

**PREA Audit: Subpart B
DHS Immigration Detention Facilities
PREA Audit Report**



**Homeland
Security**

AUDITOR INFORMATION

Name of auditor:	Thomas Eisenschmidt	Organization:	Creative Corrections, LLC
Email address:	[REDACTED]	Telephone number:	315-730-[REDACTED]

AGENCY INFORMATION

Name of agency:	U.S. Immigration and Customs Enforcement
------------------------	--

FIELD OFFICE INFORMATION

Name of Field Office:	EL PASO FIELD OFFICE, ALBUQUERQUE
ICE Field Office Director:	DIANE L. WITTE
PREA Field Coordinator:	[REDACTED]
Field Office HQ physical address:	5441 WATSON DRIVE SE, ALBUQUERQUE, NM 87106
Mailing address: (if different from above)	

INFORMATION ABOUT THE FACILITY BEING AUDITED

Basic Information About the Facility			
Name of facility:	ALBUQUERQUE HOLD ROOM		
Physical address:	5441 WATSON DRIVE SE, ALBUQUERQUE, NM 87106		
Mailing address: (if different from above)			
Telephone number:	505-452-4702		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	WILLIAM M. JEPSEN	Title:	AFOD
Email address:	[REDACTED]	Telephone number:	505-452-[REDACTED]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	ROSALVA OLVERA	Title:	SDDO/COR
Email address:	[REDACTED]	Telephone number:	915-225-[REDACTED]

AUDIT FINDINGS

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.

This was the initial PREA audit of the Albuquerque Hold Room (AHR). The audit was conducted on November 27-28, 2018 by PREA certified Auditor Thomas Eisenschmidt for Creative Corrections, LLC. AHR is one of the Hold Rooms operated by Immigration and Custom Enforcement (ICE) of the Department of Homeland Security (DHS). The facility is located on the first floor in an office building located at 5441 Watson Drive SE, Albuquerque, NM 87106. This two story building contains office space for Enforcement and Removal Operations (ERO) staff, Homeland Security Investigations (HSI) and the Hold Room.

As previously noted this was the first PREA audit for AHR to determine compliance with the Department of Homeland Security (DHS) PREA standards. Team Lead [REDACTED] from the External Reviews and Analysis Unit (ERAU) provided the completed Pre-Audit Questionnaire (PAQ) along with supporting documents for AHR according to staff on the secure ERAU SharePoint website approximately three weeks prior to the on-site portion of the audit. Pre-audit preparation included a thorough review of all documentation and supporting materials provided by the facility along with the data included in the completed PAQ. The documentation received included agency policies with corresponding attachments, procedures, Memoranda of Understanding (MOUs), forms, training records and curricula, facility schematic, and other PREA-related materials provided to demonstrate compliance with the PREA standards. The documentation submitted was complete and allowed the Auditor to conduct a comprehensive audit review of the facility.

The Team Lead and the Auditor arrived at the AHR at 7:55 am on the 27th of November 2018 and proceeded to the Conference Room where the in-briefing was conducted by Team Lead [REDACTED]. Those in attendance were:

[REDACTED]	ICE Assistant Field Office Director (AFOD)
[REDACTED]	ICE Supervisory Deportation and Detention Officer (SDDO)
[REDACTED]	ICE OPR/ERAU Team Lead
[REDACTED]	ICE OPR/ERAU

After introductions and a brief question and answer period the in-briefing ended and the tour of the Hold Room began. The Hold Room has seven holding rooms, four interview rooms, one control room, one property room, a large processing area, and a secure sally port area for bus transfers. Each of the hold rooms contains a toilet, telephone, posters on the walls in Spanish and English informing detainees of how and whom to report (in writing, anonymously, third party, to the Office of Inspector General (OIG)) any allegations of sexual abuse, an area to sit and a [REDACTED] surveillance for the Officer in the [REDACTED]. The cameras present no privacy issue as each toilet has a half wall around it and the cameras are [REDACTED] around the toilet allowing no viewing. There are sitting areas outside of the rooms in the processing area for juveniles and families. The AHR is staffed by ERO staff Supervisory Deportation and Detention Officers (SDDO) and a Detention Officers (DO) only. Their "typical hours" of operation are 7:30 am- 3:30 pm but there is no one assigned to the AHR until detainees are being processed. When detainees are present in the hold room staffing includes a Supervisory Deportation and Detention Officer according to the random staff interviewed. There are no volunteers or contractors allowed into the Hold Room at any time; only sworn law enforcement personnel. The ABH can receives males, females, families, and juveniles pending processing and relocation by ICE ERO staff or through transportation provided by contract transportation providers. During the two days of the audit there were no detainees processed at the ABH. As a result the auditor on the first day had an SDDO walk through the intake process and on the second day a DO explained the intake process as well.

Detainees typically arrive in handcuffs and receive a pat search prior to being placed in one of the holding rooms. Juveniles, families and pregnant women are never placed into the hold rooms. They are placed in a sitting area in the processing area of the Hold Room away from other detainees until released or transferred.. The pat search is typically performed by the same gender as the adult being searched unless the safety of the Officer is in jeopardy. There are usually female staff available to perform these pat searches and if not the Supervisor must approve them absent the safety of the Officer. If the DO or the SDDO has information, prior to the risk assessment being completed, that the detainee has been a victim of sexual abuse or is an abuser they are separated and the victim is placed in an empty hold room or an office under direct supervision. Each detainee is then brought up individually and processed. The process is set up for every language, those who may be deaf, blind or unable to read, and includes an assessment for risk of victimization. The typical time to be held at the AHR is three hours. Detainees can not be held longer than 12 hours. Those there longer than 6 hours or upon request are given snacks to eat and something to drink.

Immediately following the tour, the Auditor interviewed staff as there were no detainees at the facility during the two day site visit. Staff interviews were conducted in a secure, private setting. Random staff interviews [REDACTED] were selected by the Auditor utilizing the staff rosters provided by the SDDO. The Auditor also interviewed individuals from the SANE Collaborative, Headquarters SME, and the Rape Crisis Center of Central New Mexico as part of the audit.

The Auditor also conducted a records review on the second day of the on-site audit. This included a sample of [REDACTED] personnel files, all staff training records, and five old detainee files. There have been no allegations of sexual abuse reported at the AHR for the last 36 months according to staff.

SUMMARY OF OVERALL 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.

On Wednesday, November 28, 2018, an exit briefing was held at approximately 11:15 a.m. in the AFOD Conference Room to discuss the audit findings. ERAU Team Lead [REDACTED] opened the meeting and then turned it over to the Auditor for an overview of the findings. In addition to the Team Lead and the Auditor in attendance were:

- [REDACTED], ICE Assistant Field Office Director (AFOD)
- [REDACTED] ICE Supervisory Deportation and Detention Officer (SDDO)
- [REDACTED] ICE OPR/ERAU

The Auditor thanked everyone present and the entire staff at AHR for their cooperation during the visit. The Auditor reported there were no issues that were encountered during the visit but would be unable to tell them a score until he reviewed documentation and interviews before making a final determination.

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	1
Number of standards met:	28
Number of standards not met:	1
Number of standards N/A:	1

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. If additional space for notes is needed, please utilize space provided on the last page.

§115.111 – 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:

a) The Agency has a policy, Directive 11062.2 Sexual Abuse and Assault Prevention and Intervention, mandating zero tolerance toward all forms of sexual abuse and details their approach to preventing, detecting and responding to such conduct. Directive 11087.1, Operation of ERO Holding Facilities, outlines the means for implementation of the agencies prevention, detection and responding direction. The AFOD discussed the policy during his interview stressing the importance of sexual safety for detainees. The staff who were formally interviewed were aware of the agency policy of zero tolerance against all forms of sexual abuse and sexual assault.

§115.113 – 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) Holding Facility Supervision and Monitoring, section 4.1 of policy 11087.1, details the Field Office Director (FOD) responsibilities regarding the maintaining of sufficient supervision of detainees through appropriate staff levels. The policy further requires that annually the facility review their supervision guidelines taking into account video monitoring, detention and correctional practices, layout of the facility, composition of detainee prevalence of substantiated or unsubstantiated instances of sexual assault or sexual abuse and any incident review recommendations. The Auditor spoke with the AFOD, SDDO's, and DO's during the site visit. The AFOD explained that the facility conducts an annual Holding Facility Self-Assessment Test (HFSAT). One of the areas this assessment reviews is supervision and monitoring. The assessment looks at camera placement, the physical plant, detainee complaints, current staffing levels, types of detainees including those with specialized needs. The last HFSAT was completed 12/5/2018 and the Auditor interviewed the SDDO who completed it.

Interviews with the SDDO and DO staff described the typical staffing at the AHR. As noted in the facility description the "normal" hours of operation are 7:00am to 3:00pm. However there could be an occasion where there may be a detainee brought in at any time. All interviewed DO's and SDDO's stated that anytime a detainee is in the Hold Room a DO is always present along with a SDDO. Each [REDACTED] has a [REDACTED] where the detainee is under direct supervision being monitored by staff member. The detainee could also be monitored under direct supervision by the [REDACTED]. All of the staff interviews, [REDACTED] in total, explained that supervision of detainees requires regular visual monitoring via the [REDACTED] as well as [REDACTED]. There were no detainees present during the site visit for the auditor to observe monitoring practices.

§115.114 – Juvenile and family detainees.

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

Notes:

(a)(b) Policy 11087.1 section 4.3 Placement of Detainees with Specialized Needs describes the conditions under which juveniles and families will be detained at AHR. The AFOD during his interview stated that both juveniles and families detainees are detained in the least restrictive manner as possible. He stated unaccompanied minors and families are never placed in hold rooms unless they have a violent history, criminal history or, are an escape risk. These individuals are placed in seating areas in the hold room under the direct supervision of the DO or SDDO. He also informed the auditor the unaccompanied minors are always held apart from adults and if necessary interview rooms would be used with an Officer stationed in the room.

Interviews with each SDDO and DO confirmed this process as described in policy and explained by the AFOD. Their interviews also detailed for the auditor that an unaccompanied minor may temporarily remain with a non-parental adult family member until the family relationship is established or until it has been established that remaining with the adult family member is appropriate.

As previously noted there were no detainees present at the facility at the time of the audit for the Auditor to interview. The Auditor however walked through the intake process and was shown the areas where minors and families are normally seated and the interview rooms that could also be used if needed.

§115.115 – Limits to cross-gender viewing and searches.

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

Notes:

(b)(c)(d)(e)(f) Section 4.5, Searches of Detainees, from policy 11087.1 details for staff at AHR the conditions under which cross-gender pat searches, strip searches and body cavity searches are authorized. The AFOD provided the Auditor the ICE training curriculum for staff titled "Best Practices for Cross-Gender, Transgender and Intersex Searches". The curriculum covers: search techniques; cross-gender pat searches of male detainees being conducted, only after reasonable diligence, when staff of the same gender is not available at the time the pat search is required or in exigent circumstances; cross-gender pat searches of female detainees not being conducted except in exigent circumstances; and performing searches of transgender and intersex detainees. Anytime a cross-gender strip search is performed it must be documented including the exigent circumstances. If the gender of the detainee is unknown it may be determined during conversations, review of medical records or as a result of a broader medical exam done in private by a medical practitioner. Policy 11087.1 and this training curriculum informs staff that strip searches/body cavity searches be documented and conducted in a manner designed to ensure as much privacy for the detainee as practicable and performed by

the same gender as the detainee except in exigent circumstances including considerations for the officers' safety or when performed by medical staff. Visual body cavity searches of juveniles may only be performed by medical staff.

As previously noted only law enforcement staff are allowed entrance into the ABH. During the interviews with the SDDO and DO staff each detailed the process followed performing all searches, pat and strip, in a professional and respectful manner. They indicated their training included the requirement that that all cross gender searches be documented, the conditions for cross-gender pat searches of male detainees only after reasonable diligence, when staff of the same gender is not available and the female detainee requirement in exigent circumstances only. At the conclusion of the training each was required to document they had received this training which the auditor verified, by written documentation that was available for each of the employees currently working for AHR. They also indicated that if they entered into one of the holding rooms in which there were cross gender detainees they would knock and announce prior to entering. [REDACTED] Each of these rooms has toilet, with a half wall around. [REDACTED] in order to provide privacy to the occupant. [REDACTED] in the Hold Room has a shower which is typically never used, due to the time of stay of the detainees. This room [REDACTED] There have been no cross-gender searches or strip searches/body cavity searches conducted at AHR in the last 12 months.

§115.116 – Accommodating detainees with disabilities and detainees who are limited English proficient.

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

Notes:

(a)(b)(c) Section 4.4 Detainees with Disabilities and Detainees who are Limited English Proficient, of Policy 11087.1 outlines the specific requirements of these three subparts. ABH ensures that each detainee arriving has an equal opportunity to participate in or benefit from the facility's effort to prevent, detect and respond to sexual abuse. Such steps shall include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, providing access to in-person, ERO telephonic interpretive services that enable effective, accurate, and impartial interpretation. The AFOD, SDDO's and the DO's that were interviewed detailed the intake process. All indicated most detainees have a limited English proficiency that they encounter. Upon arrival the detainee is placed in a hold room prior to being interviewed. In each of the seven hold rooms affixed to the walls is information about the facility and agency PREA policy relating to reporting, and preventing sexual abuse. The DO is the individual who normally processes the detainee. If the detainee does not speak a language the DO is fluent in, the staff utilizes the poster with the "I speak" language identification information. Once the language is determined the DO utilizes the telephone and calls the ERO Language Service. This service provides interpretive and translation services for ABH staff and detainees. Although the PREA documents located in each hold room are in Spanish and English, the DO performing the intake asks the detainee questions about his/her safety and PREA concerns while on the phone with the Language Service. Although the facility has no TTY phone, deaf or hard of hearing detainees, according to the SDDO, would be relocated to a secure office having video telephone conferencing (VTC) abilities. The Auditor was informed the facility did not have blind, deaf or illiterate detainees during the last 12 months but if they did receive one, according to the SDDO, they would utilize local resources from the community to aid the facility in providing information to the detainee based on their specific needs. He also stated that the use of detainees as interpreters is covered under section 5.6 from policy 11062.2 allowing use when the detainee requests a preference for another detainee and ICE determines it appropriate and consistent with DHS policy. He further stated that the use of minors, those witnessing the alleged assault or those detainees with a relationship with the alleged abuser is not appropriate.

§115.117 – 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) Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 require anyone entering into or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the type of work, is thorough to include education checks, criminal records check, neighbor and residence checks, financial checks and prior employment checks. The policy documents above outline misconduct and criminal misconduct being grounds for unsuitability including material omissions or making false or misleading statement in the application. During the interview with Headquarters Subject Matter Expert (SME) the Auditor was informed all suitability is considered for hiring and promotions and all staff is obligated to disclose any misconduct to their supervisor. The HQ SME indicated employee candidates are questioned directly about any previous misconduct both during their background check and during the job interview if he/she gets that far in the process. She also indicated that suitability background checks are performed prior to each promotion. The Auditor was also told that unless it was prohibited by law HR would provide information on ex-employees seeking new employment. The Auditor reviewed [REDACTED] employee personnel records.

(c)(d) Federal Statute 731.00 Employment Suitability and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 requires the agency to conduct a thorough investigation on everyone to determine access into government employment or into one of their facilities. Federal Statute 731.105 requires reinvestigations every 5 years. The Auditor did a random check on [REDACTED] employees at AHR. Each of their backgrounds were current and up to date. As previously noted there are no contractors allowed access to the Hold Room. If contractors were allowed he/she would receive the same background check as employees.

§115.118 – Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) The building that AHR is located in was activated in March 2013 and has made no substantial expansion or modification since opening according to the AFOD. He also indicated that [REDACTED]. The standard requirements are for those facilities built or acquired after May 2014. The AFOD indicated to the Auditor that any upgrades to the facility either structurally or with technology would follow Section 4.10 from policy 11062.2

§115.121 – 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) Section 5.9, Investigation of Allegations, found in policy 11062.2 follows a uniform evidence protocols that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocols include, where feasible, securing and preserving the crime scene and safeguarding information and evidence, conducting prompt thorough and objective investigations with qualified staff, and arrange forensic medical exams where appropriate. Office of Professional Responsibility (OPR) staff that was interviewed by the Auditor detailed this practice and adherence to the policy. She indicated the agency OPR follows evidence protocols that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. She stated the protocol were developed in coordination with DHS and are appropriate for juveniles.

(b)(c)(d) Policy 11062.2 requires and AHR has entered into an agreement with the Rape Crisis Center of Central New Mexico to make available victim services for any victim of sexual assault. The auditor interviewed the Center's PREA advocate who detailed the service the agency would provide if requested by staff or detainee at AHR. It includes crisis intervention, support during forensic examinations, support during investigative stages and aftercare referral if needed. The Auditor also interviewed the Director of the SANE Collaborative which is the medical facility where a detainee would go from AHR if a forensic exam was needed at no cost to the detainee. The Collaborative Director indicated that if someone has been sexually assaulted within the previous 120 hours, they are taken to the Albuquerque SANE Collaborative to be examined by a Sexual Assault Nurse Examiner. An advocate from the Rape Crisis Center of Central NM will accompany the victim to their exam and shall be allowed for support during a forensic exam and investigatory interviews. The facility has had no occasions in the last 12 months to use either service. Compliance is based on policy reviews and interviews conducted with the AFOD, Rape Crisis Center, and the SANE Collaborative Director.

(e) To the extent that the agency is not responsible for investigating allegations of sexual abuse, AHR requested in writing, provided to the Auditor, that the Albuquerque Police Department follow the requirements of paragraphs (a) through (d) of this section. The Albuquerque Police Department responded by email that it would comply with the provisions (a-d) of the standards.

§115.122 – 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)(c)(d) Section 5.7 Notification and Reporting Following an allegation, from policy 11062.2 requires AHR to report all allegations of sexual assault and sexual abuse to appropriate law enforcement agencies. Notifications are made to Headquarters and the determination made as to who will conduct the sexual abuse allegation (Federal, State, or local law enforcement, DHS OIG and/or OPR). According to the interview with the AFOD and OPR Headquarters SME, the initial notifications of sexual assault or sexual abuse would be made to OPR and the Albuquerque Police Department. The AFOD then would follow the Significant Event Notification (SEN) procedures which would include notifications to the Office of the Inspector General, Joint Intake Center, Assistant Director for Field Operations, and PSA Coordinator. The HQ SME informed the Auditor that the protocols were approved by DHS and record retention is 25 year minimum.

(b) A provision of subpart (b) of this standard is the facility provide their investigative protocols on their website. The Agency does provide their investigative policy (11062.2) on its website but the policy details criminal investigations and does not include protocols for administrative investigations.

Recommendation: The agency needs to post the updated investigation protocol/policy on their website once the protocol/policy is updated to include the administrative investigations protocol practice as noted in Standard 115.171.

(e) During the interview with the SDDO's the auditor was informed that any alleged detainee victim of sexual abuse that is criminal in nature is provided timely access to U nonimmigrant status visa information. The auditor was provided this document. As noted there were no detainees available to interview or sexual abuse case files to review. Compliance based on the interviews noted with the AFOD, SDDO's and OPR Headquarters SME.

§115.131 – Employee, contractor and volunteer training.

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

Notes:

(a)(b)(c)Section 5.2 Training, from policy 11062.2 requires all new staff, that has contact with detainees, be trained on the agency zero-tolerance policy on sexual abuse and sexual harassment their first year of service and must have biennial refresher so they will be current with ICE policies/procedure thereafter. The policy and the training curriculum details the zero-tolerance policies for all forms of sexual abuse. It outlines specific definitions and examples of prohibited and illegal sexual behavior. It explains the right of detainees and staff to be free from sexual abuse and from retaliation for reporting it. It describes situations where sexual abuse may occur while providing signs of physical, behavioral, and emotional symptoms of sexual abuse while describing methods of preventing and responding to such occurrence. Staff is informed on how to avoid inappropriate relationships with detainees and provided information on how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming detainee. Each staff member is informed on the procedures for reporting knowledge or suspicion of sexual abuse and their requirement to limit reporting sexual abuse information to personnel except in an official capacity or a need-to-know basis in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. There are no contractors or volunteers at AHR. Only law enforcement staff are allowed in the Hold Room. This was confirmed by staff interviews and personal observations. The auditor interviewed nine staff members while at AHR. Each of them detailed the content of their PREA training they received outlining their responsibilities to enforce the zero tolerance policy. Each staff member carries on their person a credit card size document outlining their responsibilities for reference. The auditor reviewed the training records for all 21 employees at AHR. All are current with their Sexual Assault Training requirement. The training was documented by signature in all cases.

§115.132 – Notification to detainees of the agency's zero-tolerance policy.

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

Notes:

Section 4.10 Sexual Abuse Assault Prevention, from policy 11087.2, requires AHR to ensure that key information regarding ICE's zero-tolerance policy for sexual abuse and assault is visible and continuously and readily available to detainees. During the interviews with the AFOD, SDDO's, and DO'S, the Auditor was informed that sexual safety information for detainees is available in each of the holding rooms through posters affixed to the walls. These posters are available in English and Spanish alerting the detainee to zero tolerance of sexual abuse and how to report it. The DO's, the primary Intake staff, also informed the Auditor that during the intake process detainees are asked by them or through the ERO Language Service about any concerns that they have or if they have any questions about the zero tolerance policy. During the tour the Auditor did observe the zero tolerance and reporting posters affixed to the walls in each of the holdings rooms and in the common areas. As noted there were no detainees present or being processed at the time of the site visit. Compliance based on policy review, staff interviews and personal observations during the tour.

§115.134 – Specialized training: Investigations.

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

Notes:

(a)(b)Section 5.2 Training, from policy 11062.2, requires that in addition to the training provided to employees ICE shall provide specialized training on sexual abuse to agency investigators who conduct investigations into allegations of sexual abuse at holding facilities. All investigations into alleged sexual abuse and sexual assault must be conducted by qualified investigators. The auditor spoke with OPR Headquarters SME staff who primarily handle sexual abuse investigations for ICE with the assistance of local Police agencies. OPR Headquarters staff detailed to the Auditor the investigative training. She stated it includes: the agency zero tolerance policy review, effective cross agency coordination, techniques for interviewing sexual abuse and assault victims in confinement settings, sexual abuse and assault evidence collection. Investigators are required to sign that they have received the training. The auditor reviewed the PowerPoint training and signatures of OPR Investigators that have received this training and confirmed what was told by OPR Headquarters staff. There were no case files for the Auditor to review to ensure that those cases were handled by a trained Investigator. Compliance based on policy review, interview with OPR Headquarters staff, review of the required training curriculum, completed training records review, and the requirement of a signature of those who completed the training.

§115.141 – 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) Section 4.10 Sexual Abuse and Assault Prevention Section, from policy 11087.2, requires AHR staff consider whether, based on the information before them, if a detainee may be at a high risk of being sexually abused and, when appropriate, take necessary steps to mitigate any such danger to the detainee. As noted earlier, detainees are held for a short period of time. The typical amount of time is 4 hours or less and most detainees are not held overnight. On a rare occasion a detainee may be picked up after midnight and brought to a hold room and have to wait until early morning to be transferred. In these rare cases, the detainee would be provided a mattress to sleep on. The Auditor interviewed five DO's who perform the intake utilizing the Risk Classification Assignment on every detainee who enters the Hold Room. This assessment is a computerized program that addresses specific vulnerabilities including: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; and the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. If the DO believes the individual may be at high risk of being victimized they are placed on direct supervision, alone in a separate hold room by the DO. As noted earlier [REDACTED] has a [REDACTED] which can also be monitored. The interviews with both the SDDO's and DO's confirmed that during the intake process at the Hold Room a DO and SDDO are present during processing and the SDDO must review the Risk Classification Assignment document. All nine interviews with the SDDO's and DO'S confirmed that information obtained during the intake process is not disseminated except on a need to know basis. Paper copies of PII is kept secured under lock and key and computer file PII is allowed only by password for those individuals with a need for this information having access to the password to access the file.

§115.151 – Detainee reporting.

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

Notes:

(a)(b)(c) Section 4.10 (3) Sexual Abuse and Assault Report, from policy 11087.1, requires the agency to develop policies and procedures to ensure that the detainees have multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or violations of responsibilities that may have contributed to such incidents. According to interviews conducted with the DO's and SDDO's detainees are informed that they may make allegations by privately reporting to any staff person verbally, in writing, anonymously (DHS Office of the Inspector General) or by third parties during intake processing. As noted earlier in the report if the detainee does not speak a language the DO is fluent in, the staff utilizes the poster with the "I speak..." language identification information. Once the language is determined the DO utilizes the telephone and calls the ERO Language Service. This service provides interpretive and translation services for ABH staff and detainees. Although the PREA documents located in each hold room are in Spanish and English, the DO performing the intake asks the detainee questions about his/her safety and PREA concerns while on the phone with the Language Service. These staff also indicated allegations made verbally must be put into writing by the individual receiving the allegation to his/her supervisor. This same policy requires detainees be provided contact information for the DHS Office the Inspector General (OIG) in order to report sexual abuse to a public entity not part of AHR. These OIG posters are also located in each of the hold rooms as well as posted in the common areas. They display in Spanish and English United States Postal Service (USPS) mailing address, the email address, and a toll free phone number for reporting. The posters indicate that reports are treated confidentially and anonymously. As noted there were no detainees present to be interviewed. Compliance based on policy review, interviews with the AFOD and staff, and observance of the posters noting how to report that were located in each holding room and common areas.

§115.154 – Third-party reporting.

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

Notes:

Section 4.9 (3 b) Sexual Abuse and Assault Report, from policy 11087.1, requires staff to receive third party reports verbally or in writing. Reports received verbally must be documented in writing by the staff member receiving the allegation to his/her supervisor. The interviews conducted with the AFOD and [REDACTED] staff interviewed confirmed the policy and practice of receiving third party reports and reducing those received verbally in

writing. The Agency web site www.ice.gov/prea has a tab labeled Reporting Allegations of Sexual Abuse and/or Assault available for making third party reports by the public as well.

§115.161 – 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) Section 5.3 Obligation to Report Information and Prohibition of Retaliation, from policy 11062.2 requires employees to immediately report to their supervisor or a designated official any knowledge, suspicion, or information regarding any incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or in violation of responsibilities that may have contributed to an incident or retaliation. It also requires staff to not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions. The ICE Deputy Director memo allows staff to report any sexual abuse or sexual assault outside their chain of command to OPR. Interviews with AFOD, SDDO'S and DO'S confirmed their obligation to immediately report any incidents of sexual assault, sexual abuse, retaliation and staff neglect in duties that may have contributed to the sexual abuse or sexual assault. Staff indicated their responsibility to immediately report verbally any allegations of sexual abuse to their supervisors and document the known facts to their supervisors in writing as soon as possible but prior to the end of their shift. They informed the Auditor their obligation not to disclose any information that they become aware of except on a need to know basis. They were also aware of their ability to report outside their chain of command if necessary to OPR.

(d) Policy 11062.2, section 5.7 (f) requires that if the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws. The AFOD confirmed this reporting obligation during his interview. He indicated he would be responsible to contact the relevant ICE Office of Principal Legal Advisor (OPLA) of the Chief Counsel and if the resident was determined to be a juvenile or vulnerable adult, he would be required to report the allegations to the designated State or local services agency as required by mandatory reporting laws and policy. The AFOD informed the Auditor he has never heard of any situation of this type at AHR.

§115.162 – Agency protection duties.

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

Notes:

Section 5.4 Protection of Individuals at Risk, from policy 11062.2 requires that whenever any ICE employee has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee. The SDDO's and DO's were questioned about this very situation in each of their interviews. All indicated the safety of the detainee would be their primary concern and their first response would be to remove them from the threat by placing them under direct supervision of an Officer and then notify their supervisor.

§115.163 – Report to other confinement facilities.

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

Notes:

(a)(b)(c) Section 5.7 2(b) Notification and Reporting Following an Allegation, from policy 11062.2, requires that upon receiving an allegation that a detainee was sexually abused while confined at another facility, the agency that received the allegation shall notify the appropriate office of the agency or the administrator at the facility where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The notification must be documented in writing to the facility and made part of the detainee file. The AFOD, during his interview, indicated that he would make the notifications as required by policy but has not had any incidents in the last 36 months.

(d) If AHR receives a notification that while at the Hold Room an allegation of sexual assault or sexual abuse occurred, to the extent the facility can, would ensure that the allegation is referred for investigation in accordance with these standards. The AFOD indicated he would conduct the notifications as required including notifying OPR to initiate an investigation. There were no required notifications during the last 36 months at AHR.

§115.164 – Responder duties.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b) Section 4.11 Responding to Sexual Abuse and Assault Incidents, from policy 11087.1, requires upon learning that a detainee was sexually abused, the first law enforcement staff member to respond to the report shall: separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; if the sexual abuse occurred within a time 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. As previously noted only law enforcement staff are allowed in the Hold Room. The DO and SDDO staff interviews detailed how each would respond to any allegation of sexual assault or sexual abuse. Staff members carry a card (size of a credit card) outlining their responsibilities in response to any allegation of sexual assault/abuse. The facility management and staff exceeds the normal requirements of the standard of preparing staff to respond to incidents of sexual abuse by providing additional tools (cards) ensuring the safety of the alleged victim, preservation of the crime scene and proper notifications are carried out. It was evident to the Auditor the staff was well trained and informative on ensuring the safety and well-being of detainee victims.

§115.165 – Coordinated response.

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

Notes:

(a)(b)(c) Section 4.11 Responding to Sexual Abuse and Assault Incidents, from policy 11087.1, requires the facility to ensure a coordinated multidisciplinary response to allegations of sexual assault and sexual abuse. This section of the policy also requires if a victim of sexual abuse or sexual assault is transferred between a holding facility, a detention facility or to a non-ICE facility, they inform the receiving facility of the incident and the victim's potential need for medical or social services. The interview with the AFOD indicated when any allegation of sexual abuse or sexual assault occurs his response would be to report the incident via policy following the Significant Event Notification (SEN) procedures which would include notifications to the Office of the Inspector General, Joint Intake Center, Assistant Director for Field Operations and PSA Coordinator. He

would also ensure coordinated responses by the Albuquerque Police Department, Albuquerque SANE Collaborative, and the Rape Crisis Center of Central New Mexico. The notification to any receiving facility would include information on the medical or social needs of the victim.

§115.166 – 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:

Section 5.8 1(f) Response: Intervention and Health Care, from policy 11062.2, requires ICE employees, facility employees, contractors or volunteers suspected of perpetrating sexual abuse or sexual assault be removed from all duties requiring detainee contact pending the outcome of the investigation. During the interview the AFOD verified the policy and verified that the policy and standard would be followed in every case. As noted there are no contractors or volunteers at the Hold Room. There have been no cases requiring the removal of staff pending an investigation during the last 36 months.

§115.167 – Agency protection against retaliation.

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

Notes:

Section 5.3 (4) Obligation to Report Information and Prohibition of Retaliation, from policy 11062.2 prohibits employees from retaliating against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The AFOD and a SDDO were interviewed and both indicated that retaliation in any form against any one by anyone is not permitted. Section 5.3 (1) Obligation to Report Information and Prohibition of Retaliation, from policy 11062.2 requires staff report to a supervisor or designated official any retaliation they become aware of. The individual at AHR designated for staff to report incidents of retaliation is the SDDO. The SDDO having the responsibility for any retaliation occurring at AHR stated to the Auditor that retaliation was not reported or observed in the last 12 months at AHR.

§115.171 – Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(e) Section 5.9 2ii (Investigation of Allegations), from policy 11062.2 requires the FOD to conduct a prompt, thorough and objective investigation by qualified Investigators. This individual is also required under section 5.9 2 vi to cooperate with outside investigators and endeavor to remain informed about the progress of the outside investigation. This same policy section requires OPR to coordinate investigative efforts with federal, state or local law enforcement in accordance with ICE policies and procedures. Most all criminal sexual abuse cases would be handled by the local Albuquerque Police Department (APD). This was confirmed during conversation with the APD and the OPR staff.

(b) This subpart of the standard requires upon the conclusion of a criminal investigation where the allegation was substantiated, an Administrative Investigation be conducted. In cases where the investigation is unsubstantiated, the facility should review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations are to be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The administrative investigation process was confirmed through OPR staff interviews.

(c) The Pre-Audit Questionnaire (PAQ) and the PREA Pre-Audit: Policy and Document Request DHS Holding Facilities list Directive 11062.2 (Sexual Abuse and Assault Prevention and Intervention) as the document detailing the Administrative Investigations requirements of (c) 1-6 of this standard. Interviews with facility staff and HQ OPR staff confirmed to the Auditor this policy 11062.2 documents the requirements for Administrative Investigations as required by (c) 1-6. However, upon further review by the Auditor, policy 11062.2 does not address the requirements of subpart (c) of the standard. This subpart (c) is non compliant.

(d) Section 5.9 1 (e) requires the departure of the alleged abuser or victim from the employment or control of the agency will not result in the termination of the investigation. The Auditor confirmed this requirement with the OPR staff and the APD.

§115.172 – Evidentiary standard for administrative investigations.

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

Notes:

Section 5.9 (e) Investigations of Allegations, from policy 11062.2, requires administrative investigations shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The interview with the AFOD confirmed that a preponderance of evidence is the standard utilized when substantiating an allegations of sexual abuse. There have been no administrative investigations conducted at AHR during the last 36 months.

§115.176 – Disciplinary sanctions for staff.

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

Notes:

(a)(c)(d) Section 5.9 Investigations of Allegations, from policy 11062.2 and Table of Offenses and Penalties section B (Discriminating Behavior) lists inappropriate physical behavior, sexual in nature, indicating removal may be warranted on the first offence in egregious cases. The facility is required to impose disciplinary sanctions, including adverse action up to dismissal, for violation of the agency zero tolerance policy. Section 5.9 (I) requires OPR, upon notification from a FOD or Special Agent in Charge from Homeland Security Investigations, report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies, unless the activity was clearly not criminal and to any relevant licensing bodies, to the extent known. The interview with the AFOD confirmed the disciplinary outcome of removal from service for violation of the sexual abuse policy. He also indicated that the facility requirement to notify OPR of removals as outlined in section 5.9) of the policy would be done.

§115.177 – 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:

AHR does not have contractors or volunteers at the facility. As noted only law enforcement staff have access to the Hold Room. However referenced on page 13 of 11062.2, 5.8.1(f), requires that any contractor or volunteer suspected of perpetrating sexual abuse or assault would be removed from all duties requiring detainee contact pending the outcome of an investigation. Policy further indicated that disciplinary action for contractors and volunteers would have to be addressed by their management as per individual contract. In the case of an incident of substantiated sexual abuse by a contractor or volunteer, ICE management would notify the contractor's or volunteer's management, the appropriate law enforcement agency, as well as to the Joint Intake Center or another appropriate DHS investigative office in accordance with DHS policies and procedures. This process is specified in the above referenced policy and was verified during the interview with the AFOD. He further stated that although the facility currently has neither contractors or volunteers it would follow the requirement of policy 11062.2 should they ever get them.

§115.182 – Access to emergency medical services.

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

Notes:

Section 4.11 4 (a,b) Responding to Sexual Abuse and Assault Incidents, from policy 11087.2 requires detainee victims of sexual abuse have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The Auditor interviewed the AFOD who stated that victims are sent to the Albuquerque SANE Collaborative, a Medical provider, at no expense to the detainee regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor also interviewed the Director of the SANE Collaborative and the PREA advocate at the Rape Crisis Center of Central New Mexico. The Collaborative provides emergency medical services including information on contraception and sexually transmitted disease prophylaxis if needed. The Rape Crisis Center provides crisis intervention services including mental health referrals when warranted or requested.

§115.186 – Sexual abuse incident reviews.

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

Notes:

Section 4.11 6 (a) Responding to Sexual Abuse and Assault Incidents, from policy 11087.2, requires a sexual abuse incident review at the conclusion of every investigation of sexual abuse and assault, unless the allegation was determined to be unfounded, and prepare a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. Such reviews shall occur within 30 days of the agency receiving the investigation results from the investigative authority. The agency shall implement the recommendations for improvement, or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the agency PSA Coordinator. The AFOD confirmed the facility would conduct an incident review after each allegation, unless it was determined unfounded, making recommendations in practice or policy if warranted. The review would be conducted within 30 days of the completion of the investigation and the report forwarded to the PSA Coordinator. AHR reported no sexual abuse/assault allegations during the last 36 months. The facility also reported no investigations as a result of no allegations therefor no reviews were required.

§115.187 – Data collection.

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

Notes:

Section 5.12 (3), Data Storage and Publications, from policy 11062.2 requires a secure area for agency case records associated with claims of sexual abuse, in accordance with these standards and applicable agency policies, and in accordance with established schedules. The DHS Office of Inspector General maintains investigative files related to claims of sexual abuse investigated by the DHS Office of Inspector General. The AFOD informed the Auditor during his interview that cases files are kept for at least 10 years. Although there were no case files to see secured, the area where files would be kept was visited and secure.

§115.193 – Audits of standards.

Outcome: Low risk

Notes:

The Auditor considers Albuquerque Hold Room "low risk". This is based on the physical layout of the facility that provides an excellent environment for detainee supervision allowing direct contact and observation of detainees enhanced by noninvasive video monitoring. The facility has not experienced any allegations of sexual abuse or sexual assault during the past 36 months. Staff was very knowledgeable about their duties and responsibility in providing a sexual safe facility.

§115.201 – Scope of audits.

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

Notes:

The audit of the Albuquerque Hold Room involved a complete examination of the physical plant while on site and random interviews with ICE staff including the AFOD. Each of those interviewed detailed their training and responsibilities at the facility as they relate to PREA and sexual safety. The Auditor also reviewed training records and other paperwork without restrictions.

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 March 26, 2019
Auditor's Signature & Date

**PREA Audit: Subpart B
DHS Holding Facilities
Corrective Action Plan Final Determination**



**Homeland
Security**

AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	Organization:	Creative Corrections, LLC
Email address:	[REDACTED]	Telephone number:	315-730-[REDACTED]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	EL PASO FIELD OFFICE, ALBUQUERQUE		
ICE Field Office Director:	DIANE L. WITTE		
PREA Field Coordinator:	[REDACTED]		
Field Office HQ physical address:	5441 WATSON DRIVE SE, ALBUQUERQUE, NM 87106		
Mailing address: (if different from above)			
INFORMATION ABOUT FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	ALBUQUERQUE HOLD ROOM		
Physical address:	5441 WATSON DRIVE SE, ALBUQUERQUE, NM 87106		
Mailing address: (if different from above)			
Telephone number:	505-452-4702		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	WILLIAM M. JEPSEN	Title:	AFOD
Email address:	[REDACTED]	Telephone number:	505-452-[REDACTED]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	ROSALVA OLVERA	Title:	SDDO/COR
Email address:	[REDACTED]	Telephone number:	915-225-[REDACTED]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The initial PREA audit of the Albuquerque Hold Room (AHR) was conducted on November 27-28, 2018 by Department of Homeland Security (DHS) and Department of Justice (DOJ) PREA certified Auditor Thomas Eisenschmidt for Creative Corrections, LLC. AHR is one of the Holding Rooms operated by DHS Immigration and Custom Enforcement (ICE). The Auditor was provided guidance and review by ICE PREA Program Manager Barbara King, a DHS and DOJ PREA certified Auditor. The Program Manager's responsibilities include providing oversight to the ICE PREA audit process with the ICE External Review and Analyst Unit (ERAU) section. The purpose of the audit was to determine compliance with the 31 DHS PREA Standards.

Of the 31 standards reviewed, the Auditor found AHR compliant with 28, exceeding in one standard (115.164), one non applicable (115.118), and one non-compliant (115.171).

The Auditor received a Corrective Action Plan dated September 22, 2019. The Auditor reviewed the corrective action plan (CAP) and disagreed with the plan action and documentation submitted for compliance on standard 115.171. The facility had not made compliance with all of the DHS PREA standards.

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence relied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit.

§115. 171 - Criminal and administrative investigations

Outcome: Does not Meet Standard

Notes:

(a)(e) Section 5.9 2ii (Investigation of Allegations), from policy 11062.2 requires the FOD to conduct a prompt, thorough and objective investigation by qualified Investigators. This individual is also required under section 5.9 2 vi to cooperate with outside investigators and endeavor to remain informed about the progress of the outside investigation. This same policy section requires OPR to coordinate investigative efforts with federal, state or local law enforcement in accordance with ICE policies and procedures. Most all criminal sexual abuse cases would be handled by the local Albuquerque Police Department (APD). This was confirmed during conversation with the APD and the OPR staff.

(b) This subpart of the standard requires upon the conclusion of a criminal investigation where the allegation was substantiated, an Administrative Investigation be conducted. In cases where the investigation is unsubstantiated, the facility should review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations are to be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The administrative investigation process was confirmed through OPR staff interviews.

(c) The Pre-Audit Questionnaire (PAQ) and the PREA Pre-Audit: Policy and Document Request DHS Holding Facilities list Directive 11062.2 (Sexual Abuse and Assault Prevention and Intervention) as the document detailing the Administrative Investigation requirements of (c) 1-6 of this standard. Interviews with facility staff and HQ OPR staff confirmed to the Auditor this policy 11062.2 documents the requirements for Administrative Investigations as required by (c) 1-6. However, upon further review by the Auditor, policy 11062.2 does not address the requirements of subpart (c) of the standard.

(d) Section 5.9 1 (e) requires the departure of the alleged abuser or victim from the employment or control of the agency will not result in the termination of the investigation. The Auditor confirmed this requirement with the OPR staff and the APD.

CAP: The Pre-Audit Questionnaire (PAQ) and the PREA Pre-Audit: Policy and Document Request DHS Holding Facilities list Directive 11062.2 (Sexual Abuse and Assault Prevention and Intervention) policy as the document detailing the administrative investigations requirements of (c) 1-6 of this standard. The Agency also submitted policy 11087.1, (Operations of ERO Holding Facilities) for the CAP to demonstrate compliance to subpart (c). Neither of the documents detail the six requirements of subpart (c) of the standard. The agency's SAAPI Directive 11062.2 (Section 5.9(2)a), which refers to the Performance-Based National Detention Standards (PBNDS) 2.11, states the facility shall comply with investigation mandates established by PBNDS 2.11, as well as other detention standards and contract requirements. PBNDS 2.11 (3) Procedures for Administrative Investigations states the "facility" shall develop written procedures for administrative investigations, including provisions requiring: preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation.

The Auditor, during a subsequent audit, was asked by the Team Lead to discuss the subpart requirements with ICE Headquarters (HQ) staff. The Auditor agreed to the request. The Team Lead made the call and remained in the room during the entire telephone conversation but was not hearing the comments from the HQ staff person. The Auditor explained that neither document met the requirements of the standard subpart. This woman, from ICE HQ, informed the Auditor the Agency was not going to change the policy and felt the policies, although the subpart requirements were not specifically stated, were implied. The Auditor informed this individual again neither document stated or implied these requirements and the standard determination would remain non-compliant. The Auditor suggested, until such time ICE added the requirements of the subpart to the agency policy, the facility could write a local policy detailing the requirements, as long as, the agency approved the local policy. The HQ individual agreed that AHR could in fact write a local policy, receiving approval through the agency, until such time the agency policy was changed to address the administrative investigation protocols. She further stated that local policies would need to be written by ICE facilities to address the administrative investigation protocols until a change in the agency policy addresses the administrative investigation protocols. On May 23, 2019, the Team Lead emailed the Program Manager and stated a conference call was held on May 22, 2019 with ERO/Custody Management Division/Detention Evaluation and Analysis Division (DEAD) personnel and Mr. Eisenschmidt; and that DEAD will reach out to the facility per the auditor's suggestion to include 115.171(c)(1-6) in their local policy to find the facility in compliance.

The Auditor was not provided with the facility's written procedures for administrative investigations in accordance with the mandate established by PBNDS 2.11, policies 11062.2 and 11087.1, and the standard language at the completion of the CAP deadline nor was an updated agency policy provided to support the standard language. Subpart (c) of the standard 115.171 remains non-compliant.

§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:

§115. Choose an item.

Outcome: Choose an item.

Notes:

§115.193

Outcome: Not Low Risk

Notes:

Based on the non-compliant standard 115.171 (c) regarding administrative investigations; the facility risk level is not low risk.

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 October 25, 2019
Auditor's Signature & Date

Barbara King October 25, 2019
Program Manager's Signature & Date