PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	8/9/2022	**To:**	8/11/2022
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Philadelphia
Field Office Director:	David O'Neill
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	114 North 8th Street Philadelphia, PA, 19107
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:	Berks County Residential Center		
Physical address:	1040 Berks Road Leesport, PA 19533		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	610-396-0310		
Facility type:	D-IGSA		
PREA Incorporation Date:	7/28/2014		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Executive Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	610-393-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	610-393-(b) (6), (b) (7)(C)

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 U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Berks County Residential Center (BCRC) was conducted on August 9-11, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA Standards for the audit period of February 7, 2020 through August 11, 2022. The facility's last PREA audit was February 4-6, 2020. The BCRC is a Berks County operated facility and operates under contract with the DHS/ICE, Office of Enforcement and Removal Operations (ERO). The facility processes adult female detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the BCRC are from Haiti, Venezuela, and Cuba. The facility does not house juveniles, males, or family detainees. The facility is located in Leesport, Pennsylvania.

On August 9, 2022, an entrance briefing was held in the BCRC conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing and then turned it over to the Auditor. In attendance were:

Berks County Staff
(b) (6), (b) (7)(C) Executive Director
(b) (6), (b) (7)(C) PSA Compliance Manager

ICE Staff
(b) (6), (b) (7)(C) Inspections and Compliance Specialist (ICS), OPR/ERAU
(b) (6), (b) (7)(C) ICS, OPR/ERAU

Creative Corrections
Thomas Eisenschmidt - Certified PREA Auditor

The Auditor introduced himself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. Approximately four weeks prior to the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's PAQ, agency and facility policies, and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA is 28.010, Sexual Abuse and Assault Prevention and Intervention (SAAPI). All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Auditor for the interviews with staff and detainees. The Auditor also reviewed the facility's website, https://www.co.berks.pa.us/Dept/BCRC/Pages/PREA.aspx. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels and in daily practice. He further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews.

On the first day of the audit, there were three female detainees housed at the BCRC. The current rated capacity for the facility is 96 female detainees. The detainee in-processing area consists of one large process room near the detainee entrance of the facility. This area has seating, toilets, telephones, and a monitor for PREA videos. Detainees remain here for a short time until taken to the medical area where the classification and intake process takes place. Posters are provided in each of the areas, consisting of the consulate contact information, the SAFE Berks (community advocate) contact information, DHS-prescribed ICE Sexual Abuse Awareness (SAA) information pamphlet and the DHS ICE Zero Tolerance for Sexual Abuse poster with phone and other contact information. The facility has two housing units (East and West) with a staff duty station between each of the units. Each of these sides has eight dorm type bedrooms accommodating four to six detainees. There are six showers within each location (East and West). There is always female staff assigned to each unit and signage requiring male staff to announce themselves before entering the hallway to each unit is provided. No male staff is permitted to enter a detainee room. The medical unit has three beds, and the facility has no segregation unit. (b) (7)(E) The Auditor reviewed each camera assigned to areas that monitored ICE detainees and found no privacy concerns. According to the PAQ and the interview with the PSA Compliance Manager, there are 50 county staff, 12 medical staff (IHSC), 2 mental health staff, and 5 contractors. Volunteers have not been at the facility for over two years.

At the conclusion of the tour, the Auditor was provided with staff and detainee rosters and randomly selected personnel from each to participate in formal interviews. A total of 25 staff were interviewed, including 12 random staff (line-staff and first-line supervisors) and 17 specialized staff positions held by 13 people. Those specialized interviews included the Executive Director, PSA Compliance Manager, Training Coordinator, Retaliation Monitor, Incident Review Team member, Intake staff (2), Orientation staff, non-security first responders (2), Grievance Coordinator, acting Assistant Field Office Director (AFOD), Food Service (2), Health Services

Administrator (HSA), Medical Practitioner, and Mental Health staff. A total of three random detainees were interviewed (all detainees present during the on-site audit days). All three detainees interviewed were limited English proficient (LEP) and required the use of a language line through Language Services Associates (LSA), provided by Creative Corrections. There were no transgender or intersex detainees available for interview at the time of the site visit. There were no allegations of sexual abuse reported at BCRC for the audit period.

On August 10, 2022, an exit briefing was held in the BCRC visiting room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing and then turned it over to the Auditor. In attendance were:

Berks County Staff
(b) (6), (b) (7)(C) Executive Director
(b) (6), (b) (7)(C) Program Director
(b) (6), (b) (7)(C) PSA Compliance Manager

ICE Staff
(b) (6), (b) (7)(C) ICS, OPR/ERAU
(b) (6), (b) (7)(C) ICS, OPR/ERAU
Lieutenant Commander (LCDR) (b) (6), (b) (7)(C) ICE Health Service Corps (IHSC) Nurse Manager/HSA

Creative Corrections
Thomas Eisenschmidt, Certified PREA Auditor

The Auditor spoke briefly about the staff and detainee knowledge of the BCRC PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit and that he would need to discuss his findings and review interviews conducted (staff and detainee) prior to making a final determination on compliance. The Auditor acknowledged how impressive the detainee orientation process was. The Auditor explained the audit report process time frames 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: 4
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.31 Staff training
§115.33 Detainee education
§115.35 Specialized training: Medical and Mental Health Care

Number of Standards Not Applicable: 2
§115.14 Juvenile and family detainees
§115.18 Upgrades to facilities and technologies

Number of Standards Met: 33
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations.
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 2
§115.43 Protective custody
§115.68 Post-allegation protective custody

PROVISIONS

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

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

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

Notes:

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 28.010 stating, "It is the policy of the Berks County Residential Center (BCRC) to adhere to a standard of zero-tolerance for sexual abuse and assault of residents and staff." This policy provides definitions of prohibited behavior, the means to report it, consequences for violations, training of staff and training for detainees. The Executive Director confirmed that this policy was reviewed and approved by the agency and provided the Auditor with documentation of this policy review by the agency. The informal and formal questioning of staff and detainees indicated they were aware of the facility's zero-tolerance policy on sexual abuse.

(d) The Auditor determined compliance with this subpart of the standard based on review of policy 28.010, that states, "This facility has a designated PSA Compliance Manager who serves as the facility point of contact for the ICE PSA Coordinator. The PSA Compliance Manager has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures." The PSA Compliance Manager was questioned about her duties, and she informed the Auditor that she has sufficient time and authority to effectively complete her duties as the PSA Compliance Manager at BCRC. She also indicated she is the point of contact for the agency's PREA Coordinator. A review of the facility organizational chart confirmed her position as a direct report to the Program Director.

§115.13 – Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) The Auditor was provided the staffing plan for each shift at BCRC. The Auditor also reviewed the staff rosters, medical staff rosters, post orders, interviewed each shift supervisor, and interviewed the Executive Director about staff coverage for detainees and made personal observations during the site visit. The Auditor was informed by the Executive Director that the number of security positions is established by Berks County and ICE during the contract discussions based on the number of detainees. She also stated that staffing at BCRC is modeled after direct supervision utilizing staff and cameras to protect detainees. If a detainee is in any area, there is a staff member present. BCRC has three shifts, eight hours each, and during the site visit the Auditor observed adequate detainee supervision. The facility stated that they considered, as part of their staffing development, subpart (c) requirements as part of this review. The Auditor was provided a memorandum from the Executive Director stating that the last staffing review was conducted in December 2021 and that the next would be completed in December 2022.

Recommendation: The Auditor recommends that BCRC include, as part of its future documented staffing and guidelines reviews, the specific information that was considered during the review, which may include elements of subpart (c) requirements.

(d) The Auditor determined compliance with this subpart based on review of policy 28.010 that requires, "Supervisors shall conduct and document unannounced rounds covering all shifts, and all areas of the facility, to identify and deter staff sexual abuse or harassment. This policy prohibits staff members from alerting other staff as to when or where these rounds are occurring, unless related to the legitimate operational needs of the facility." Supervisors from each shift were interviewed and each of them confirmed rounds are made on their shift of all area detainees have access. They also indicated rounds are made at random times and random locations. The Auditor reviewed random entries made in the supervisors' logbook as well as the review of random PREA unannounced documentations sheets. Each of the 12 random security staff interviewed during the site visit confirmed supervisors make frequent rounds in their areas. They also acknowledged their understanding of the policy restriction prohibiting them from alerting other staff that supervisors were making rounds.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

BCRC does not accept juveniles or family detainees. This was confirmed in the PAQ and with interviews conducted with the Executive Director, PSA Compliance Manager, and personal observations while onsite; therefore, this standard is not applicable.

§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) This subpart does not apply to BCRC as it only accepts adult female detainees.

(c)(d) The Auditor determined compliance with this subpart of the standard based on review of policy 27.010, Search of Detainees, that requires, "A pat-down is an inspection of a resident, using the hands. The staff uses their sense of touch when patting or running

the hands over the clothed resident's body. It is considered the least intrusive of the body searches and must only be conducted by a staff member of the same gender. Only in an exigent circumstance will the opposite gender staff be utilized to conduct a pat search. This will be approved by the Executive Director and documented." The Auditor interviewed 12 security staff (7 females and 5 males) during the site visit. Each was aware of the policy and requirements for approval and documentation for any cross-gender pat searches performed. The PAQ and documentation provided to the Auditor by the PSA Compliance Manager indicated that cross-gender pat-down searches were not conducted at BCRC during the audit period. The PSA Compliance Manager indicated that cross-gender searches would be documented in a logbook if performed. The three detainees interviewed confirmed that they were never searched by a male staff member.

(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 27.010 that requires, "A strip search, also referred to as a visual search may not be authorized or conducted without the explicit consent of the ICE facility administrator. A strip search shall only be conducted by two (2) ICE/ERO personnel members of the same gender as the resident and only under circumstances where it can be shown that a life or public safety issue is clearly established. In every instance where it is established that a foreign object is located within a body cavity, only a qualified medical authority shall be authorized to locate and remove the object. Only ERO in conjunction with the Field Office Director can authorize this type of search." BCRC has no juveniles. The Executive Director confirmed that no BCRC staff would conduct a strip search. Those searches would be done by ICE staff and IHSC staff and be documented. Interviews with the Executive Director, PSA Compliance Manager, and the review of the PAQ confirmed BCRC had no instances of cross-gender strip searches or body cavity searches conducted during the audit period.

(g) The Auditor determined compliance with this subpart of the standard based on review of policy 20.030, Personal Hygiene, that requires, "Staff will allow residents to shower, perform bodily functions, and change clothing without being viewed by any staff, except in the event of exigent circumstance or when such viewing is incidental to a room check. When staff of the opposite gender are entering an area where resident are likely to be changing their clothing, performing bodily functions, or showering, a "knock and announce" must be conducted. Staff must state "male entering or female entering." This also applies if you are with another staff." During the tour of the facility, the Auditor observed signage, at the entrance of each of the living area hallways, reminding cross-gender staff to make announcements prior to entering the hallway to the rooms. Male staff are not allowed in any female room except in an emergency response. The three female detainee interviews confirmed that male staff announce themselves prior to entering into their housing unit hallways. The review of the camera system and observations during the site visit revealed no privacy concerns with the shower or toilet areas. The interview with the Executive Director and PSA Compliance Manager stated that the monitored bowel movement or connection with a medical examination exception to cross-gender viewing is in place at BCRC and will be added to the updated policy.

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

(i) The Auditor determined compliance with this subpart of the standard based on the interviews with the Training Coordinator and the 12 random security staff. The Training Coordinator confirmed that search training staff receives includes the prohibition, of all staff, from physically examining a detainee for the sole purpose of determining their genital characteristics. The 12 random staff confirmed to the Auditor this prohibition and stated that the search training they receive covers this restriction.

(j) The Auditor determined compliance with this subpart of the standard based on review of policy 27.010 that requires, "Searches of residents (with Facility Administrator authorization), housing, and work areas will be conducted without unnecessary force and in ways that, insofar as is practical, preserve the dignity of residents. All searches will be conducted in a professional manner." The Auditor was provided and reviewed the search training curriculum for security staff at BCRC. This curriculum covered proper techniques for conducting all pat searches including cross-gender, transgender, and intersex detainees in a least intrusive, professional, and respectful manner, that addressed the standard requirements. The Auditor reviewed eight security staff training files and found completed search training documentation in each of their files. According to the Executive Director, BCRC receives no transgender detainees and there were no intersex detainees at the facility during the audit period. Interviews with each of the three detainees confirmed that if searched, they were conducted in a professional and respectful manner.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of policy 28.010 that requires, "During intake and orientation, residents will be provided with information on how to access outside community resources related to sexual abuse. During orientation, residents will receive education on sexual abuse and harassment (Prevention, detection and reporting etc.). This will also be provided in the resident's main language via an interpreter or through language services." At the time of the site visit, there were no detainee arrivals at BCRC. Two intake staff briefed the Auditor about the detainee arrival process. According to them, each detainee, upon arrival at BCRC, receives an initial briefing on sexual safety, sick call operation, use of the phone and use of the tablet. Each of these two staff also confirmed that detainees with disabilities (to include those 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 the ability to benefit and participate in all aspects of the BCRC's efforts to prevent, detect, and respond to sexual abuse. They stated that each detainee arriving at BCRC is provided the BCRC Facility Handbook in Spanish and English, DHS-prescribed SAA information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed SAA information pamphlet is available in nine languages (English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi). The ICE National Detainee Handbook is available in 14 of the

most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). During specific questioning by the Auditor, the two intake staff stated that if they encounter a detainee who is hearing impaired, detainee information is predominately written information and is provided to them in this format or through use of one of the text telephones (TTY). If during the intake process, they encounter a detainee with limited sight or blindness, the detainee would receive the information orally either through a staff member or through the audio portion of the orientation and sexual safety videos. These intake staff indicated that if they were to encounter a detainee with low intellect, mental health concerns, or limited reading skills, staff would assess the detainee to determine their specific needs and then provide information orally, written format or in a manner that ensures their understanding of the material. Both these intake staff also indicated that they deal with limited English proficient (LEP) detainees on a daily basis and utilize their pocket translators for minor issues and the contracted interpretive language service to assist them with interviews if a staff interpreter is not available. Within 24 hours of the detainee arrival, she is presented with an in-depth overview of the facility efforts to prevent detect and respond to sexual abuse. Included in this overview is a facility orientation. All detainees, regardless of the language she speaks, must attend this presentation. The Auditor reviewed these presentation materials and reviewed documentation demonstrating the use of interpreter services during the presentation. This orientation is documented and acknowledged by signature of the detainee. The Auditor interviewed three detainees, and each confirmed the initial briefing on arrival and in-depth presentation within a day. The review of 10 detainee files confirmed the signed acknowledgement of the orientation and receipt for arrival documents. The Auditor feels the facility exceeds the standard requirements with this process.

(c) The Auditor determined compliance with this subpart based on interviews conducted with the 12 random staff. Each of their interviews confirmed their knowledge that the use of staff interpreters or contracted interpreter services is appropriate and that the provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. There were no allegations of sexual abuse reported at BCRC for the audit period.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(e)(f) The Auditor determined compliance with these subparts of the standard based on review of Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive that collectively require, to the extent permitted by law, to decline to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity as outlined above. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in November 2021 that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. During the site visit, the Auditor interviewed the BCRC Human Resources Manager (HRM), who detailed the hiring procedure for the facility. She indicated that BCRC follows the ICE hiring guideline for all employees and when a vacancy occurs the job is posted on the Berks County web site. The individual submits an application and if he/she meets the position criteria, an interview is scheduled. During the interview, the individual is asked directly about any misconduct outlined in subpart (a) of the standard. If he/she responds affirmatively to those questions, the person does not go any further in the hiring process. Once the interview is concluded, a State Police background is conducted. If that investigation is successful, the individual goes through the ICE hiring and approval process. She further stated that during the thorough ICE background investigation, the persons entire employment record would be scrutinized. According to the HRM, BCRC would terminate employment and withdraw any offer of employment based on material omissions regarding such misconduct under subpart (a), or the provision of providing materially false information. She also stated that as a condition of employment, each employee has a continuing affirmative duty to disclose to either her or their supervisor any behavior outlined in subpart (a) and confirmed that any employer requesting information about a former employee would only be told if he or she would be rehireable by her; however, she would refer any specific requests about prior investigations for substantiated allegations to the County Attorney to respond. As noted throughout the report, 12 random staff were interviewed, and each was aware of this duty to report. The Auditor also reviewed 10 employee files and found ICE approvals to hire the staff member as well as a signed self-declaration that the employee has not engaged in behavior outlined in subpart (a) of the standard and as required by policy to comply with their duty to report. One of the 10 files reviewed was a current promotion. The Auditor noted a current disclosure form was present in this individual's file as well.

(c)(d) The Auditor determined compliance with these subparts of the standard based on the HRM interview that confirmed ICE completes background checks for all staff and contractors prior to hiring them and then again, every five years. Review of documentation provided by ICE's PSO confirmed that the 10 employees (7 facility staff and 3 ICE staff) randomly selected for review had background checks performed prior to hiring. This documentation also confirmed the due dates for the five-year background rechecks. The Auditor determined the provided background check information was compliant with the standard requirement.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

This standard subpart is not applicable as the Executive Director and PAQ confirmed that BCRC did not expand the facility or add additional video equipment during the audit period.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on review of policy 28.010 that requires, "To the extent, Bern Township is responsible for investigating allegations of sexual abuse, it shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." The Warden, and PSA Compliance Manager discussed the policy and procedures for conducting investigations at the BCRC facility are outlined in policy 28.010, as approved by ICE. The agency's Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. Policy 11062.2 requires when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS OIG, OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted. There were no allegations reported at BCRC for the audit period.

(b)(d) The Auditor determined compliance with these subparts of the standard based on the letter to BCRC from SAFE Berks and the brochure from this advocacy group outlining their program. The letter acknowledges no MOU between them and the facility but indicates it would provide information and services to BCRC detainee victims of sexual abuse, including access to a victim advocate for emotional support services during any forensic examination and any law enforcement interviews. Interviews with medical staff and the PSA Compliance Manager confirmed all victims at BCRC would be provided information about SAFE Berks upon receiving the allegation. The Auditor observed this advocate information posted in the detainee living areas. There were no allegations reported during the audit report period.

(c) The Auditor determined compliance with this subpart of the standard based on interviews with Berks IHSC medical staff and review of a letter from St. Joseph Medical Center in Leesport, Pennsylvania. There is no MOU with St. Joseph Medical Center. The medical staff interviews confirmed all victims of sexual assault at BCRC are taken to St. Joseph Medical Center for any forensic examinations. The HSA confirmed that although there is no MOU with the St Joseph Medical Center, detainee victims would be sent there for forensic examination by a SANE practitioner at no cost to the detainee. She also stated the facility had no forensic examinations during the audit period. A letter provided to the Auditor from the hospital to BCRC IHSC staff confirmed they have SANE practitioners to perform the examination.

(e) The Auditor determined compliance with this subpart of the standard based on review of Policy 28.010 that requires, "To the extent the facility is not responsible for investigating allegations of sexual abuse, it shall request that the investigating agency follow the requirements of this section." The Auditor was provided and reviewed a letter from the Bern Township Police Department (BTPD) that stated they will criminally investigate allegations of sexual assault occurring at BCRC and comply with subparts (a) through (d) of this standard. As noted earlier, there were no reported sexual abuse allegations made at BCRC during the audit period.

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

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

Notes:

(a)(b)(c) Policy 28.010 requires, "It is the facility[y's] policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. Bern Township Police will conduct its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Bern Township shall retain all written reports required by this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. The facility shall ensure that an administrative investigation is completed for all allegations of sexual abuse and sexual harassment."

As the facility is not responsible for conducting administrative or criminal investigations, the agency policy 11062.2 is the ruling policy which outlines the investigative protocols for the agency. The policy further outlines the responsibilities of the DHS investigative entities, OPR, and the facility. The agency's policy 11062.2 includes that documentation of all reports and referrals of allegations of sexual abuse be maintained for at least five years. The agency's protocol is posted on the agency's website; https://www.ice.gov/prea. The website includes information on the agency's PREA overview, PREA policies, reporting methods with

addresses and phone numbers, SAAPI standards, ICE National Detainee Handbook, ICE PREA Zero Tolerance poster, and Sexual Abuse and Assault Awareness pamphlet.

The Director and PSA Compliance Manager confirmed that all allegations of sexual abuse are reported to the BTPD and to the JIC. The JIC routes the allegation for assessment, to determine if it falls within the PREA purview. The PREA allegations are then referred to DHS OIG or OPR. DHS OIG has the first right of refusal on all employee-, volunteer-, or contractor-on-detainee sexual abuse allegations. Once the allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused by DHS OIG, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Investigative Inquiry Unit (AIU) for action, and the agency would assign an administrative investigation to be completed. There were no allegations of sexual abuse reported during the audit period. Interviews with the PSA Compliance Manager and Executive Director confirmed the facility has no trained investigator and conducts no administrative investigations. The facility had no allegations of sexual abuse or harassment reported within the audit period; therefore, no documentation was available for review by the Auditor to demonstrate the practice.

(d)(e)(f) The interviews with the Executive Director and PSA Compliance Manager confirmed that the AFOD and SDDO are both notified of every allegation of sexual abuse occurring at BCRC. The Auditor interviewed the acting AFOD who confirmed once notified of a sexual abuse allegation occurring at BCRC, he is responsible for making all the ICE notifications, including to the JIC. There were no allegations of sexual assault reported at BCRC during the audit period.

Recommendation (d)(e)(f): The Auditor recommends that the reporting and notification requirements listed in subparts (d)(e)(f) be included in the facility's policy 28.010.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor determined compliance with this subpart of the standard based on review of policy 28.010 that requires, "All staff will be trained on recognition, procedures, prevention, and protocols related to physical and sexual abuse and assault. Training must include: definitions and examples of prohibited and illegal behavior; DHS prohibitions on retaliation against residents and staff who report sexual abuse including housing changes, removal of alleged staff or detainee abusers from contact with victims, emotional support services for detainees or staff that fear retaliation for reporting sexual abuse or for cooperating with an investigation; instructions that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; recognition of the physical, behavioral, and emotional signs of sexual abuse and/or assault and ways to prevent such occurrences; the investigation process and how to protect evidence; prevention, recognition, and appropriate response to allegations or suspicions of sexual assault involving residents with special needs; instruction on reporting knowledge or suspicion of sexual abuse and/or assault and how to make intervention referrals to the facility's IHSC unit; and instruction on documentation and referral procedures of all allegations or suspicions of sexual abuse and/or assault. The Executive Director shall maintain all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling for 5 years. These records shall be maintained in individual, confidential, incident files. All such files will be retained in accordance with established schedules. The ICE Residential Standard on Medical Care and the requirements of the ICE Residential Standard on Detention files will be followed. The Executive Director will keep two types of files. The two types of files will be kept separately. General files shall include: The name, A number, date of birth, and country of birth of the (alleged) victim(s), and (alleged) assailant(s) of a sexual assault; Crime characteristics; Detailed reporting timeline, including the name of the staff member receiving the report of sexual assault, date and time the report was received, and steps taken to communicate the report up the chain of command; and all formal and/or informal action taken. Investigative files shall include: All reports; Medical forms; Supporting memos and videotapes, if any; and any other evidentiary materials pertaining to the allegation. The Executive Director shall maintain these files chronologically in a secure location." The Auditor determined compliance with these subparts of the standard based on review of training curriculum, review of training files and interviews with staff. The Training Coordinator was interviewed and confirmed all BCRC staff completed SAAPI training in 2021 and signed the Training Acknowledgement form. He also provided the Auditor with the PREA training curriculum that is presented to all staff including contractors. A review of this curriculum demonstrated it covers each of the subpart (a) requirements. The interviews with the 12 BCRC staff and 1 ICE staff member confirmed that each receives SAAPI training annually and detailed the material provided. The Auditor reviewed 10 BCRC staff training files and noted current SAAPI training documented. Contractors receive training on the same SAAPI curriculum all BCRC staff received. The PAQ lists the CURA Group as a food contractor providing services every day; therefore, for purposes of this audit, these employees fall under 115.31 instead of 115.32. The Auditor interviewed two of these staff and reviewed their training records and found a signed Training Acknowledgement form in each of their files. The Auditor also reviewed certificates of SAAPI training for 10 ICE staff. The Auditor feels the facility exceeds the standard, as the standard requires refresher training every two years and the facility documentation and interviews confirmed the SAAPI refresher training is completed annually.

§115.32 - Other training.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on review of training curriculum and interviews with the Training Supervisor and Executive Director. BCRC currently has no volunteers or contractors as defined under subpart (d) of the standard.

§115.33 - Detainee education.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c)(e)(f) The Auditor determined compliance with these subparts of the standard based on review of policy 28.010 that requires, "During intake and orientation, residents will be provided with information on how to access outside community resources related to sexual abuse. During orientation, residents will receive education on sexual abuse and harassment (Prevention, detection and reporting etc.). This will also be provided in the resident's main language via an interpreter or through language services." At the time of the site visit there were no detainee arrivals at BCRC. Two intake staff briefed the Auditor about the detainee arrival process and orientation. According to them each detainee, upon arrival at BCRC, receives an initial briefing on sexual safety, sick call operation, use of the phone and use of the tablet. Each of these two staff also confirmed that detainees with disabilities (to include those 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 the ability to benefit and participate in all aspects of the BCRC's efforts to prevent, detect, and respond to sexual abuse. They stated that each detainee arriving at BCRC is provided the BCRC Facility Handbook in Spanish and English, the DHS-prescribed SAA information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed SAA information pamphlet is available in nine languages (English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi). The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). During specific questioning by the Auditor, these two staff stated that most of the PREA information provided to detainees is in written format, which could be provided to a detainee who is hearing impaired, although they have not encountered that situation before. They could also provide the PREA information through the use of one of the text telephones (TTY). If during the intake process, they encounter a detainee with limited sight or blindness, the detainee would receive the information orally through a staff member or through the audio portion of the orientation and sexual safety videos. They indicated that if they were to encounter a detainee with low intellect, mental health concerns, or limited reading skills, staff would assess the detainee to determine their specific needs and then provide information orally, written format or in a manner that ensures their understanding of the material. Both these intake staff also indicated that they deal with LEP detainees on a daily basis and utilize their pocket translators for minor issues and use the contracted interpretive language service to assist them with interviews if a staff interpreter is not available. Within 24 hours of the detainee arrival, she is presented with an in-depth overview of the facility efforts to prevent detect and respond to sexual abuse for a second time along with a facility orientation regardless of the language she speaks. The Auditor reviewed the presentation materials, which at a minimum address the six subpart (a) requirements, and documentation of the use of interpreter services for a presentation. This orientation is documented and acknowledged by signature of the detainee. This process is the same for detainees speaking English. The Auditor interviewed 3 detainees, and each confirmed this process and confirmed that they received the sexual safety and orientation information. The review of 10 detainee files confirmed the signed acknowledgement. The Auditor feels the facility exceeds the standard requirements with this process.

(d) The Auditor determined compliance with these subparts of the standard based on the interview with the PSA Compliance Manager who indicated BCRC posts the DHS prescribed sexual awareness notice with her name, as the PREA Compliance Manager, on each and is posted in every area of the facility detainees have access to. During the onsite visit, the Auditor observed these postings in each of the housing units and the name and contact information for SAFE Berks throughout the BCRC facility. Interviews with the detainees confirmed their knowledge of the PSA Compliance Manager and the postings.

§115.34 - Specialized training: Investigations.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of Agency policy 11062.2, which states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The Auditor reviewed the ICE OPR Investigating Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to investigate sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The agency provides rosters of trained investigators and the specialized training curriculum on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirements. There were no allegations of sexual abuse at BCRC during the audit period. Interviews with the PSA Compliance Manager confirmed the facility has no trained investigator and conducts no administrative investigations.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after a review of IHSC Directive 03-01, Sexual Abuse and Assault Prevention and Intervention that requires "in addition to the general training provided to all employees, the agency shall

provide specialized training to DHS or agency employees who serve as full and part-time medical practitioners or full and part-time mental health practitioners in immigration detention facilities where medical and mental health care is provided." The HSA confirmed the specialized training covers all four elements outlined and required in subpart (b) of the standard; how to detect and assess signs of sexual abuse; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; and how and to whom to report allegations of sexual abuse. She also confirmed medical staff at BCRC are prohibited from conducting forensic examinations. If a forensic examination would be required, the detainee is sent to the St. Joseph Medical Center where a SANE will examine the victim. Interviews with medical and mental health staff indicated they received this additional specialized training and do so on an annual basis. The HSA confirmed all medical and mental health staff receive this training annually and are currently up to date. The Auditor randomly chose two medical training files and verified this training was received. The Auditor determined the facility exceeds the specialized training requirement as the standard only indicates the training is a one-time event and the facility requires it annually.

(c) The Auditor determined compliance with this standard subpart based on the interviews with the HSA and the PSA Compliance Manager, who indicated the agency reviewed and approved the facility's policy and procedures for examining and treating victims of sexual abuse.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d)(e) The Auditor determined compliance on these subparts of the standard after a review of policy 28.010 and Local Operating Procedures (LOP) 00-02 that require detainees arriving at BCRC receive a risk assessment, utilizing the criteria outlined in subparts (c) and (d). The facility is also required to conduct reassessments in compliance with subpart (e). The risk assessment, which is part of the classification process, is performed by the medical staff on the PREA Risk Classification form. This form was reviewed and found to comply with the subparts (c) and (d) requirements of this standard. The HSA confirmed detainees are kept separate from general population until the entire classification process is completed, which is typically done within the first couple hours but never beyond 12 hours. She also confirmed that vulnerability assessments at BCRC are completed according to policy and standard requirements. Ten random detainee files were reviewed during the onsite visit. The Auditor observed completed risk assessments conducted utilizing this form on the day of the detainee's arrival. The interview with the three detainees confirmed their classification and risk assessments were completed within their first couple hours after arriving at BCRC. The three detainees also confirmed that they remained in the medical area until the process was complete. None of the 10 detainee files reviewed were for detainees held at BCRC beyond 90 days. The Auditor was provided documentation of a completed 60-90 day reassessment by the medical department. There were no detainee allegations of sexual abuse made during the audit period.

(f) The Auditor determined compliance with these subparts of the standard based on interviews with the IHSC HSA and medical staff. The HSA and medical practitioner who completes these vulnerability assessments confirmed detainees are not to be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked about whether the detainee has a mental, physical, or developmental disability; identifies as LGBTI or gender non-conforming; experienced prior sexual victimization or has any concerns about [their] physical safety.

(g) The Auditor determined compliance with these subparts of the standard based on interviews with IHSC HSA and the PSA Compliance Manager who informed the Auditor that completed PREA Risk Classification form are maintained in the detainee's medical file and detention file under double lock and restricted key.

§115.42 - Use of assessment information.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard after a review of policies 28.010 and LOP 00-02 that collectively require the use of information from the risk assessment under 115.41 to inform assignment of detainees to housing recreating and other activities, and voluntary work. LOP 00-02 states, "The purpose of this issuance is to set forth local policies and procedures for Berks ICE Health Service Corps (IHSC) staff regarding the initial assessment and classification of all detainees for the risk of victimization and or abusiveness, as well reassessment of all detainees every 60-90 days during their detention. This issuance will also provide guidance on housing and management of detainees identified as vulnerable to potential victimization, as well as detainees demonstrating potentiality of abusiveness. Residents will be screened upon intake for risk of sexual victimization or abusiveness and housed accordingly. Once notified of a resident(s) with a history of sexual abuse or assault, reasonable efforts will be made to accommodate the temporary placement of the resident(s). The facility may or may not be able to facilitate long term care depending on the circumstances of each individual case. Immigration Health Service Corp (IHSC) will identify potential residents with risk and immediately notify BCRC with instructions for care." The Executive Director, PSA Compliance Manager and HSA confirmed BCRC does not accept detainees with any type of violent history. She also stated that if she were to receive any detainee with a history of violence, she would either place them in the medical bed or utilize a vacant room on the East or West housing unit. She also stated she would immediately notify the AFOD to help expedite the detainee's movement to another facility. The Case Manager and HSA indicated that detainee housing, recreation, work programs, and other activities are made on each individual detainee's risk assessment and classification based on the collective information obtained from both the medical portion of the screening and the classification portion. The Case Manager does the final review of the combined information to ensure proper housing, recreation,

work, programs, and other activities decisions are made. As noted earlier, 10 detainee detention files were reviewed, and the auditor observed the initial assessment and classification documents that demonstrated individualized determinations being conducted.

(b)(c) The facility provided documentation to the Auditor from the AFOD that indicated BCRC does not accept transgender or intersex detainees. If a detainee were to disclose upon arrival to the facility identification as transgender or intersex, the FOD would be notified immediately to determine next steps.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e) The Auditor determined compliance with these subparts of the standard after a review of policy 28.010 that requires, "BCRC is a residential center, we do not have a formal locked segregation unit. However, should a need arise to protect or isolate a resident due to sexual abuse assault or vulnerability, the residents shall be placed in the least restrictive housing that is available and appropriate. Residents will be offered daily recreation, access to legal and phone calls. If appropriate housing options are not available, the BCRC will consult with the ICE Field Office Director to determine if ICE can provide additional assistance. Residents may be assigned to the administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. The facility will conduct a review within 72 hours of resident placement to see if placement is still warranted. Facility will notify ICE no later than 72 hours after initial placement into segregation on the basis of vulnerability to sexual abuse or assault." As noted in policy and based on Auditor observation, BCRC has no secure segregation. The interview with the Executive Director confirmed that, if necessary, she would place a vulnerable detainee in medical. She also stated that she would notify the AFOD of such placement and have the detainee's placement reviewed as required by subpart (d). BCRC has had no incidents requiring the placement of any detainee in the medical unit for vulnerability concerns during the audit period

(d) This subpart requires "A supervisory staff member shall conduct, at a minimum, a placement review after the detainee has spent seven days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter." BCRC's policy or practice does not address this requirement.

Does Not Meet (d): To become compliant, the facility must include this requirement in their written protocols and notify affected staff of these requirements. Documentation of revised protocols and notification to affected staff must be provided to the Auditor for compliance review.

§115.51 - Detainee reporting.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on review of policy 28.010 that requires, "During orientation, residents will be informed of the multiple ways to privately report sexual abuse, retaliation, staff neglect, or violations of responsibilities. For example, but not limited to: ICE/ERO, OIG, Medical/ Mental Health, filing a "time-sensitive" grievance, contacting outside resources." Detainees arriving at BCRC receive reporting information through the BCRC Facility Handbook, ICE National Detainee Handbook, the DHS-prescribed SAA Awareness information pamphlet and posted signs throughout the facility. Information on reporting is also posted prominently through the facility including by the detainee telephones. The 3 detainees interviewed all confirmed their knowledge of how to report allegations of sexual abuse. The 10 detainee files reviewed demonstrated signed copies of receipt of these materials. ICE has established the following reporting methods: Directly report to the [DHS OIG] complaint hotline toll-free telephone number at 1-800-323-8603 (this number also has an option to report outside of ICE); Contact the ICE Detention and Reporting Information Line (DRIL) toll-free telephone number 1-888-351-4024 or 9116#; Tell an ICE/ERO staff member who visits the facility; Write a letter reporting the sexual misconduct to the ICE [OIC], ICE AFOD, or ICE FOD using special mail procedures; File a written formal request or emergency grievance to ICE; Contact ICE OPR JIC toll-free hotline number 1-877-246-8253; By mail to DHS OIG, Office of Investigations Hotline; 245 Murray Drive, SW, Building 410/Mail Stop 0305, Washington, DC 20528. The Auditor tested the telephone reporting line on two telephones and found both operational and that they can be utilized without a detainee PIN.

(c) The Auditor determined compliance with this subpart of the standard based on review of policy 28.010 that requires, "Staff will accept sexual abuse reports from residents in the following ways: verbally, in writing or anonymously and from third parties. Staff will privately and promptly document all verbal reports and notify a supervisor immediately of any reports received." The Auditor interviewed 12 random staff who confirmed their knowledge of the facility policy requirement that they are to accept and immediately report allegations of sexual abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors for investigation referral. There were no allegations of sexual abuse made at BCRC during the audit period.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after a review of policy 11-0.10, Grievance Process, that requires upon admission, detainees are notified that the resident handbook containing the copy of their rights and responsibilities can be found on the facility tablet. They are informed the handbook outlines the procedure by which the resident may file an informal, formal, or emergency grievance with the facility for any alleged violations of their rights without fear of retaliation. The

policy also requires the detainee be able to file an emergency grievance either orally or in writing for matters that involve an immediate threat to their safety or welfare. Emergency grievances will receive immediate attention and the report of resolution will be forwarded to the Executive Director. The policy requires detainees be informed that they may file a formal grievance at any time. The policy also requires staff respond to emergency grievances/ time sensitive grievances in an expeditious matter and that once the staff receiving staff receives the information pertaining to an immediate threat to a resident's health, safety or welfare related to sexual abuse, the receiving staff will immediately notify on-duty Supervisor. The policy informs detainee that to prepare a grievance, the detainee may obtain assistance from another detainee in the same housing unit, the housing staff, other facility staff, or legal representatives. The policy also details that the Program Director will conduct an investigation into the grievance's complaint. And upon the completion of the investigation, shall provide the detainee with a written response which includes the final disposition of the grievance and the reason for the disposition in five business day and will respond to an appeal of the grievance decision within 30 calendar days. The interview with the Program Director confirmed there are no time limits when a detainee may file a grievance related to sexual abuse and that each is handled as an emergency grievance. He indicated he responds to these type grievances in compliance with the subpart (e) requirements. He also stated all facility staff are trained to bring medical emergencies to the immediate attention of medical personnel for assessment. He further informed the Auditor that he provides the grievance decision and any appeals to the Executive Director and the AFOD. Staff interviews confirmed their awareness that a detainee is allowed to receive assistance from another detainee, the housing officer or other facility staff, family members, or legal representative to prepare a grievance and their proper response to the subpart (d) requirements. The facility had no sexual abuse allegations reported during the audit period.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance on these subparts of the standard after a review of policy 28.010 that states, "During intake and orientation, residents will be provided with information on how to access outside community resources related to sexual abuse." As noted in standard 115.21, BCRC does not have an MOU with SAFE Berks, the community advocate service. The Auditor was provided a letter from the advocate that acknowledges no MOU exists between them and the facility but indicates it would provide information and services to BCRC detainee victims of sexual abuse. Services would include access to a victim advocate for emotional support services for victims, support during any forensic examination and any law enforcement interviews. SAFE Berks is not a reporting agency. Interviews with medical staff and the PSA Compliance Manager confirmed all victims at BCRC would be provided information about SAFE Berks upon becoming aware of the allegation. The Auditor observed this advocate information posted in the detainee living areas. The BCRC Handbook informs the detainee the extent to which the calls are monitored.

§115.54 - Third-party reporting.

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

Notes:

The Auditor determined compliance with the standard after a review of policy 28.010 that requires, "Instructions on 3rd party reporting will be posted on the facility website as well as in the public lobby for access to the following: Explanation of the BCRC's zero-tolerance policy on sexual assault and abuse: How to report; Facility contacts; Bern Township Police Department; and ICE phone number." At the BCRC entrance the Auditor observed this reporting information in Spanish and English, advising how and to whom to report allegations of sexual abuse on behalf of any detainee. The Auditor also visited the following web sites (https://www.ice.gov) and (https://www.co.berks.pa.us/Dept/BCRC/Pages/PREA.aspx) and found reporting information as well. All three detainees interviewed were aware that family members and friends could report sexual abuse on their behalf.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after a review of policy 28.010 that requires, "Staff shall immediately report to the on- duty supervisor once identification of sexual abuse or assault has been made. It is imperative that all suspicions, incidents and allegations of abuse and assault be handled with confidentiality and care. Staff may also report misconduct out of the chain of command. Staff may notify Executive Director or Program Director via email, voicemail or in person. Staff shall take seriously all statements from residents claiming to be victims of sexual abuse and assault and shall respond supportively and non-judgmentally. Staff should be alert to signs of potential situations in which sexual assaults might occur, and for making reports and intervention referrals as appropriate. An immediate report shall be made regarding any retaliation against detainees or staff who reported any incidents or sexual abuse or assault. Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation, shall be immediately reported. If reporting any incidents of sexual abuse or assault by staff/supervisor up the chain of command is not applicable and needs to be completed anonymously, the report can be made to any of the local ICE personnel within the facility. The ICE personnel must then follow through with their reporting procedures to process the incident." The random security staff and non-security staff interviewed confirmed their responsibilities of reporting sexual abuse as required in policy and the standard. Each was also aware of their ability to report allegations of sexual assault and other misconduct outside their chain of command if necessary. As noted earlier, the 28.010 policy was approved by the Agency.

(d) The Auditor determined compliance with this subpart of the standard after the interview with the Executive Director. She confirmed BCRC does not accept juveniles. She also stated that any vulnerable detainee alleging sexual assault would have the

incident reported to BTPD, ICE and to the Berks County legal Department for proper notification(s) to any designated agencies. BCRC has had no instance of sexual assault of a vulnerable detainee during the audit period.

§115.62 – Protection duties.

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

Notes:

The Auditor based compliance on this standard through interviews with the Executive Director and 12 random staff. Each was specifically questioned about the action they would take when it became known to them that a detainee is subject to a substantial risk of imminent sexual abuse. Regardless of title each confirmed they would take immediate action to mitigate the threat to the detainee, which would initially require removing her from the area. There were no allegations of sexual assault made during the audit period.

§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)(d) The Auditor determined compliance on these subparts of the standard after a review of policy 28.010 that requires, "Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the facility receiving the allegation must: Notify the appropriate office of the facility where the sexual abuse is alleged to have occurred as soon as possible, but no later than 72 hours after receiving the allegation; and document all efforts that were taken to notify." The Executive Director, PSA Compliance Manager, and review of the PAQ confirmed BCRC did not receive any reports of sexual abuse from a detainee on arrival at BCRC nor were they ever contacted by another facility informing them a detainee made an allegation of sexual abuse upon arrival there of an incident occurring at BCRC. During the Executive Director interview, she confirmed if an allegation was reported to the facility from another facility that occurred at BCRC, an investigation would be conducted and the AFOD notified within 72 hours. The interview with the acting AFOD confirmed that he makes all required notifications to ICE personnel as required by the standard.

§115.64 - Responder duties.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard after a review of policy 28.010 that requires, "Upon learning of an allegation that a detainee was sexually abused, the first line staff member to respond to the report, shall be required to: Separate the alleged victim and abuser; Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a period that still allows for the collection of physical evidence, request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and if the sexual abuse occurred within a period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating." The 12 random security staff confirmed their responder duties during interview. They informed the Auditor that responder duties are not only reviewed annually at training, but every BCRC staff member is provided a pocket responder protocol card that they carry. There were no sexual abuse allegations at BCRC during the audit period.

(b) The Auditor determined compliance with this subpart of the standard after a review of policy 28.010 that requires, "If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." Two non-security staff were specifically questioned about responding to detainee allegations of sexual abuse. Both indicated that their initial response would be to secure the detainee, ensuring that no evidence is destroyed through cleaning up and then they would immediately notify a security staff member. There were no sexual abuse allegations at BCRC during the audit period.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The Auditor determined compliance on these subparts of the standard after the interview with the Executive Director. She confirmed that the 28.010 policy contains the written coordinated response utilized by the facility when responding to incidents of sexual abuse. The multidisciplinary approach and responsibilities are addressed. The policy details the responsibilities for security staff, non-security staff, medical staff, and mental health practitioners. Furthermore, during interviews with these staff, each detailed their specific duties in response to sexual abuse allegations. There were no allegations of sexual assault at BCRC during the audit period.

(c)(d) The Auditor determined compliance on these subparts of the standard after a review of policy 28.010 that requires, "If a victim of sexual abuse is transferred between facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services. If a victim of sexual abuse and assault is transferred from a DHS immigration detention facility to a facility not covered above, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requires otherwise." The Executive Director, HSA, PSA Compliance Manager and the PAQ confirmed that BCRC has had no instances of victim transfers between DHS or non-DHS facilities covered by DHS PREA during the audit period. The Executive Director and HSA further confirmed that, if they were to transfer a victim of sexual abuse, all proper notifications would be made in accordance with the 28.010 policy.

§115.66 - Protection of detainees from contact with alleged abusers.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

The Auditor determined compliance with this standard after review of policy 28.010 that requires, "Staff who violates any provisions of this policy will be subject to administrative, disciplinary, and criminal sanctions. Individuals suspected of perpetrating such abuse shall be removed from all duties requiring resident contact pending the outcome of an investigation." The interview with the Executive Director confirmed any Berks County staff member, contractor or volunteer suspected of violating any provision of the zero-tolerance policy would be removed from detainee contact pending the results of the investigative process. There were no sexual abuse allegations at BCRC during the audit period.

§115.67 - Agency protection against retaliation.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after review of policy 28.010 that states, "prohibitions on retaliation against residents and staff who report sexual abuse including: Housing changes; Removal of alleged staff or detainee abusers from contact with victims and emotional support services for detainees or staff that fear retaliation for reporting sexual abuse or for cooperating with investigations." The Auditor confirmed retaliation monitoring at BCRC is conducted by each shift supervisor. The Auditor interviewed one of these supervisors, who detailed for the Auditor what monitoring for retaliation would entail as the facility had no allegations of sexual assault for the audit period. He stated that his monitoring would include a face-to-face meeting with the staff member or the detainee at least monthly for a period of 90 days unless the situation required it continue beyond the 90 days. He stated the meeting would be documented on the PREA Retaliation Monitoring Sheet. He would offer emotional support to both staff and detainees contacting mental health if needed. He also confirmed he would ask of any concerns that they may have. His monitoring for detainees would include reviewing misconduct reports, room change requests and his speaking with the housing unit staff about noted behavior changes. He also stated that when monitoring staff retaliation, his review would include performance reviews, time off refusals, or shift changes. There were no allegations during the audit period; and therefore, no retaliation monitoring required.

§115.68 – Post-allegation protective custody.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a) This subpart requires the facility place victims of sexual abuse in protective custody subject to the requirement of standard 115.43. As noted in 115.43, the facility does not perform reviews in accordance with requirements of the standard.

Does Not Meet (a): The facility must demonstrate subpart requirements of 115.43, and ensure staff is provided notification of the updated requirements. Documentation of staff notification must be provided to the Auditor for compliance review.

(b)(c)(d) The Auditor determined compliance with these subparts of the standard after a review of policy 28.010 that requires, "BCRC is a residential center, we do not have a formal locked segregation unit. However, should a need arise to protect or isolate a resident due to sexual abuse assault or vulnerability, the residents shall be placed in the least restrictive housing that is available and appropriate. Residents will be offered daily recreation, access to legal and phone calls. If appropriate housing options are not available, the BCRC will consult with the ICE Field Office Director to determine if ICE can provide additional assistance. Residents may be assigned to the administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days." As noted in standard 115.43, BCRC has no formal segregation unit. The interview with the Executive Director indicated a detainee needing to be moved from her current housing as a result of a sexual assault would be moved to another room on her current unit or to a room on another unit or to the medical unit. A vulnerability reassessment would be completed based on the incident. The Executive Director further stated that if the detainee were placed in the medical unit, a reassessment would be completed prior to her being placed back in population.

§115.71 - Criminal and administrative investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d) As the facility is not responsible for investigating allegations of sexual abuse, agency policy 11062.2 is the governing policy for criminal and administrative investigations. Policy 28.010 states "[t]he Program Director or designee will initiate an internal review of the incident as soon as the initial inquiry has concluded." All investigations are to be reported to the JIC who assesses allegations to determine which allegations fall with the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on resident 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 resident-on-resident 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 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 investigated by the OPR field office or referred to the ERO Administrative Investigative Unit (AIU) for investigation. The ERO AIU would assign an administrative investigation to be completed by an ERO Fact Finder or to the AFOD who then would assign is to a manager for management inquiry completion. All investigations are closed with a report of investigation. The agency's policy 11062.2 outlines the evidence and investigation protocols and requires that the investigation not be terminated solely due to the departure of the alleged abuser or victim

from employment or control of ICE. BFRC policy 28.010 requires that the on-site supervisor inform the Executive Director, Program Director, IHSC, SAAPI coordinator, the highest-ranking Center ICE/ERO representative, and Philadelphia Field Office immediately. During interviews with the Executive Director, PSA Compliance the Auditor confirmed all allegations would be promptly reported to the BTPD, JIC, ICE OPR, and the DHS OIG.

(e)(f) The Auditor determined compliance with these subparts of the standard after a review of policy 28.010 that requires the departure of the alleged abuser or victim from the employment or control of the facility or agency would not provide a basis for terminating an investigation and that the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. The Auditor's interview with the Executive Director and PSA Compliance Manager confirmed these two subpart requirements. There were no allegations during the audit period; and therefore, no mean to address practical application of the policy.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with this standard after a review of agency policy 11062.2 (SAAPI) that requires administrative investigations will impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse or assault. There were no allegations Auditor reviewed the completed sexual abuse investigation and confirmed that the proper standard of evidence was adhered to. The facility is not responsible for conducting administrative investigations. Based on the facility having no allegations reported within the audit period, there were no case files for the Auditor to review to verify practice.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with the standard after interviews with both the Executive Director and PSA Compliance Manager. According to them, once they are notified either by ICE and/or BTPD of an investigation outcome, they would notify the detainee of the results. There were no sexual abuse allegations at BCRC during the audit period.

§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) The Auditor determined compliance with these subparts of the standard after review of policy 28.010 requiring, "Staff who violates any provisions of this policy will be subject to administrative, disciplinary, and criminal sanctions. Individuals suspected of perpetrating such abuse shall be removed from all duties requiring resident contact pending the outcome of an investigation. Should the investigation find staff is involved in acts described in this policy, they will be subject to disciplinary sanctions up to and including termination. The results of these investigations must be reported to ERO." The Executive Director confirmed that any attempt to engage in, or threat to engage in sexual abuse as defined in the 28.010 policy, by a staff member, would result in their removal from Berks County employment and Federal Service. She also stated any removal from employment, resignations in lieu of being removed for violation of the zero-tolerance policy would be reported to ICE, BTPD and appropriate licensing bodies. As noted in standard 115.11, the 28.010 Policy regarding dismissal from service for violations with the zero-tolerance policy was approved by the Agency. The were no allegations of sexual abuse during the 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) The Auditor determined compliance with these subparts of the standard after review of policy 28.010 requiring, "Sexual conduct between residents and staff (to include contractors and volunteers), regardless of consensual status, is prohibited. Individuals suspected of perpetrating such abuse shall be removed from all duties requiring resident contact pending the outcome of an investigation. Should the investigation find staff is involved in acts described in this policy, they will be subject to disciplinary sanctions up to and including termination. The results of these investigations must be reported to ERO." As noted above in 115.76, the Executive Director's interview confirmed that any attempt, or threat to engage in sexual abuse as defined in the 28.010 policy, by any contractor or volunteer, would result in their removal from Berks County employment and Federal Service. She also stated any removal from employment, resignations in lieu of being removed for violation of the zero-tolerance policy would be reported to ICE, BTPD and appropriate licensing bodies. Her interview also confirmed BCRC would consider prohibiting detainee contact to contractors and volunteers who have not engaged in abuse but violated other standard provisions.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 28.010 and policy 04.010, that collectively require, residents be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the resident engaged in sexual abuse or assault, consistent with the requirements in the ICE Family Residential Standard on Behavior Management. The BCRC will not discipline a resident for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For disciplinary action, a report of a sexual abuse or assault made in good faith based upon a reasonable belief that the alleged conduct occurred, will not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Sanctions will be designed to

correct poor behavior and to encourage appropriate behavior. Their use will be limited to those instances where other intervention has been tried and been proven unsuccessful. All sanctions will be commensurate with the severity of the infraction and intended to encourage the resident to conform to rules and regulations in the future. The committee's decision will be based solely on information pertaining to the offense, evidence derived, and staff, resident, and witness statements. The resident will be provided with a copy of the 04.1 00F and may choose to appeal the Disciplinary Committee's decision. When a resident has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, will be consulted to provide input as to the resident's competence to participate in the behavior management process, any impact the resident's mental illness may have had on his or her responsibility for the problematic behavior, and information about any known mitigating factors in regard to the behavior. The PSA Compliance Manager detailed the detainee disciplinary process at BCRC for the Auditor. According to her, the process allows for progressive levels of reviews, appeals, procedures, and is documented. There were no allegations of sexual abuse reported during the audit period.

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

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on the interview with the HSA and five detainee medical files reviewed who disclosed prior victimization upon arrival. As noted in standard 115.41 the initial risk assessment is completed upon arrival at BCRC by the medical department. The HSA informed the Auditor that anyone disclosing prior victimization is questioned about having any medical concerns based on the prior victimization. If the detainee does, they are typically handled at the time of arrival but no later than two (2) working days from the time of the assessment. The electronic referral for mental health typically results in a mental health evaluation no later than seventy-two (72) hours after the referral. The interview with the mental health practitioner confirmed that the detainee who is referred for disclosing prior victimization will be seen within two days of her arrival. The review of the five detainee medical files noted each detainee was seen within two days of her arrival by mental health.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after review of policy 03-01 that requires the facility, "Provide emergency medical and mental health services to detainees who are victim of sexual abuse. Services include initial evaluation, ongoing mental health care, examination, and referrals; emergency medical treatment; crisis intervention services including emergency contraception, sexually transmitted infections testing, and prophylaxis; provide treatment services to the victim without financial cost, regardless of whether the detainee names the abuser or cooperates with any investigation. Provide continuity of care, in accordance with professionally accepted standards." The HSA confirmed that her staff is not allowed to perform forensic examinations by policy. Detainees requiring these services are stabilized by her staff and prepared for transport to St. Joseph Medical Center. She also confirmed that BCRC, except for the forensic examination, can provide all other services for any alleged victim of sexual assault, including emergency medical treatment and crisis intervention services, emergency contraception including sexually transmitted infections prophylaxis, would be provided without cost, and performed within professionally accepted standards of care. The facility PAQ and HSA confirmed there were no detainees sent out for a forensic examination during the audit period.

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

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after review of policy 03-01 that requires, "Ongoing medical and mental health care; Evaluation and treatment of victims as appropriate; Follow up services for sexually transmitted infections; treatment plans and long-term care; and when necessary, referrals for continued care following their transfer, placement in other facilities, or release from custody; Provide continuity of care, in accordance with professionally accepted standards; Pregnancy tests, for female detainees who experienced vaginal penetration by a male abuser while incarcerated. Victims receive timely and comprehensive information about lawful pregnancy related medical services and timely access to all lawful pregnancy-related medical services. Provide treatment services to the victim without financial cost, regardless of whether the names the abuser or cooperates with any investigation." The HSA informed the Auditor that any detainee, who experiences sexual abuse while at BCRC, would receive a medical and mental health evaluation. The service she would receive would be consistent with the community-level of care or better. She further stated that services provided to these victims is without any cost to the detainee, regardless of whether he/she cooperates with the investigation arising from the incident. She also confirmed the medical and mental health departments are more than capable of providing on-site crisis intervention services, sexually transmitted infections treatments and other infectious diseases testing along with prophylactic treatment to victims and pregnancy testing and service if necessary. As noted throughout this report, there were no allegations of sexual abuse reported for the audit period.

(g) The Auditor determined compliance with this subpart of the standard after the interview with the HSA and the mental health practitioner. Both stated that any abusive detainee would be removed from the facility as the custody level at BCRC allows only low-level detainees with no abusive history. However, prior to the detainee being identified and removed as well, detainees found to have perpetrated sexual abuse at the conclusion of an investigation would be offered an evaluation and follow up treatment. There were no allegations of sexual abuse reported at BCRC during the audit period.

§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) The Auditor determined compliance with these subparts of the standard after review of policy 28.010 that requires," The facility shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility shall implement their commendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the agency PSA Compliance Manager. The facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the Executive Director, Field Office Director, and PSA Compliance Manager." The Auditor interviewed one of the staff that participates in the incident review. He confirmed a review is conducted at the conclusion of every investigation of sexual abuse within 30 days of the completion taking into account the subpart (b) requirements. He also confirmed that copies of these reviews are provided to all parties required by the standard. There were no incidents of sexual abuse reported during the audit period.

(c) The Auditor determined compliance with this subpart of the standard after review of policy 28.010 that requires, "Each facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, Field Office Director or his or her designee, and the agency PSA Compliance Manger." The Auditor was provided the facility annual review (negative) of sexual abuse allegations and subsequent incident. The PSA Compliance Manager confirmed a copy of this review was provided to the FOD and the agency PSA Compliance Manager.

§115.87 - Data collection.

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

Notes:

(a) The Auditor determined compliance on this subpart of the standard after review of policy 28.010 that requires, "The Executive Director shall maintain all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling for 5 years. These records shall be maintained in individual, confidential, incident files. All such files will be retained in accordance with established schedules. The ICE Residential Standard on Medical Care and the requirements of the ICE Residential Standard on Detention files will be followed." The Auditor was shown the location where and how these documents are stored at BCRC and found them under a double lock and restricted key to only those staff with a need to know.

§115.201 - Scope of audits.

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

Notes:

(d) The Auditor was allowed access to BCRC and able to revisit areas of the facility as needed during the site visit.
(e) The Auditor was provided with and allowed to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j) The Auditor observed audit notices posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor received no staff, detainee, or other party correspondence.

AUDITOR CERTIFICATION

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	4
Number of standards met:	33
Number of standards not met:	2
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 9/29/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/29/2022

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/29/2022

Assistant Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Philadelphia		
Field Office Director:	David O'Neill		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	114 North 8th Street Philadelphia, PA, 19107		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Berks County Residential Center (BCRC)		
Physical address:	1040 Berks Road Leesport, PA 19533		
Mailing address: *(if different from above)*			
Telephone number:	610-396-0310		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Executive Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	610-393-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	610-393-(b) (6), (b) (7)(C)

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.

During the audit, the Auditor found BCRC met 33 standards, had 4 standards (115.16, 115.31, 115.33 and 115.35) that exceeded, had 2 standards (115.14, 115.18) that were non-applicable, and 2 non-compliant standards (115.43 and 115.68). As a result of the facility being out of compliance with 2 standards, the facility entered into a 180-day corrective action period which began on September 29, 2022, and ended on March 28, 2023. The purpose of the of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

The Auditor received notification of the first CAP via email on October 3, 2022, from ERAU. The CAP was reviewed and approved by the Auditor for the two standards that did not meet compliance during the PREA audit site visit and documentation review. The Auditor received the final CAP documents for review in November 2022 which were provided by the facility to demonstrate compliance with these standards. This documentation was reviewed, and the Auditor determined that the facility demonstrated compliance with each of the two standards found non-compliant at the time of the site visit.

Number of Standards Met: 2

§115.43 Protective custody

§115.68 Post-allegation protective custody

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.

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

(d) This subpart requires "A supervisory staff member shall conduct, at a minimum, a placement review after the detainee has spent seven days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter." BCRC's policy or practice does not address this requirement.

Does Not Meet (d): To become compliant, the facility must include this requirement in their written protocols and notify affected staff of these requirements. Documentation of revised protocols and notification to affected staff must be provided to the Auditor for compliance review.

Corrective Action Taken (d): The BCRC updated their Sexual Abuse and Assault, Prevention, and Intervention Policy, Policy 28.010 on October 13, 2022. The policy states "A placement review after a detainee has spent seven days in the administrative segregation room will be performed to determine the need for protective custody and then every week thereafter for the first 30 days and then every 10 after that." BCRC management trained all staff members on the updated policy and required all staff to document that they have read the policy via a Sign-Off List. BCRC is now compliant with the requirements of this standard.

§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) This subpart requires the facility place victims of sexual abuse in protective custody subject to the requirement of standard 115.43. The facility does not perform reviews in accordance with requirements of the standard.

Does Not Meet (a): The facility must demonstrate subpart requirements of 115.43, and ensure staff is provided notification of the updated requirements. Documentation of staff notification must be provided to the Auditor for compliance review.

Corrective Action Taken (a): The BCRC provided the Auditor Policy 28.010, with a revision date of October 13, 2022. These revisions included addition of the required language for compliance with provision (a), aligning post-allegation protective custody with the requirements of 115.43. The policy updates require a supervisory staff member shall conduct, at a minimum, a placement review after the detainee has spent seven days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter. Via memorandum from Management, dated October 13, 2022, the facility has designated the admission unit bedroom on the activity floor (2nd floor) as the location to house any detainee requiring protective custody. The facility also provided a roster dated October 13, 2022, through October 23, 2022, indicating during that period all staff have read the revised Policy 28.010. BCRC is now compliant with the requirements of this standard.

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

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

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

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

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

Thomas Eisenschmidt November 19, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) November 27, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) November 28, 2022
Program Manager's Signature & Date