contains all the elements of the standard. The Auditor accepts the submitted documentation for compliance. The facility is in compliance with subsection (c) of the standard.

§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:

(a)(b)(c): Policy 14-2-DHS dictates that "detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facilities efforts to prevent, detect, and respond to sexual abuse." Policy 14-2-DHS further dictates that "when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall attempt to accommodate the detainee by providing access to in-person, telephonic, or video interpretive services, access to written materials related to sexual abuse in formats or through methods that ensure effective communication; and auxiliary aids such as readers, materials in Braille (if available), audio recordings telephone handset amplifiers, telephone telecommunications devices for deaf persons (TTY's), interpreters, and note takers." In addition, policy 14-2-DHS states, 'That the facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its program and activities." There were zero intakes during the on-site visit; and therefore, the Auditors toured intake processing with the guidance of the Intake Supervisor who narrated step by step the intake process. The Auditors were advised that upon intake, detainees are provided with the LPCC facility handbook. It was unclear, however, if the facility provided the detainee with the ICE National Detainee Handbook in the detainee's preferred language as LPCC does not request this information from the detainee upon arrival. In an interview with the Intake Supervisor, the Lead Auditor was advised that should a detainee request an ICE Handbook in a language that is not covered by the hard cover handbooks on site, specifically English, Spanish, Punjabi, Portuguese, and Spanish, another language one would be printed out for him and pointed out a few hand printed copies in other languages. She could not however, pull up the link needed to print the various languages not available on-site. 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, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. Although the LPCC facility handbook provides detainees with information on the Agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse, as well as information on detainees' rights and responsibilities, available programs and services, and facility rules, it was only available in English, Spanish, and Punjabi. The facility also made available to the Auditor, the DHS-prescribed Sexual Assault Awareness Information pamphlet. The pamphlet is handed out at intake and is available in English and Spanish, which provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault. The pamphlet was not available in other languages the agency has available; the pamphlet is available through ICE in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. A video, available in English, Spanish, Chinese, and Punjabi, is only played on DVD, as needed, in a small holding area that through observation could not accommodate a large intake of detainees. The video is also played in the housing unit, in English and Spanish daily. This is logged into the unit logbook. There is no accommodation, however, for detainees who do not speak the languages offered in the video. The medical staff advised if a detainee coming through intake spoke a language that was not available in a written format, they will utilize the interpretive service, Language Line Associates. The Intake Supervisor interviewed also stated that if staff encountered detainees who spoke a language not available during intake, they would utilize a language line (Voice Interpretation Services). A review of the logbook while on site revealed that the language line had only been utilized 11 times from 12/8/20 – 8/21/21. In the 16 investigative files reviewed, the Lead Auditor determined the facility did not utilize another detainee to interpret during the investigations. The Auditors also reviewed 17 randomly chosen detainee detention files. Although the detainees signed a document indicating they received PREA materials, the files did not provide documentation confirming the use of the language line and/or interpreters for those detainees who did not speak English or Spanish. Interviews with the 17 detainees who were LEP reported they did not receive information in a language they understand and that detainees were advised to call the "number" indicated on the English version of the DHS-prescribed Sexual Assault Awareness Information pamphlet. During the on-site visit, the Intake Supervisor confirmed that the practice was to hand the detainee the DHS-prescribed Sexual Assault Awareness Information pamphlet and advise them to call the number should they have any questions. The Intake Supervisor further confirmed that there is no practice in place to provide 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 with access to information regarding sexual abuse as required by the standard

Does Not Meet (a)(b): The Audit Team toured intake processing during the on-site visit and discussed the process with the Intake Supervisor. During the tour, the Auditors observed a simulated practice and confirmed that LEP detainees were not provided with PREA information in a language they could understand as required by the standard. The Auditors confirmed that the facility only had available the DHS-prescribed Sexual Assault Awareness Information pamphlets in English and Spanish and staff could not readily provide the Audit Team with the link to print the pamphlets in French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic. In addition, there was no available documentation to confirm that LEP detainees received the ICE Handbook in a language they could understand. The detainees reported, which was confirmed by staff interviews, they do not receive PREA information at intake, but are advised to call the Hotline number on

the pamphlet should they have any questions. During the on-site, the Auditors informally interviewed random detainees while touring the pods, who confirmed that they did not receive the ICE National Detainee Handbook. A video, available in English, Spanish, Chinese, and Punjabi, is only played on DVD, as needed, in a small holding area that through observation could not accommodate a large intake of detainees and although the video is played daily on the housing unit, it is only available in English and Spanish. The log verifying the use of the language line only confirmed 11 uses between 12/8/20 and 8/21/21. The Intake Supervisor further confirmed that there is no practice in place to provide 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 with access to information regarding sexual abuse as required by the standard. For compliance, the facility must demonstrate how LEP detainees are provided the PREA information in a manner they understand, and all detainees receive an ICE National Detainee Handbook in a language they understand, if available, or document how the information is provided to them in another method. In addition, the facility must demonstrate how they provide the PREA information to those 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 with access to information regarding sexual abuse as required by the standard. The facility must provide 10 LEP detainee intake files documenting the PREA information was provided to the detainee in a manner they understand; the documentation must demonstrate a variety of languages, other than English and Spanish over a month period. In addition, if available, the facility must provide an additional 10 detainee intake files of those 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 to confirm that there is a practice in place that provides detainees with disabilities access to information regarding sexual abuse as required by the standard.

Corrective Action Taken (a)(b): The facility provided the Auditor with 13 detainee intake files from detainees who spoke a variety of languages, other than English and Spanish confirming that the detainees received the PREA information in a manner they understand. In addition, the facility implemented a new practice allowing detainees who are deaf or have limited hearing access to the Language Line Sign language interpreter service to provide the PREA information. Also, if the detainee presented as blind or with limited sight the facility will make available staff to read the information to the detainee. Per documentation provided by the facility, there have been no detainees received at the facility, during the CAP period, who are deaf or hard of hearing, blind or have low vision, or have intellectual, psychiatric, or speech disabilities; and therefore, they are unable to provide 10 detainee files that confirm they were providing access to information regarding sexual abuse. The facility is now in compliance with standard 115.16 subsections (a) and (b).

§115. 31 - Staff training

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

Notes:

(a)(b)(c): Policy 14-2-DHS outlines how the facility trains all employees who may have contact with detainees, and for all facility staff/contractors to be able to fulfill their responsibilities and includes each element of the standard. "Training on the facility's Sexual Abuse or Assault Prevention and Intervention SAAPI Program shall be included in training for all new employees and shall also be included in annual refresher/in-service training thereafter. Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards." During the Pre-Audit phase of documentation review, the Lead Auditor reviewed the LPCC PREA training curriculum and determined it to be compliant with the standard in all material ways. The Lead Auditor randomly selected 10 employee/contractor files and reviewed training documentation of the employee/contractors for proof of completion and determined the training was compliant per the standard's requirement. Staff/contractor training documentation is maintained within the employee/contractors' training files. Interviews with the Training Supervisor confirmed staff/contractors receive the required PREA training and refresher training as required by the standard. Facility staff, in conjunction with policy 14-2-DHS, receive PREA training annually. However, although compliant with the standard to provide refresher training every two years, the facility was not in compliance with facility policy that mandates annual refresher training, as five staff did not receive refresher training in 2020. In addition, during the on-site portion of the audit, the Lead Auditor reviewed the training records of four ICE employees, who had contact with detainees at LPCC, and determined that none of the four were compliant with the requirement to have refresher training every two years. Specifically, two ICE staff received their last training in 2015, one received his last training in 2016, one received her last training in 2017.

Does Not Meet (b)(c): The Lead Auditor was provided with the PREA training records on four ICE employees who have contact with detainees. Upon review, the Lead Auditor determined that the documentation provided confirmed that ICE staff did not meet the two-year refresher requirement of the standard. Specifically, the training records confirmed that two ICE staff received their last training in 2015, one received his last training in 2016, one received her last training in 2017. In a follow up email with the ICE SDDO it was confirmed that the documentation provided was the most recent training received by the four ICE staff. To come into compliance LPCC must provide the Lead Auditor with documentation to show that a sample of ICE employees have received refresher training every two years as required.

Corrective Action Taken (b)(c): The facility provided the Auditor with three examples of ICE employee PALMS e-learning certificates that documented they received refresher training as required by the standard. The facility is now compliant with subsection (b)(c) of the standard.

§115. 33 - Detainee education

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

Notes:

(a)(b)(c)(e)(f): Policy 14-2-DHS indicates that "during the intake process, all detainees shall be notified of the facility's zero-tolerance policy on sexual abuse and assault." The policy further indicates that "the facility will provide the information (orally and in writing) about the facility's SAAPI program." Documentation submitted with the PAQ indicates that PREA information was provided to detainees through the ICE Sexual Assault Awareness Information pamphlets, DHS posted signage "ICE Zero-Tolerance," the ICE National Detainee Handbook, and the LPCC facility handbook. The Auditors reviewed 17 randomly chosen detainee files which contained signed documentation indicating the distribution of the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the LPCC facility handbook. The Lead Auditor's review of the receipt of handbook(s) signed by the detainee is in English and doesn't provide confirmation that the handbooks were distributed in a language the detainee understands. In addition, 12 detainees interviewed indicated that they either did not receive either handbook or that the handbook they received was not in a language they understand. There were zero intakes during the on-site visit; and therefore, the Auditors toured intake processing with the guidance of the Intake Supervisor who narrated step by step the intake process. The Auditors were advised that upon intake, detainees are provided with the LPCC facility handbook. It was unclear, however, if the facility provided the detainee with the ICE National Detainee Handbook in the detainee's preferred language as LPCC does not request this information from the detainee upon arrival. In an interview with the Intake Supervisor, the Lead Auditor was advised that should a detainee request an ICE Handbook in another language, one would be printed out for him and pointed out a few hand printed copies in other languages. She could not however, pull up the link needed to print the various languages not available on-site. The LPCC facility handbook provides detainees with information on the Agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse, as well as information on detainees' rights and responsibilities, available programs and services, and facility rules but it was only available in English, Spanish, and Punjabi. The facility also made available to the Auditors, the DHS-prescribed Sexual Assault Awareness Information pamphlet. The pamphlet is handed out at intake and is available in English and Spanish, which provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault; however, the pamphlet was not available in the other languages which are provided through ICE: Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. In an interview with the Intake Supervisor, the Lead Auditor was informed that the detainee is handed the pamphlet in English with the number to the OIG circled and is advised to call the number should they have any PREA-related questions. During the on-site visit, the Auditors were advised by the Intake Supervisor that a video, available in English, Spanish, Chinese, and Punjabi, is only played on DVD, as needed, in a small holding area that through observation could not accommodate a large intake of detainees. The video is also played in the housing unit, in English and Spanish daily, which is logged into the unit logbook when played. There is no accommodation, however, for detainees who do not speak the languages offered in the video. Policy 14-2-DHS states, "Detainee orientation and instruction must be in a language, or manner that the detainee understands, including for those who are LEP, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills." Interviews with line staff confirmed that a PREA video is presented in four languages: English, Spanish, Chinese, and Punjabi. However, staff could not account for the detainees who spoke a language not covered by the video, or if the detainee was deaf, visually impaired, or otherwise disabled. Of the 32 detainees interviewed by the Second Auditor, the majority indicated that they did not see the PREA video and indicated that "staff told them to look at the number on the poster and call it.

Does Not Meet (a)(b)(c)(e)(f): The Lead Auditor, through both interviews and on-site observation, determined that the PREA intake information is not provided to detainees as required by subparts (a, b, c, e, and f) of the standard. Although the facility has the detainee sign a Detainee Summary Form as required by subpart (c) of the standard, the form does not reflect what actually occurs during the intake process nor if the detainee received the handbooks in a language they understand. While touring detainee intake processing, the Audit Team confirmed that the facility did not have readily available copies of ICE National Detainee Handbooks, and/or, the DHS-prescribed Sexual Assault Awareness Information pamphlet in languages the agency had available to ensure all detainees were given access to information in a language they could understand. In an interview with the Intake Supervisor, the Lead Auditor was informed that the detainee is handed the pamphlet in English with the number to the OIG circled and advised to call the number should they have any PREA related questions. The facility must ensure that detainees are informed about the Agency's and the facility's zero-tolerance policies for all forms of sexual abuse that addresses standard elements in (a) and document the process properly. The PREA orientation must be documented and provided in a language or manner the detainee understands. The Auditor will request intake lists from various days to select random detainee files for compliance review on the PREA orientation process.

Corrective Action Made (a)(b)(c)(e)(f): The facility submitted 10 LEP detainee intake files reflecting that the PREA orientation was documented and provided in a language or manner the detainee understands. The facility is now in compliance with standard 115.33. Per documentation provided by the facility, there have been no detainees received at the facility, during the CAP period, who are deaf or hard of hearing, blind or have low vision, or have intellectual, psychiatric, or speech disabilities, and therefore, they are unable to provide 10 detainee files that confirm they were providing access to orientation during the intake process. The facility is now in compliance with subsections (a)(b)(c)(e)(f) of the standard.

§115. 41 - Assessment for risk of victimization and abusiveness

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

Notes:

Does Not Meet (e): According to the Lead Auditor's interviews with the Classification Supervisor and Lead Investigator, although reassessment of a detainee's risk level for victimization or abusiveness is conducted by the appropriate case manager following an incident of sexual abuse, utilizing the Sexual Abuse Screening Tool, it is not completed within the requirement of 24 hours as dictated by PBNDS 2011. In addition, the Lead Auditor reviewed seven investigative files while on-site and further confirmed that the completion of the reassessments following an incident of sexual abuse are in fact untimely. Therefore, section (e) of the standard is non-compliant. To become compliant the facility must provide, if available, a sample of sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse. In addition, the facility must provide confirmation that both the classification staff and investigators have received training regarding the requirement to complete the reassessment within 24 hours following the incident.

Corrective Action Taken (e): Based on new guidance from ERO, the 24-hour requirement in the PBNDS-2011 does not apply to the reassessment required following an incident of abuse or victimization. Based on this new guidance and previous misinterpretation, this provision is no longer a deficiency. The facility is now in compliance with subsection (e) of the standard.

§115. 63 - Reporting 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): Policy 14-2-DHS requires "when facility staff becomes aware of any allegation of sexual abuse that took place while the alleged victim was at another facility, the facility is to contact the facility head or appropriate office of the facility where the alleged abuse took place as soon as possible, but no later than 72 hours after receiving the allegation information. All such contacts and notifications shall be documented on the 5-1 B Notice to Administration (NTA)." Out of the 17 detainee files reviewed, the Lead Auditor discovered 5 intake screenings in which the detainee alleged sexual abuse at another facility. Upon review, four out of five investigation files confirmed the facility failed to document the allegations as required. During the on-site visit, the facility presented the Lead Auditor with a Continuous Improvement Plan of Action dated 7/18/19 covering the standard deficiency; however, all four incidents occurred post training.

Does Not Meet (a)(b)(c): Although the facility noted that a Continuous Improvement Plan of Action, dated 7/18/19, was needed to bring staff/contractors into compliance with sections (a)(b)(c) of the standard, they continued to show non-compliance with these subsections of the standard. Four out of five investigative files reviewed where a detainee reported a history of sexual abuse at another facility did not contain the required documentation. To come into compliance, the facility must further train its staff/contractors on the importance of notifying the facility where there is a sexual assault allegation reported to LPCC. In addition, if available, the facility must provide any investigative files that occurred following the on-site portion of the audit for compliance review.

Corrective Action Taken (a)(b)(c): The facility submitted documentation that staff completed training on the requirement that when a LPCC detainee reports a sexual assault occurring at another facility, that facility must be notified within 72 hours. Per documentation, provided by the facility, there were zero instances during the CAP period in which the facility was required to notify a facility of a sexual abuse incident that occurred while the detainee was housed at their facility. The facility is now in compliance with subsections (a)(b)(c) of the standard.

§115. 66 – Protection of detainees from contact with alleged abusers

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

Notes:

Policy 14-2-DHS requires "any staff, contractor, or volunteer suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of an investigation." The Warden confirmed he would remove anyone suspected of sexual abuse from the facility and from contact with any detainee. Of the 17 investigative files reviewed by the Lead Auditor, 7 files were determined to be staff/contractor-on- detainee. A review of six detainee investigative files indicated that the staff/contractors were removed of all duties requiring detainee contact; however, all staff/contractors were returned to duty once the facility determined the outcome of the investigation, and not when the outcome was determined by ICE OPR. Interviews with the Warden and Investigator confirmed that the staff/contractor is

separated, following the allegation, and returned to duties requiring detainee contact, after consultation with the ERO OIC while the investigation is still officially an open investigation with the agency.

Does Not Meet: Through review of seven investigative files that involved staff/contractors and interviews with the Warden and Facility Investigator, it was confirmed that the facility returned staff/contractors to duties requiring detainee contact prior to the official outcome of the investigation. To come into compliance, the facility must change the current practice of returning the staff/contractor to duties requiring detainee contact from clearance by the Officer in Charge (OIC) to official outcome determined by ICE OPR. To confirm practice, the Lead Auditor will review all available staff/contractor-on-detainee allegations that occur following the on-site visit.

Corrective Action Made: The facility submitted a memo, dated 11/2021, requiring a staff member continue to be assigned to a non-contact post following an allegation of sexual abuse pending ICE conclusion of the allegation. The Auditor accepts the facility documentation for compliance. The facility is in compliance with standard 115.66.

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.

Sabina Kaplan June 3, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) June 3, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) June 3, 2022
Program Manager's Signature & Date