PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	2/4/2020	**To:**	2/6/2020
AUDITOR INFORMATION			
Name of auditor:	Sabina Kaplan	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	914-474
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-381
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Philadelphia Field Office
Field Office Director:	Simona Flores
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 Family Residential Center		
Physical address:	1040 Berks Road Leesport, PA 19107		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	610-396-0310		
Facility type:	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:**	610-396-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Line Supervisor
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	610-396-(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 Prison Rape Elimination Act (PREA) audit of the Berks Family Residential Center (BFRC) was conducted on February 4-6, 2020 by Sabina Kaplan, U.S. Department of Homeland Security (DHS) and Department of Justice (DOJ) certified PREA Auditor for Creative Corrections, LLC. BFRC operates the program through an inter-governmental service agreement with Immigration Customs Enforcement (ICE)/Enforcement and Removal Operations (ERO). The facility is a dedicated Inter-Governmental Service Agreement (IGSA). The purpose of the audit was to determine compliance with the DHS PREA Standards. This was the second DHS ICE PREA audit of the facility. The audit period covered the previous twelve months from February 2019 through February 2020.

Approximately two months prior to the audit, External Review and Analysis Unit (ERAU) Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form and within folders for ease of auditing. The main policy that provides facility direction for PREA is 28.010 Sexual Abuse and Assault Prevention and Intervention (SAAPI). All the documentation, policies, and PAQ was reviewed by the Auditor. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (b) (6), (b) (7)(C) and Assistant ICE PREA Manager (b) (6), (b) (7)(C), 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 ERAU section during the audit report review process. The ERAU Team Lead and facility staff provided additional documentation during the on-site portion of the audit. During the post audit review, the Auditor continued to request further information from the facility and ERAU Team Lead. The Auditor also reviewed the facility's website, co.berks.pa.us. A tentative daily time schedule was provided by the ERAU Team Lead for the on-site audit.

Before the start of the audit, the Auditor met with agency and facility staff. The Team Lead opened the entry briefing at 8:00 A.M. on the first day of the on-site visit. In attendance were:

- (b) (6), (b) (7)(C), Management and Program Analyst, Office of Professional Responsibility (OPR)/ERAU, ICE
- (b) (6), (b) (7)(C), Acting Field Officer Director (AFOD), ICE
- (b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (SDDO) ICE/ERO
- (b) (6), (b) (7)(C), Line Supervisor, Prevention of Sexual Assault (PSA) Compliance Manager, BFRC
- (b) (6), (b) (7)(C), LCOR, Acting Health Services Administrator (AHSA), ICE Health Service Corp (IHSC)
- (b) (6), (b) (7)(C), Psychologist, IHSC
- (b) (6), (b) (7)(C), Licensed Clinical Social Worker (LCSW), IHSC

Brief introductions were made and the detailed schedule for the audit was covered. The Auditor provided an overview of the on-site audit process and methodology used to demonstrate PREA compliance. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures, but also, to ascertain whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, additional on-site documentation review, and conducting both staff and resident interviews. It was shared that no correspondence was received by any resident. During the length of the audit, the facility provided the requested information to be used for the random selection of residents and staff to be interviewed (random and specific category) including an alpha and housing listing of all residents housed at the facility, lists of staff by duty position and shifts, and a list of volunteers/contractors on-site during the audit. Lists of residents for specific categories to be interviewed was not provided. The Auditor informed the staff that she would like to observe the intake and classification process, however, there were no intakes that took place during the on-site portion of the audit.

A facility tour was completed by the Auditor with key staff which included the ERAU Team Lead, the AFOD, and the PSA Compliance Manager. All areas of the facility where residents are afforded the opportunity to go or provided services were observed by the Auditor, including the intake processing area, the housing unit, the medical services department, recreation areas, food service, the library, visiting room, classrooms, telephone rooms, and other facility support areas. During the tour, the Auditor made visual observation of the program/service areas and housing unit including bathrooms, staff post sight lines, and camera locations. Sight lines were closely examined as were the potential for blind spots throughout the areas where residents are housed or have accessibility. The Auditor spoke to random staff and residents regarding PREA education and center practices during the tour. Review of the housing unit logbooks was conducted to verify staff rounds. All facility staff were very cooperative and informative during the audit process.

BFRC opened in 2001. The facility is a four-story building with a design capacity of 96 residents. BFRC houses non-violent, non-criminal detainee families awaiting completion of immigration proceedings for ICE. On the first day of the audit, the facility ICE resident population was 57 (30 males and 27 females). Of the 57 residents, 27 were juveniles (under the age of 18) all of whom were accompanied by adult family members. The resident population for the last twelve months was 506 (347 males, 159 females, and 257 juveniles). The average time in custody is 32 days. The top four nationalities of the resident population are Honduran, Guatemalan, Brazilian, and Romanian.

The facility has contracts with Cura Hospitality for food service, Berks County Intermediate Unit (BCIU) for educational services, and Berks Conference of Churches for religious services. IHSC operates medical and mental health. Volunteers provide music and other activities as well as supplementing religious services.

The mission of BFRC is to maintain a safe and caring environment that promotes positive growth and behaviors through competent counselors who display professional spirit and to ensure that policies operate within the legislative framework provided for the protection of children and families in their care.

Entrance into the facility for visitors is through the main lobby. Staff enter from their own entrance in a different part of the building. The facility administrative offices and ICE offices are located in the administrative section of the facility. The design of the facility is made up of an activity floor and a housing unit floor.

The areas where residents can volunteer are the kitchen, cleaning the housing unit, dayroom, telephone room, the dining room bathroom, the toddler room, library/movie room, the resident fitness room, chapel, and activity/art room. The kitchen staff are contractors through Cura Gourmet Dining and are also supervised by two-line staff. A review of the kitchen logbook during the on-site audit verified sufficient staff rounds. At the time of the on-site audit there were four residents who were volunteering in the area. Meals are prepared in the kitchen and consumed in the dining room adjacent to the kitchen. The coolers, freezers, and dry storage areas are always monitored by staff and residents are directly supervised while in these areas. There are no cameras in the kitchen area, however they are located in the dining hall and the dry storage area. Resident laundry is handled on a schedule. The laundry room is a locked room and at no time is staff allowed into the room with a resident. When the resident is ready to do their laundry, they must notify staff who will walk them to the locked laundry room and let them in. The staff member places the soap in the washing machine while the resident remains in the hallway corridor. Once the soap is in the machine the staff person and resident switch places so that the resident can place their laundry into the machine. Once the laundry is complete the staff informs the resident.

The housing consists of 16 bedrooms with a capacity of 96 residents, located on a single floor of the four-story building. Attached to the housing unit is a resident day room. The line staff post is located in the dayroom and affords continuous monitoring of the bedroom corridors. Bedroom doors are not locked, and residents are permitted free movement except in administrative office areas. Male family members, who are not designated as the head of household, sleep separate from the family. There are female and male showers located on opposite bedroom corridors. The showers are monitored by line staff of the same gender who are situated outside in the corridors when in use. There are cameras in the housing area that overlook the dayroom and bedroom corridors.

There is video monitoring of the facility through (b) (7) cameras. The cameras do not have sound capability. (b) (7)(E) [redacted]. The Auditor observed the camera monitoring displays in the camera room. Camera placement allows privacy to the residents for showering, changing clothes, and performing bodily functions. Cameras operate on a continuous loop allowing for approximately three weeks of viewing prior to recording over previous recordings unless downloaded and saved. The cameras have the ability to zoom but cannot tilt or pan.

All facility staff and resident interviews were conducted on-site during the three-day audit. Ten formal resident interviews, randomly selected from the housing unit, were conducted (5 male and 5 female) and 3 residents were informally interviewed during the facility tour (22.8% of the 57-resident population). Of the 10 formal resident interviews five involved juveniles, in the presence of and with the approval from a parent. Language Services Associates (LSA) through the Creative Corrections LLC contract for translation services was utilized for all residents interviewed. The language line was utilized for residents that spoke Spanish, Lingala, Gujarati, Haitian Creole, and Punjabi. All residents were interviewed using the Random Detainee Interview form and the Limited English Proficient (LEP) form. As the Facility Administration was not being advised of residents who reported sexual victimization from the medical department who conducts the screening, the facility administration or the medical department could not provide a listing of any residents who reported a history of sexual victimization. There were no other specialized residents to interview, so no further interviews were conducted.

A total of 23 staff were formally interviewed, and an additional 3 informal staff interviews were also conducted during the facility tours (34.6% of the 75 staff). Six line staff were randomly selected who were assigned to each of the three shift rosters. Additionally, specialized staff were interviewed including the Executive Director (1), PSA Compliance Manager (1), First Line Supervisors (3), Medical and Mental Health (3), Administrative/Human Resources (2), Non-Security Volunteers/Contractors (2), Investigator (1), Training Supervisor (2), Grievance Coordinator (1), Classification Supervisor (1), and intake staff (2). The Auditor was unable to interview any volunteers as there were none that reported to the facility during the on-site audit.

There was one sexual abuse allegation reported during the audit period. The allegation was an adult resident on a juvenile resident. The facility does not have a facility investigator or conduct sexual abuse investigations; all investigations are referred to ICE for investigation. The allegation was also reported to the Berks Township Police Department, who reported to the facility and investigated the matter in conjunction with an ICE investigator. The allegation was found to be unsubstantiated. A review of the closed case was conducted on-site by the Auditor who was given access to the Joint Integrity Case Management System (JICMS) by the Team Lead. A review of the agency's documentation, ICE Staff Trained on Investigating Incidents of Sexual Abuse and Assault, 10/15/19, revealed the ICE Investigator who conducted the investigation was not trained to conduct sexual abuse investigations.

The Auditor also reviewed two staff personnel records, three staff training records, and three resident files. There were no resident intakes for the Auditor to observe during the on-site audit.

An exit briefing was conducted by the Auditor at the completion of the on-site audit. The following participants were in attendance:

- (b) (6), (b) (7)(C) Management and Program Analyst, OPR, ERAU, ICE
- (b) (6), (b) (7)(C), Executive Director, BFRC
- (b) (7)(C), (b) (6), ERO AFOD, ICE
- (b) (6), (b) (7)(C), Program Director, BFRC
- (b) (6), (b) (7)(C), Line Supervisor, PSA Compliance Manager, BFRC
- (b) (6), (b) (7)(C), Line Supervisor, BFRC

- (b) (6), (b) (7)(C), Line Supervisor, BFRC
- (b) (6), (b) (7)(C), Line Supervisor, BFRC
- (b) (6), (b) (7)(C), LCDR, AHSA, IHSC
- (b) (6), (b) (7)(C), Psychologist, IHSC
- (b) (6), (b) (7)(C), LCSW, IHSC

While the Auditor could not give the facility a final finding per standard, the Auditor did provide a preliminary status of her findings based on the site visit and previously reviewed documents. Recommendations were shared with the facility that will be addressed under the appropriate standard in the narrative section. The Auditor suggested that the facility revisit their intake process procedures in an effort to guarantee that residents are interviewed and that all intake information is properly shared and utilized for resident housing, recreation and other activities, and voluntary work assignments.

The Auditor shared with those in attendance her appreciation of the hospitality received and for the professionalism provided by all staff during the visit. The Auditor observed interactions between staff and residents in a positive manner throughout the audit. The Auditor thanked the Berks Family Residential Center, Executive Director, AFOD, Line Supervisor/PSA Compliance Manager, and all the facility staff for their work and commitment to the Prison Rape Elimination Act.

After the on-site audit, additional information was provided by the facility to the Auditor through email.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2

§115.31 Staff training
§115.32 Other training

Number of Standards Met: 35

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.14 Juvenile and family detainees
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.33 Detainee education
§115.35 Specialized training: Medical and mental health care
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.82 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: 4

§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.81 Medical and mental health assessments; history of sexual abuse

Number of Standards Not Applicable: 0

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.

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

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

(c): The facility has a written policy 28.010 Sexual Abuse and Assault, Prevention and Intervention (SAAPI) mandating zero tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment. The policy provides definitions of sexual abuse and general PREA definitions. Through observation of bulletin boards, posters, educational handouts and materials, review of the facility's resident handbook, and interviews with staff and residents, it was apparent that the agency and the facility is committed to zero tolerance of sexual abuse. Each staff member also carries an informational card that outlines first responder requirements. The zero-tolerance policy is publicly posted on the Berks County Department of Corrections website, co.berks.pa.us.

(d): The facility's Executive Director appointed a PSA Compliance Manager at the supervisory level who oversees the facility's compliance efforts with the implementation of PREA. The Auditor determined compliance through the review of facility policy 28.010 (SAAPI) and an interview with the PSA Compliance Manager, who is also a center line supervisor. During the interview, the PSA Compliance Manager indicated that she reports to the Executive Director and AFOD, and confirmed she has sufficient time and authority to oversee facility efforts to comply with the sexual abuse prevention and intervention policy. The facility PSA Compliance Manager is responsible to oversee that policies and procedures relative to the PREA, ensure facility compliance, collecting and analyzing PREA data, and preparing required reports. During the interview with the PSA Compliance Manager, she appeared extremely knowledgeable regarding her responsibilities for coordinating the facility's efforts to comply with the PREA standards.

§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): A review of the PAQ indicated the facility's staffing level is 75 staff that may have recurring contact with residents. The facility's line staff is comprised of 60 BFRC staff; 31 males and 29 females. Line staff work three 8-hour shifts. Sufficient supervision of residents was observed through on-site observations of line, program, and medical staff supervising and interacting with residents. The Auditor reviewed daily shift rosters/assignments for all shifts and determined the facility is ensuring staffing levels are being maintained in accordance with the standard. There are always line staff assigned to the housing unit who provide direct supervision of residents. The Executive Director indicated that the number of staff is determined by Family Services standards staffing ratios of one staff to eight residents (6 years old and older) and one to six (younger than 6) with a night-time ratio of 1-8. Video cameras operate 24 hours a day, 7 days a week. There is a total of (b) (7)(E) surveillance cameras strategically located throughout the facility. All cameras are stationary and can zoom, but do not have the ability to pan or tilt. There are no cameras located in or have the capability to see into resident bedrooms, restrooms, and showering areas. (b) (7)(E) . Recorded video footage is available for review for up to three weeks. The line supervisor advised video footage utilized during a PREA sexual abuse investigation would be archived. In review of investigative files, the auditor determined there was adequate supervision provided. The Executive Director, PSA Compliance Manager, and facility AFOD have capabilities to view the cameras in the camera room located directly outside the Executive Director's office.

(b)(d): The policy 28.010 (SAAPI) and facility post orders outline the comprehensive resident supervision guidelines to meet resident supervision needs. The post orders outline the responsibilities of resident supervision including frequent and unannounced "day-time sweeps" on day and night shifts. Per a clarification email from the PSA Compliance Manager, (b) (7)(E) The line supervisor is also required to make a round into each housing area (b) (7)(E) per shift which is also logged on PREA round sheets. The Auditor reviewed PREA unannounced round documentation for unannounced rounds by supervisors and determined compliance. The rounds sheets are filed in the line supervisor's office and reviewed and monitored by administration staff. Policy 21.010 Post Orders requires that the post orders will be reviewed at least annually and updated as needed. The supervision guidelines (post orders) are distributed on an annual basis. The annual review began in December of 2019, approved by both the Executive Director and AFOD, and will continue throughout the 2020 year on a scheduled basis. All post orders reviewed by the Auditor have been reviewed and approved within the previous year. During the review of the single sexual abuse incident review, the PSA Compliance Manager reviews staffing supervision requirements. A review of the incident review indicated no staffing deficiencies. Policy 28.010 (SAAPI) states 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. It further states that the policy prohibits staff members to be aware of these rounds from alerting other staff as to when or where these rounds are occurring, unless related to the legitimate operational needs of the facility. The Auditor was able to verify line staff to include supervisors are conducting frequent unannounced security inspections/rounds both on day and night shifts through the review of PREA unannounced round documentation for unannounced rounds by supervisors.

Recommendation: The Auditor recommends that the line staff rounds are documented at all times.

(c): Through interviews with the Executive Director and PSA Compliance Manager, they indicated all elements outlined in provision (c) of the standard are considered when developing and or updating the supervision guidelines. The facility takes into consideration adequate levels of resident supervision, the need for additional video monitoring, considers the generally accepted detention and facility correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors. Review of the investigative file further confirmed compliance with the standard.

§115.14 - Juvenile and family detainees.

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

(a): The BFRC houses juveniles in the least restrictive setting appropriate to their age and special needs as dictated by the standard as confirmed by observation during the on-site audit and interviews with juveniles in the accompaniment of a parent, and staff.

(b)(c)(d): Unaccompanied minors are not housed at this facility at any time. Juveniles are housed with the female head of household when one exists. Juveniles without a female head of household present will be housed with the male head of household. When both parents are present, the male will house alone outside the presence of the family. While on tour, the Auditor observed the procedure in place. It was apparent that the facility goes through great lengths to maintain the safety of the juvenile residents in the least restrictive setting appropriate. Although BFRC accepts families previously screened by ICE officials for family relationships, the facility will rescreen the resident family upon arrival for further documentation of a family relationship. Should it be determined through interviews and records that a family relationship does not exist, the center will contact ICE immediately and recommend removal. In the one allegation investigation for the audit year, the facility reviewed the safety of the alleged victim in the presence of an adult member of the family unit and determined she was safe in her current living arrangements. All residents are screened by ICE prior to being sent to BFRC for housing. When it is determined that the juvenile is not accompanied by a parental head of household, they are not referred to BFRC for housing.

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

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

Notes:

(b/c/d): ICE Best Practices for Cross-Gender, Transgender, and Intersex Searches (training document) states that pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. It further states that pat-down searches of female detainees shall not be conducted unless exigent circumstances, and all cross-gender pat-down searches shall be documented. Staff interviewed indicated that pat-down searches are not conducted on the residents at BFRC. They further indicated that they had not conducted or were aware of any cross-gender pat-down searches conducted during the audit year. This was further supported by a memo to file and the PAQ. No pat-down searches were observed during the audit.

(e/f): ICE Best Practices for Cross-Gender, Transgender, and Intersex Searches states that cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety or when performed by medical practitioners and all strip searches or cross-gender searches shall be documented. Interviews with line staff confirmed staff are aware of the ICE policy for conducting strip or body cavity searches, and if performed shall be approved by a supervisor and documented by incident reports. During the audit year no cross-gender strip or body cavity searches were conducted. This was documented through memo to file and interviews. In addition, through interviews with line staff it was confirmed that strip search and visual cavity searches of residents, including of juveniles, are not conducted at BFRC.

(g/h): The facility's policy 20.030 Personal Hygiene states, staff will allow residents to shower, perform bodily functions, and change clothing without being viewed by any staff, except in the event of exigent circumstances or when viewing is incidental to a room check. Policy 20.030 also states that when staff of the opposite gender are entering an area where residents are changing their clothing, performing bodily functions, or showering, a "knock and announce" must be conducted. Residents interviewed indicated they felt they had sufficient privacy to change their clothes, shower, and perform bodily functions. They indicated they were not observed by staff of the opposite gender. Staff also confirmed the residents have privacy for these functions. The Auditor observed that the individual shower stalls are covered with PREA privacy curtains and are directly monitored outside the shower area by same gender staff during shower times. The Auditor also observed the toilets located in the individual bedrooms that were covered by curtains for privacy. The toilet in the medical housing bedroom was also observed during the tour and provided privacy. Residents interviewed stated that they did not recall opposite gender staff announcing themselves, however, interviews with staff indicated that "knock and announce" policy was upon entering a bedroom of which the residents stated staff never do. During the facility tour, the Auditor entered bedrooms of female detainees with female facility staff. The male facility staff member did not enter the area, therefore, the "knock and announce" policy was not observed during the on-site audit. The detainee interviews also stated that staff do not enter their bedrooms as a practice.

(i): ICE Best Practices for Cross-Gender, Transgender, and Intersex Searches states that at no time shall any search be conducted solely for the purpose of determining a detainee's genital characteristics or gender. It further states that if a detainee's gender is unknown it may be determined during conversation with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination. The review of the training lesson plans, PREA ICE Facilities and Pre-Service Prison Rape Elimination Act ICE 2017, documented these policies are covered in annual training. During interviews with staff, they indicated that they do not conduct cross-gender, transgender, or intersex searches at the facility. No searches have occurred in the audit period per documentation memo and interview with line staff. Per memo submitted by the Executive Director, transgender and intersex residents are not housed at BFRC.

(j): ICE Best Practices for Cross-Gender, Transgender, and Intersex Searches states that all searches be conducted in a professional and respectful manner, consistent with security needs. Interviews with the Training Supervisor and staff, the review of the training lesson plans reinforcing these policies in the annual training, and the review of staff training records confirmed that training is conducted as required by the standard. When staff were randomly asked how a transgender pat-down search would be completed, they indicated the transgender/intersex detainee could request the gender of the officer to conduct the pat-down search and were clear about the difference of using the blade of the hand.

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

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

Notes:

(a): BFRC takes appropriate steps to ensure residents with disabilities and residents with LEP have an opportunity to participate in and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse. Upon intake, residents are provided with the facility's local resident orientation handbook. The Auditor reviewed the facility local orientation handbook, available in English, Spanish, Acateo, Achi, Ixil, Kiche, Mam, and Qanjobal. According to the PSA Compliance Manager, the ICE detainee handbook, available in 11 different languages, including English and Spanish, is available upon request. The handbooks provide detainees with information on the agency and facility's zero tolerance policy for sexual abuse and how to report incidents of sexual abuse, as well as information on residents' rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS. Also, made available to the Auditor was a PREA pamphlet, handed out at intake and available in English and Spanish, which provided information for residents on the prevention, detection, and reporting of sexual abuse. PREA informational posters were strategically posted in the intake area and throughout the facility so that all residents would have the opportunity to review and staff post orders include verbiage that states line staff assist residents with all postings. The medical and intake staff advised if a resident coming through intake spoke a language that was not available in a written format, they will utilize an interpretive service, Lionbridge, which is under contract with the facility for providing interpretive services to residents. In review of the completed investigation for the previous 12 months, the Auditor determined the appropriate steps were taken in accordance with the standard to ensure equal opportunities to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Interviews with staff confirm that orientation for the disabled, including those who are blind and those with low vision would be accomplished through personally reading the PREA information to the resident upon intake utilizing the language line if the resident was also LEP. This practice was also confirmed through resident interviews. Staff further indicated that they could contact a local organization and request the services of a sign language interpreter in the case of a resident who was deaf or hard of hearing should a need arise. They further indicated that the resident would be afforded the use of a Text Telephone (TTY) machine. There were no residents identified that had disabilities during the on-site audit to interview.

(b): DHS/ICE PREA posters are posted throughout the facility, including the bulletin board located immediately off the bedroom corridors, in English and Spanish and contain the name of the facility PSA Compliance Manager. Also, posted on the housing unit bulletin board is the Lionbridge poster. The contact information for victim advocacy services through SafeBerks was located in the phone rooms. During the audit, all resident interviews were conducted with LEP residents. The Creative Corrections language line, Language Services Associates, was utilized for residents that spoke Spanish, Lingala, Gujarati, Haitian Creole, and Punjabi. The residents indicated they were provided information through the language line, facility postings, and staff assistance. Those LEP residents formally interviewed and other residents randomly interviewed during the facility tour, all indicated they knew the PREA information and knew how to report if needed. The intake staff interviewed stated the residents are provided written materials in a language they understand through handbooks and the language line when needed for interpretation. A review of resident files confirms the use of the language line for those residents who were LEP. The documentation noted the language the resident spoke and if interpretive services was utilized. All detainees interviewed recalled receiving information during the intake/orientation process on the facility's and agency's zero tolerance policy and efforts to prevent, detect, and respond to sexual abuse.

(c): Interviews with facility staff indicated the use of interpreter services by minors, alleged abusers, residents who witnessed the alleged abuse, and other residents who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. The facility has a contract with Lionbridge for translation services. The facility also has bilingual staff on all three shifts. Staff interviewed indicated a detainee would request a staff member for translation or the use of the language line. The LEP residents interviewed indicated they would communicate with a staff member for the need of a translation services or have another resident that spoke English tell an officer the need for the services. In the one allegation investigation the Auditor determined that the facility did not utilize another resident to interpret during the investigation.

§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): Through review of Executive Order 10450 Security Requirements for Government Employment and the Office of Personnel Management Section Part 731 Suitability; and ICE Policy system Directive Title ICE Personnel Security and Suitability Program, it was determined that the agency has established a system of conducting criminal background checks for new employees, contractors, and volunteers who have contact with residents to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement setting; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in such activity. Department of Homeland Security 6 Code of Federal Regulations Part 115 (Standards to Prevent, Detect, and Respond in Sexual Abuse and Assault Confinement Facilities) form contains a statement indicating that applicant responses are true and correct to the best of his/her knowledge. If the applicant does knowingly and willfully give a false response it may result in a negative finding regarding falsifying or omitting information, and he will be rejected from the selection process. The Human Resource Manager interviewed confirmed the wording on the application and that a person would not be hired or would be terminated for falsifying information. During the review of the two employee personnel files, the wording was verified on the employee application forms. The standard addresses the utilization of this process in the promotional system, after reviewing the above policies, and during the Executive Director interview, if any employee or contractor were involved in any misconduct of this nature, they would not be employed or contracted by ICE. Employees also have a continuing affirmative duty to report misconduct. The Human Resource Manager stated staff are required to report any misconduct to their supervisor who is responsible to make a report to the AFOD. The AFOD is then responsible to report to the Joint Intake Center (JIC) managed by ICE. This requirement is shared with staff in the PREA training. If the agency receives an arrest notification, this will be forwarded to the OPR Investigation Unit and Labor Relations.

(c/d): During a training session on September 25, 2018, and the training documentation available on the ERAU SharePoint site; the OPR Personnel Security Unit (PSU) Unit Chief explained that all ICE staff and any ICE contract employees must clear a background investigation through PSU before hiring or promoting any staff or contractor who may have contact with detainees. The contractor or staff complete an Electronic Questionnaires for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE; if it is a contract employee, the office informs the contractor that the employee cannot perform work on behalf of ICE. The Unit Chief explained the sexual misconduct questions are asked of the potential employee as part of the e-QIP. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a supervisor. For this facility, ICE PSU conducts background checks on ICE employees. The Auditor submitted

five ICE employee names to PSU to verify the background check process. All were compliant. Documentation also confirmed the due dates for the five-year background rechecks. There was one staff where a five-year background check was required and was in the process of being conducted. A review of employee, contractor, and volunteer personnel files confirmed background checks are completed and resubmitted as required by the standard.

(e): ICE Directive 6.8 ICE Suitability Screening Requirements for Contractor Personnel and 5 CFR 731 states that the agency will make an unsuitability determination if the contractor personnel or employee provide a materially, intentional false statement or deception, or fraud in examination or appointment. The interview of the Executive Director confirmed BFRC's compliance with this section of the standard. As reported by the Human Resource Manager, there were no incidents reported in which employees provided false or deceptive information.

(f): Executive Order 10450 Security Requirements for Government Employment states the appointment of each civilian officer or employee in any department or agency of the Government shall be made subject to investigation. The scope of the investigation shall be determined in the first instance according to the degree of adverse effect the occupant of the position sought to be filled could bring about, by virtue of the nature of the position, on the national security, but in no event shall the investigation include less than a national agency check (including a check of the fingerprint files of the Federal Bureau of Investigation), and written inquiries to appropriate local law-enforcement agencies, former employers and supervisors. The Auditor's interview with the Executive Director confirms that when allowable by law, she will contact and respond to other county agency employers to receive/give information on substantiated allegations or sexual abuse involving a former employee of that agency.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a/b): Facility policy 28.010 (SAAPI) states that when designing or acquiring any new facility and in planning any substantial expansion or modification of the existing facilities, the facility or agency, as appropriate, shall consider the effect of the design, acquisition, expansion, or modification upon their ability to protect detainees from sexual abuse. Policy 28.010 (SAAPI) further states that when installing or updating video monitoring system, electronic surveillance system or other monitoring technology in an immigration detention facility, the facility or agency, as appropriate shall consider how such technology may enhance their ability to protect detainees from sexual abuse. The facility was constructed in 2001. Since their last DHS PREA audit dated 3/9/17, the facility modified the phone rooms to include glass paneling for better vision by staff when residents are using the phone, added mirrors to administration staircases to view incidents that may occur on the staircase, and expanded the number of workable cameras in the program areas. An interview with the Executive Director confirmed these changes. A review of PREA meeting minutes also confirms addition of PREA enhancements since BFRC's last PREA audit.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a): PREA allegations at BFRC are investigated through OPR or Office of the Inspector General (OIG). Agency policy 11062.2 Sexual Abuse and Assault Prevention and Intervention outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or a local law enforcement agency. The OPR will coordinate with the FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not accepted or assigned by DHS OIG, OPR, or local law enforcement agency, the case would be referred to ERO for assignment and completion of an administrative investigation. It was indicated in the interview with the AFOD and PSA Compliance Manager that the facility is in compliance with agency policy 11062.2. The Auditor confirmed with the AFOD that he would make notifications of the allegation to the appropriate entity who would assume investigative jurisdiction of the case. The allegations are reported to OPR and DHS OIG. The OPR would coordinate with the AFOD to ensure evidence is appropriately secured and preserved pending an investigation by federal, state, or local law enforcement, additional the OIG Policy 11062.2 further states that if the alleged victim is under the age of 18, the agency is to report the allegation to the designated State or local services agency as necessary under applicable mandatory reporting laws, and is therefore, developmentally appropriate for juveniles. During the previous year, the agency conducted one investigation that was closed with a finding of unsubstantiated; zero investigations remained open at the time of the on-site audit. The Auditor's review of the one allegation investigation confirms that the Berks County Children's and Youth Services ChildLine was contacted.

(b/d): Policy 11062.2 further outlines the availability of community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victims' needs. The facility does not have a Memorandum of Understanding (MOU) with an outside community resource for crisis intervention and counseling. Per a letter from SafeBerks, dated 9/3/19, they were unable to re-enter into an MOU with BFRC due to the request to edit/remove previous agreements which SafeBerks felt were critical to a mutual agreement of understanding. The Auditor determined in an interview with the PSA Compliance Manager that SafeBerks wanted to duplicate the mental health services already offered at the facility through IHSC. The letter continued to state that they would continue to provide necessary literature to the residents and that the residents would have continued exposure to their contact information. During the course of the audit, the Auditor called the toll-free number for SafeBerks and was able to speak with a caseworker who verified that they would provide victim advocacy services at the local hospital if contacted.

(c): BFRC Policy 28.010 outlines procedures where evidentiary or medically appropriate, to transport sexual assault victims to an outside hospital for a forensic examination without financial cost to the victim. On September 23, 2019, the Nurse Supervisor in the emergency room of Penn State Health St. Joseph (PSHSJ) Hospital confirmed that both Sexual Assault Nurse Examiner (SANE) and Sexual Assault Forensic Examiner (SAFE) nurses are available to victims of sexual assault. There is no cost to the patient. During the interview with the AHSA she indicated that the resident would be transported to (PSHSJ) Hospital for a forensic exam. An email dated 11/25/19 from (PSHSJ) confirmed a continuing RN SANE program through the Emergency Services Department.

(e): BFRC policy 28.010 states that criminal investigations will be initiated and investigated by the Bern Township Police Department and that Bern Township shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecution. It further states that 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. An email from Bern Township Police Department, dated 11/19/19, confirms that the Bern Township Police Department agreed to comply with 115.21 (a) through (e) as published in the Federal Register, Volume 79, Number 45, on March 7, 2014.

§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): All investigations are to be reported to the JIC who assesses allegations to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employees, volunteers, or contractors 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 on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and in 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 (case summary) completion. All investigations are closed with a report of investigation. The agency's policy 10062.2 outlines the evidence and investigative protocols. The agency conducted one investigation that was closed with the finding of unsubstantiated; zero allegation investigations remained open at the time of the on-site audit.

(c): The ICE website, www.ice.gov/prea 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 poster, and ICE PREA pamphlet. The Berks County website (co.berks.pa.us) includes information on the zero-tolerance policy, reporting methods with addresses and telephone numbers, an outline on how BFRC refers allegations for investigation, and possible actions that can be taken against staff, contractors, volunteers, and residents if an allegation is substantiated.

(d/e/f): BFRC policy 28.010 (SAAPI) requires that the on-site supervisor inform the Executive Director, Program Director, IHSC, PSA Compliance Manager, the AFDO, the Chief of ERO JFRMU, the ICE ERO Philadelphia Field Office, Bern Township Police Department, and in the case of a juvenile, and Berks County Children's and Youth Services ChildLine. The Executive Director and AFOD confirmed that allegations, potentially criminal in nature, are referred to the Bern Township Police Department to conduct the investigation. All administrative investigations are completed by agency staff. The Auditor reviewed the completed sexual abuse investigation which was determined to be unsubstantiated. In review of investigative documentation, and staff interviews, the Auditor determined the investigation was completed timely and the proper notifications were made in accordance with the standard. Interviews with the Executive Director, PSA Compliance Manager, and AFOD indicated all allegations are promptly reported to the JIC, the ICE OPR and the DHS OIG.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a/b/c): BFRC policy 28.010 (SAAPI) and ICE PREA training curriculum address all the PREA training components listed in the standard provision and outlines the training requirements. Three training records, staff interviews, and the training curriculum review indicated the training includes the zero tolerance policy; definitions and examples of prohibited and illegal sexual behavior; right of residents and staff to be free from sexual abuse and from retaliation for reporting of prohibited and illegal sexual behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional signs of sexual abuse and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees; and requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. The initial training begins when the staff person is assigned to BFRC during facility orientation. The training is also provided annually through the annual in-service training for all staff. Each employee is required to attend in-service annually. Line and contract staff during interviews acknowledged the methods they received training. The PAQ indicated all staff had completed training. After interviews with the PSA Compliance Manager, the Executive Director, and the Training Supervisor, it was determined all facility staff have received training. A selection of three staff training records were reviewed and all had completed the pre-service training and annual in-service. All staff training is maintained manually for each employee. Staff document the completion of training through a signature on the ICE PREA training certificate. In addition, each staff member is provided and must carry the Sexual Abuse First Responder Duties card that outlines first responder duties. The facility exceeds the training standard by requiring all staff to complete annual training instead of the standard's two-year requirement and carrying the first responder duty card. It was evident to the Auditor, staff understand their responsibilities in preventing, detecting, and responding to incidents of sexual abuse.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a/b/c): All contractors and volunteers who have contact with detainees receive PREA training prior to assuming their responsibilities. Food service, education, and religious services are provided by contractors. Volunteers are utilized to supplement religious services and for music activities. The ICE training curriculum covers the PREA training requirements of volunteers and contractors. This training includes the agency's policy and procedures regarding sexual abuse and sexual harassment prevention, detention, and response; their roles and responsibilities in sexual abuse prevention, detection, and intervention; reasons why and situations where sexual abuse and/or assault may occur; examples of barriers to detainee reporting; zero tolerance; first responder requirements; reporting methods and requirements; and PREA definitions. Interviews with two contractors and a review of their training records confirms the training is provided annually. There were no volunteers available to interview during the on-site audit. Volunteers and contractors document the completion of training through a signature on the ICE PREA training certificate. Training records are maintained by the Training Supervisor. Training records of two contractors and two volunteers were reviewed and further documented compliance. The facility exceeds the standard by providing annual training and refresher training as needed to all volunteers and contractors.

§115.33 - Detainee education.

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

Notes:

(a/c/e/f): BFRC policy 28.010 (SAAPI) states that residents and staff shall be informed of the Residential Center's sexual abuse and assault, prevention and intervention, program and the zero tolerance policy during orientation. The residents receive education on sexual abuse and harassment (prevention, detection, and reporting etc.) and are informed of the multiple ways to privately report sexual abuse, retaliation, staff neglect, or violations of their responsibilities and provided with information on how to access outside community resources related to sexual abuse. In addition, the resident

is provided with the agency's zero tolerance through the facility handbook, available in multiple languages, DHS posted signage ICE Zero Tolerance poster, ICE Sexual Assault Awareness Information pamphlets and can obtain a copy of the National ICE Detainee Handbook by requesting one from a line supervisor. During the intake process, residents who are determined to be LEP or who may have a disability, (i.e. hearing impaired, deaf, and blind, etc.) will receive interpretive services or medical and/or mental health assistance throughout the process. The Auditor was not provided an opportunity while on-site to observe an actual resident intake processing as there were none conducted during the on-site audit. The Auditor randomly reviewed three resident files and observed signed documentation indicating the distribution of the local facility handbook and DHS-prescribed Sexual Assault Awareness Information pamphlet. Any use of interpretive services is documented in the medical electronic record and on the BFRC orientation form, to include the interpretive service reference number.

(b) BFRC policy 28.010 (SAAPI) states educational information will be provided in the resident's main language via an interpreter or through LionBridge Language Line Services. The Auditor interviewed 10 residents, and all recalled receiving the required PREA information in a format they could understand upon intake through the use of interpretive services. One resident interviewed indicated that he could not read, and the staff person read him the pamphlet with the use of the LionBridge.

(d) The Auditor observed numerous PREA related informational signage throughout the facility in English and in Spanish to include the resident housing area. The DHS-prescribed sexual assault awareness notice that included the name of the PSA Compliance Manager was prevalent around the facility, as was the contact information for the local rape crisis center, SafeBerks.

§115.34 - Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b): The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as Office of Detention Oversight staff and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault that covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP, Lesbian, Gay, Bi-sexual, Transgender, Intersex, (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the ICE SharePoint to document compliance with the standard. BFRC reported one allegation of sexual abuse during the previous 12 months. In review of the investigation packet on JICMS and the records of agency investigators on the ICE SharePoint, the Auditor determined the listed investigator was not specially trained as required by the standard.

Does Not Meet: Per Sub paragraph (a) of standard 115.34, all investigations into alleged sexual abuse must be conducted by qualified investigators. The ICE investigator on record who completed the one allegation of sexual abuse reported at BFRC during the audit period was not listed on the agency training record located on the ICE SharePoint. The agency must provide specialized training to all staff required to conduct investigations. The investigator must complete specialized training.

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

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

Notes:

(a/b/c): Health care is provided to residents through IHSC medical staff. IHSC Directive 03-01 requires all IHSC staff to receive training on the agency directive Sexual Abuse and Assault Prevention and Intervention, PREA standards and response protocol. The training is required during initial orientation and annually thereafter. The Training Supervisor provided dates of orientation training for staff from the electronic record. All of the staff had received the orientation training less than one year ago, and therefore, refresher training was not required at the time of the on-site audit. The training included how to detect and assess signs of sexual abuse, professional and effective response to victims of sexual abuse, reporting procedures, evidence preservation, and effective communication with LGBTI or gender non-conforming detainees. Interviews with medical and mental health staff and a review of signed training sheets confirmed the staff received the required training.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b/c/d): BFRC policy 28.010 (SAAPI) states that IHSC will identify potential residents with risk and immediately notify BFRC with instructions for care and once notified of a residents history of sexual abuse or assault, reasonable efforts will be made to accommodate the temporary placement of the resident. BRFC policy Local Operating Procedure (LOP) 00-02 PREA Victimization and/or Abuse Initial Assessment and Reassessment Monitoring dictates that during the screening process, BFRC shall consider whether the resident has a mental, physical or developmental disability; the age of the resident; the physical build and appearance of the resident; whether the resident has been previously incarcerated or detained; the nature of the residents criminal history; whether the detainee has self-identified as LGBTI or gender nonconforming; whether the resident has any convictions for sex offenses against an adult or child; whether the resident has self-identified as having previously experienced sexual victimization;, the residents own concerns about his or her physical safety; the residents own perception of vulnerability and/or fear of being detained at the facility; and any identified heightened needs for supervision, additional safety precautions and/or separation from certain other residents. Residents are classified as soon as possible upon arrival and before assignment to general population. New residents are kept separate from the general population by maintaining them in the intake area until the classification process is completed. Generally, residents are classified the same day of their arrival. Exceptions occur when new residents are admitted during the late night hours in which classification occurs the next day; however, all residents are classified within twelve hours. The intake area was inspected during the tour. The intake area provides privacy for residents when undressing and using the restroom. The medical staff conducts interviews in a private office while the children are monitored by line staff in an activity area. PREA posters were prominently displayed in English and Spanish. The intake process and applicable policies were reviewed. Intake staff was interviewed and confirmed the timeline for processing new residents. In an interview with the acting HSA, she indicated that residents new to the facility were interviewed. According to interviews with the AFOD and Executive Director all residents of BFRC are screened by ICE for prior incidents of criminal behavior prior to being accepted into the facility. Once cleared of having a prior criminal history, the facility considers screens for each of the remaining criteria for assessing the risk of sexual victimization as outlined in the standard. This information is acquired through information received from the IHSC intake screening and the background information received from ICE prior to the arrival of the resident. The IHSC initial screening considers prior sexual abuse victimization and prior acts of

sexual abuse. It also asks the resident if they currently feel they are in danger of sexual abuse. The facility did not provide any documentation as to what is specifically considered by ICE prior to resident assignment at BFRC, nor does it address the resident's sexual identity. The Auditor reviewed four intake assessment forms and determined the forms lacked the substance needed to meet the standard.

Does Not Meet: Residents are not screened as required by the subsections of provision (c) of the standard. The facility did not make available a copy of the Risk Classification Assessment (RCA), the ICE screening prior to intake to the facility that is utilized with the IHSC Screening Tool to determine if all the required subsections of provision (c) of the standard is met. The facility's documentation shared with the Auditor relied solely on the IHSC Intake Screening form that does not include insight regarding the age or physical build of the resident. In addition, the IHSC Screening form does not inquire whether the resident had been previously incarcerated or detained, the nature of the resident's criminal history, and whether the resident has self-identified as LGBTI or gender nonconforming. As the facility does not ascertain whether the resident was previously incarcerated or detained, they lack knowledge regarding the possibility that they may be at risk of being sexually abusive. The facility must screen residents on all the subsections of provision (c) of the standard.

Recommendation: The facility should develop and implement an intake screening form that encapsulates all subsections of the standard and task the appropriate staff with the responsibility of completing the form.

(e) BFRC policy LOP: 00-02 Prison Rape Elimination Act (PREA) victimization and/or Abuse Initial Assessment and Reassessment Monitoring states that after initial intake screening and/or mental health evaluation, a mental health provider shall reassess each resident for the risk of victimization and/or abusiveness every 60-90 day period of detainment and/or at the time of any new and/or alleged PREA report. The facility conducts a reassessment of a resident's risk of victimization between 60 – 90 days from the initial assessment or any other time when warranted. The assessment is done by mental health staff and includes meeting with the resident. Most residents transfer prior to a scheduled reassessment meeting. The Auditor reviewed two resident initial and reassessment records and the reassessment record of the one allegation investigation. Both reassessments were completed within the 60-90-day requirement and the resident victim was reassessed upon receipt of the allegation.

Recommendation: It is recommended that risk assessment interviews include those residents who leave the facility, i.e. overnight hotel stays, medical stays, and overnight stays at other facilities. During the audit, the Auditor reviewed a detainee file where the detainee left the facility for about 48 hours and there was not a reassessment upon the detainee's return to the facility. In the interview with the acting HSA, she stated that residents are not screened upon returning to the facility, that only residents that were new intakes to the facility were interviewed. This interview would capture any inappropriate behavior that may have occurred during the absence from the facility that would warrant a screening reassessment be completed and respond by the facility, if necessary.

(f) BFRC policy 28.010 (SAAPI) dictates that the facility will not discipline a resident for refusing to answer, or for not disclosing complete information in response to the PREA intake questions asked. Interviews with the AFOD, Executive Director, and PSA Compliance Manager confirmed that residents are not disciplined for refusing to answer, or for not disclosing complete information in response to the PREA intake questions asked.

(g) IHSC directive 03-01 Sexual Abuse and Assault Prevention and Intervention dictates that ICE personnel maintain information regarding a resident victim's sexual abuse, assault, and/or neglect in accordance the applicable law and DHS policy. The HSA, or designee, must approve the release of information regarding sexual assault or abuse and provide information only to ICE or IHSC staff on a need-to-know basis. BFRC policy 28.010 (SAAPI) states that information about the sexual assault is confidential and shall be given only to those directly involved in the investigation and/or treatment of the (alleged) victim. Interviews with the acting HSA, AFOD, and Executive Director, a review of four resident's medical records, and the on-site viewing of the electronic records available only to those who need to know, confirmed that the facility maintains appropriate control on the dissemination of all intake documentation within the facility that pertains to resident's responses to questions asked pursuant to standard 115.41.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): BFRC policy 02-02 states that IHSC staff will complete a medical intake screening form that considers whether the resident has a mental, physical or developmental disability; the age of the resident; the physical build and appearance of the resident; whether the resident has been previously incarcerated or detained; the nature of the residents criminal history; whether the resident has self-identified as LGBTI or gender nonconforming; whether the resident has any convictions for sex offenses against an adult or child; whether the resident has self-identified as having previously experienced sexual victimization; the residents own concerns about his or her physical safety; and the residents own perception of vulnerability and/or fear of being detained at the facility. Any identified heightened needs for supervision, additional safety precautions and/or separation from certain other residents, and t any significant findings will be referred to all appropriate stakeholders (i.e. IHSC medical staff, ERO, custody senior management and IHSC Behavioral Health Unit) via email, as well as custodial staff to accommodate appropriate housing arrangements. The policy neglects the elements of the standard that include recreation and other activities, and volunteer work. In addition, the facility does not consider the resident's physical characteristics (build and appearance), age, previous incarceration or detainment, alleged offense and criminal history, whether the detainee is perceived to be LGBTI or is gender non-conforming required by 115.41. Interviews with the acting HSA, Executive Director, and PSA Compliance Manager revealed that medical does not share information as required by policy LOP 02-02 or the standard.

Does Not Meet: Interviews with the Acting HSA, AFOD, and the Executive Director confirmed that information at screening isn't always shared with the appropriate stakeholders as dictated by BFRC policy and the standard. The facility must ensure information obtained from the risk assessment is shared with the appropriate staff so that it will be effectively utilized to determine resident housing, recreation, and other activities, and volunteer work.

(b/c): Review of the PAQ and interviews with the AFOD, Executive Director, and PSA Compliance Manager confirm BFRC does not house transgender or intersex residents. Therefore, subparagraphs (b) and (c) are 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:

(a/b/c/d/e): BFRC policy 28.010 (SAAPI) states the BFRC is a family residential center and does not have a formal segregation unit. Should the need arise to protect a resident due to sexual abuse, assault, or vulnerability the resident shall be placed in the least restrictive housing that is available and

appropriate and will be offered daily recreation and access to phone calls including legal. If appropriate housing options are not available at the facility, the facility will consult with the AFOD to determine if ICE can provide additional assistance. Residents may be assigned only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed 30 days. During the on-site tour the Auditor observed one bedroom in the medical unit that staff indicated would be utilized in the case of a PREA emergency. Interviews with the Executive Director and AFOD, and a memo provided to the Auditor confirms that BFRC does not have a formal segregation unit and has not placed anyone in protective custody during the audit period.

§115.51 - Detainee reporting.

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

Notes:

(a/b/c): BFRC policy 28.010 (SAAPI) states that during orientation residents will be informed of the multiple ways to privately report sexual abuse, retaliation, staff neglect, or violations of responsibilities that may have contributed to any incidents. Interviews with random residents indicated to the Auditor they are aware of the processes in place to report incidents of sexual abuse, such as reporting to a staff member, file a grievance, place a phone call to SafeBerks or another third party, and contact their consular official or the DHS OIG. During the tour of the facility the Auditor observed numerous posters, both from SafeBerks and the agency that advised residents on how to report incidents of sexual abuse. The postings were throughout the facility, including being posted on the housing unit bulletin board and in the facility phone rooms. During intake/orientation, residents receive a copy of the local facility handbook that includes the process for residents to report allegations of sexual abuse. The Auditor placed a successful test call to SafeBerks and spoke to a SafeBerks caseworker who indicated that the community organization would accept a resident phone call concerning an incident of sexual abuse including an anonymous call. Residents can also place calls to the DHS OIG hotline number and can remain anonymous upon request. BFRC policy 28.010 (SAAPI) states that staff will accept sexual abuse reports from residents in the following ways: verbally, in writing, anonymously, and from third parties and will privately and promptly document all verbal reports and notify a supervisor immediately of any reports received. Interviews with the PSA Compliance Manager, line staff, and first-line supervisors confirmed if they were to receive a report of sexual abuse, they would document it on a facility incident report and forward it on through the appropriate channels for investigation. An on-site review of the one completed sexual abuse investigation that was completed by the agency confirms that the allegation was verbally reported to facility staff by a third party (another resident) and was completed in accordance with the standard.

§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): BFRC policy 28.010 (SAAPI) states that residents will be informed of the multiple ways to privately report sexual abuse, including the filing of an emergency grievance. BFRC policy 11.010 Grievance System states that all residents will be provided notification that they have the option to file a grievance if they perceive their rights are being violated. The facility handbook, given to the residents upon admission, outlines the procedure by which the resident may file an informal, formal, or emergency grievance. According to BFRC policy 11.010, and the resident handbook, a resident shall be able to file an emergency grievance either orally or in writing for matters that involve an immediate threat to their safety. Emergency grievances will be referred to the on-duty supervisor who will in turn contact the Program Director and Executive Director. The Executive Director will review the emergency grievance. Per the facility handbook, residents are permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. BFRC policy 11.010 also confirms a resident may obtain assistance from another resident, line staff, family members, or legal representatives with filing a grievance relating to sexual abuse. Facility staff are required to bring all medical emergencies to the immediate attention of the on-duty supervisor who in the case of a sexual abuse allegation will make all proper notifications, including medical. The facility does not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. BFRC policy further states that the facility will issue a decision on the grievance within 5 days of receipt and shall respond to an appeal of the grievance decision within 30 days. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE FOD. Interviews with Grievance Coordinator, line staff, and front-line supervisors confirm compliance with the standard. According to the facility PAQ and interview with the Grievance Coordinator, the facility has not received any grievances in the past 12 months regarding allegations of sexual abuse. Interviews with residents confirmed they are aware of the facility grievance process and that they can request assistance in filing a grievance if needed.

§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 facility does not have a current MOU with SafeBerks to provide valuable expertise and support in the areas of crisis intervention, support during sexual assault examination, prosecution, and counseling. The MOU expired September 2019. In an interview with the PSA Compliance Manager, the lack of an MOU was confirmed and it was determined there was an issue with SafeBerks wanting to replace facility mental health staff. SafeBerks did indicate, via phone call with the Auditor, that they would continue to provide outside support during a sexual assault examination, prosecution, and would provide counseling and crisis intervention as needed. The information, including mailing address and contact number, was posted in the phone rooms located on the housing unit. BFRC policy 28.010 states that during intake the residents will be provided with information on how to access outside community resources related to sexual abuse. Per the resident handbook, phone calls may be monitored with the exception of legal or court calls. During the tour of the facility, the Auditor observed numerous postings both locally, SafeBerks Crisis Center Hotline, and agency specific, i.e., ICE Zero Tolerance, posted in English and Spanish throughout the facility to include the resident housing unit bulletin board, on walls, and activity center bulletin boards. Random resident interviews confirmed they have received the information at intake and during the facility's orientation and were familiar with the information posted on the housing unit bulletin board. In the one allegation, the resident was offered mental health visits at the facility, the resident left the facility a few days later. After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility is in compliance with this standard.

Recommendation: The Auditor recommends that the facility handbook be updated to include that if an allegation of sexual abuse against a juvenile is reported that the facility, the facility has the obligation to report the allegation to the Berks County Children and Youth Services Child Line.

§115.54 - Third-party reporting.

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

Notes:

BFRC policy 28.010 (SAAPI) states that instructions on third party reporting will be posted on the facility website as well as in the lobby for public access, regarding how to report an allegation of sexual abuse utilizing facility contacts, the Berks County Children's and Youth Services ChildLine number, Bern Township Police Department and the ICE phone number. These postings were observed on the facility tour and on the county website (co.berks.pa.us) by the Auditor. A further review of the ICE website (www.ice.gov/prea) also confirmed the public is notified on how to report incidents of sexual abuse/harassment on behalf of residents. Both websites list contact numbers for the general public to report allegations of sexual misconduct. Interviews with Executive Director, PSA Compliance Manager, and line staff confirm they are aware of the requirement to accept sexual abuse notifications from third parties. BFRC verbally received one third party notification from a mother of a juvenile who reported sexual abuse of her daughter in the previous 12 months. A review of the investigation confirmed that the facility and agency accepted the report as a PREA allegation and processed it accordingly.

§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): BFRC policy 28.010 (SAAPI) states that staff shall immediately report to the on-duty supervisor once identification of sexual abuse or assault has been made, retaliation against residents or staff who report any incidents of sexual abuse or assault, and any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse, assault, or retaliation. Employees are required to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible. Staff are required to promptly document any verbal reports as well. Interviews with the PSA Compliance Manager, Executive Director, and random line staff confirmed the protocols in place as it relates to staff reporting duties, to include how staff can report allegations of sexual abuse outside of their normal supervisory chain of command, if needed. Staff can privately report sexual abuse and assault of residents directly to the Executive Director or local ICE personnel at the facility. With the exception of reporting as noted in policy, staff shall 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 residents or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions.

(d) ICE policy 11062.2 (SAAPI) states that if the alleged victim is under the age of 18 or determined, after consultation with the relevant OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under a State or local vulnerable persons statute, report the allegation to the designated State or local services agency as necessary under applicable mandatory reporting laws. BFRC policy 28.010 requires that the on-site supervisor report the incident to the Berks County Children and Youth Services' ChildLine as soon as the initial inquiry has concluded. Interviews with the Executive Director, PSA Compliance Manager, and random line staff and supervisors confirm that the facility is very familiar with their responsibility to report. A review of the one sexual abuse investigation that included an allegation of sexual abuse against a minor, further confirms the facility is in full compliance with their obligation to report.

§115.62 - Protection duties.

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

ICE policy 11062.2 (SAAPI) states that if an ICE employee has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse or assault, he or she shall take immediate action to protect the inmate. Interviews with the Executive Director, PSA Compliance Manager, and random line staff confirmed if a resident is determined to be at an imminent risk of sexual abuse, the resident would be immediately removed from the area. In review of the one sexual abuse investigations completed over the last 12 months, the Auditor determined the facility took the appropriate action required to protect the resident victim.

§115.63 - Report to other confinement facilities.

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

(a/b/c/d): BFRC policy 28.010 (SAAPI) states that upon receiving an allegation that a resident was sexually assaulted 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 the facility must document all efforts that were taken to notify. A copy of the statement of the detainee will be forwarded to the appropriate official at the location where the incident was reported to have occurred. The facility will document it has provided such notification. Upon receiving notification from another agency or another facility that a resident currently at their facility reported an incident/allegation of sexual abuse that occurred while the subject was a resident at BFRC the staff would notify the Executive Director. The Executive Director would contact the Bern Township Police Department, ICE/ERO/JFMRU, medical, and the Berks County Children and Youth Services' ChildLine if the victim was a juvenile. Documentation would be done through email. Per memo included with the PAQ, the facility has reported that there were no recorded claims of sexual allegations occurring at another facility during the previous 12 months. Interviews with the PSA Compliance Manager and Executive Director confirmed policy would be followed. They further indicated they are aware of the proper steps for making such notifications and for maintaining documentation if a notification is made.

§115.64 - Responder duties.

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

(a)(b): BFRC policy 28.010 (SAAPI) states that upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report, or if it is his or her supervisor, 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, and if the abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim, and abuser, not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Interviews with line staff, review of policy, staff first responder cards that outline first responder duties for line staff, and the one investigative file indicates all four subparts of the standard are complied with. IHSC 03-01 provides a more detailed description of medical and mental health staff responsibilities in the event of a sexual assault. BFRC policy 28.010 (SAAPI) further states that if the staff first 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 then notify staff. Interviews with line staff, and line supervisors, and contract staff confirm non-security first responders are required to request that the alleged victim not take any actions that could destroy physical evidence and are required to notify security staff. According to a memo, submitted with the facility PAQ, there has not been a non-security staff member who acted in the capacity of a first responder 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)(c)(d): BFRC policy 28.010 (SAAPI) addresses all requirements of the standard. The policy outlines the facility's coordinated response and involves first responders, BFRC management staff, IHSC health care providers, ICE/ERO personnel, local law enforcement, and if required, community health care providers for SAFE/SANE exams and victim advocates. If a resident victim of sexual assault is transferred to or received from another facility, BFRC would inform the receiving facility regarding the details of the assault. Interviews with the PSA Compliance Manager, AFOD, Executive Director, IHSC, and line staff confirmed that they were knowledgeable regarding their responsibilities in the coordinated response. A review of the one sexual abuse investigation further confirms compliance with the standard. Per memo submitted with the PAQ, there were no residents transferred due to an allegation of sexual abuse during the audit period. The interview with the Executive Director further confirmed that there were no transfers to/from BFRC due to sexual assault during the audit period.

§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:

BFRC policy 28.010 (SAAPI) states that staff, contractors, or volunteers suspected of committing sexual abuse will be removed from all duties requiring contact with residents pending the outcome of the investigation. Depending on the outcome of the investigation, if staff, contractors, or volunteers are found to have committed sexual abuse, they will be subjected to disciplinary sanctions up to and including termination. The Executive Director confirmed the above policy. Per memo, submitted with the PAQ, there had been no incidents or allegations made by a resident against any staff member, contractor, or volunteer in the past twelve months.

§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): BFRC policy 28.010 (SAAPI) prohibits any retaliatory action against any resident or staff for reporting sexual abuse or for cooperating with an investigation into an allegation of sexual abuse. ICE policy 11062.2 (SAAPI) requires that for at least 90 days following a report of sexual abuse, the facility will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility monitors include resident disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff. The facility will continue monitoring beyond 90 days, if the initial monitoring indicates a need to. The Executive Director has appointed the PSA Compliance Manager as the designated Retaliation Monitor. In an interview with the PSA Compliance Manager, she advised the Auditor that various line supervisors monitor staff retaliation. In interviews with the Executive Director and the PSA Compliance Manager, BFRC is in compliance with all elements of the standard. The Auditor reviewed the one sexual abuse allegation investigation file to determine compliance, however, the alleged victim was released from the facility within days of the investigation being opened, and therefore compliance could not be determined. Per memos submitted with the PAQ, there were no instances of resident or staff monitoring over the last twelve months. There were no PREA Retaliation Monitoring Reports implemented for the Auditor to determine documentation to support the staff interviews.

Recommendation: The Auditor recommends that the facility implement a PREA Retaliation Monitoring Report to sufficiently document monitoring of both residents and staff. The recommendation was shared with staff during the on-site audit.

§115.68 - Post-allegation protective custody.

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

Notes:

(a/b): BFRC policy 28.010 (SAAPI) states the BFRC is a family residential center that does not have a formal segregation unit. Should the need arise to protect a resident due to sexual abuse, assault, or vulnerability the resident shall be placed in the least restrictive housing that is available and appropriate. Residents may be assigned only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed 30 days. The AFOD indicated in a formal interview that alleged abusers, following the conclusion of evidence gathering, would be immediately transferred to another detention facility pending the outcome of the investigation. If appropriate housing options are not available at the facility, the facility will consult with the ICE Field Office Director to determine if ICE can provide additional assistance.

(c/d): As stated in policy, through interviews with the Executive Director and AFOD, and a memo provided to the Auditor confirms that BFRC does not have a formal segregation unit and has not placed anyone in protective custody during the audit period. During the on-site tour the Auditor observed one bedroom in the medical unit that staff indicated would be utilized in the case of a PREA emergency. Medical staff indicated that the resident would be kept in the medical unit until medically cleared and then returned to their housing unit.

§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/e): The facility does not conduct investigations. Investigations are conducted by agency investigators. 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 (case summary) completion. All investigations are closed with a report of investigation. The agency's policy 11062.2 (SAAPI) 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 (SAAPI) requires that the on-site supervisor inform the Executive Director, Program Director, IHSC, PSA Compliance Manager, AFOD, the Chief of ERO/JFRMU, the ICE ERO Philadelphia Field Office, Bern Township Police Department, and in the case of a juvenile, the Berks County Children and Youth Services' ChildLine. During interviews with the Executive Director, PSA Compliance

Manager, and AFOD it was confirmed that the investigation would not terminate should the resident be transferred or released. The Executive Director and AFOD further confirmed that allegations, potentially criminal in nature, are referred to the Bern Township Police Department to conduct the investigation. All administrative investigations are completed by agency staff. The agency conducted one investigation that was closed with the findings of unsubstantiated; zero investigations remain open at the time of the audit. The Auditor reviewed the completed sexual abuse investigation and confirmed that the proper notifications were made, the investigation was timely, and the investigation continued beyond the resident victim's release. The review of the file further indicated that the assigned investigator was not trained as required by part (a) of the standard. Interviews with the Executive Director, PSA Compliance Manager and AFOD indicated all allegations are promptly reported to the JIC, ICE OPR, and the DHS OIG.

Recommendation: Per Sub paragraph (a) of standard 115.71 states all investigations into alleged sexual abuse must be conducted by qualified investigators. The ICE investigator on record who completed the one allegation of sexual abuse reported at BFRC during the audit period was not listed on the agency training record located on the ICE SharePoint. All investigations must be completed by trained investigators. The agency must assign trained investigators to complete investigations.

(f): BFRC policy 28.010 (SAAPI) states that the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Interviews with the PSA Compliance Manager, AFOD, and Executive Director confirm that BFRC maintains an excellent relationship with the Bern Township Police Department and that they are continuously informed as to the progress of the investigation. A review of the one completed sexual abuse allegation investigation confirmed that the Bern Township Police Department kept the facility informed of their progress and the outcome of the closed investigation.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The agency policy 11062.2 (SAAPI) states that administrative investigations will impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse or assault. The Auditor reviewed the completed sexual abuse investigation and confirmed that the proper standard of evidence was adhered to.

§115.73 - Reporting to detainees.

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

Notes:

ICE policy 11062.2 (SAAPI) states that OPR shall for detainees in ICE immigration detention or where otherwise feasible, following an investigation into a detainee's allegation of sexual abuse or assault, notify the detainee as to the result of the investigation and any responsive action taken, in coordination with the FOD. The Auditor reviewed the ICE PREA Allegation spreadsheet and it confirmed the alleged resident victim was informed of the outcome of the investigation on 6/14/19, however, the Auditor's review of the actual case file on the JICMS indicated that the case was formally closed on 1/16/19 and did not include the information that the victim was informed.

Recommendation: The Auditor recommends that ICE develop a procedure to notify the victim of the outcome in a timely manner and document the notification.

§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): BFRC policy 28.010 outlines the facility response to staff discipline of a substantiated allegation of violating facility sexual abuse policies. The staff member would be subject to disciplinary or adverse action up to and including removal from their position. The Executive Director confirmed that removal from their position is the presumptive discipline for a violation of the policy and that the facility would report all removals or resignations by staff prior to removal for violations of facility sexual abuse policies to the AFOD for action and the Bern Township Department, unless clearly not criminal. The Executive Director further confirmed if the staff member was licensed, the licensing body would be notified. The facility reviewed this policy on July 1, 2008, however, there is no documentation to verify the policy was reviewed by the agency. Per memo included with the PAQ, and an interview with the Executive Director, no staff members have been disciplined within the last 12 months. The Auditor reviewed the one allegation investigation during the audit period and further confirmed that the investigation did not involve staff.

Recommendation: The Auditor recommends that the agency review and approve the policy as it pertains to disciplinary or adverse actions for staff as required by subparagraph (b) of the standard.

§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): BFRC policy 28.010 addresses the requirements of this standard. Contractors and volunteers would be subject to disciplinary or adverse action up to and including termination, for violating sexual abuse policies, would be removed from all duties requiring detainee contact pending the outcome of an investigation, and shall be reported to law enforcement agencies and to any relevant licensing body, to the extent known. The Executive Director during her interview indicated that contractors and volunteers would be removed from the facility if they have engaged in sexual abuse and/or violated any provisions of the standard. She further stated that she would immediately report to the Bern Township Police Department and advise any licensing body and the AFOD for immediate action. Per memo submitted with the PAQ and the Executive Director interview, there have been no contractors or volunteers disciplined for sexual abuse in the past 12 months.

§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): BFRC policy 04.010 Discipline and Behavior Management outlines the requirements of this standard. The policy addresses resident rights, levels of offenses, hearing and appeal procedures, and disciplinary sanctions. The policy requires that residents found guilty of sexual abuse be disciplined in accordance with the disciplinary procedures and that the sanctions shall commensurate with the nature and circumstances of the abuse

committed. The policy further states that the resident's age, disciplinary history, and mental illness and disabilities are to be considered when making all decisions. Also, that the resident will not be disciplined for unsubstantiated or unfounded allegations made in good faith or for sexual contact with a staff member unless the staff member did not consent to the contact. A review of the one sexual abuse allegation investigation confirmed that it did not result in a disciplinary report for the alleged abuse. Interviews with the Executive Director, AFOD, and PSA Compliance Manager confirm compliance with the standard.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): BFRC policy LOP 00-02 states that during intake, any detainee who is assessed and determined to be a "high risk" potential for sexual assaultive behaviors, sexual victimizations, and/or abusiveness will be referred to Behavioral Health Providers (BHPs) as soon as possible via telephone encounter or in electronic health records. It further states that BHPs shall schedule an appointment and evaluate the resident within 24 hours or the next scheduled business day. Interview with the acting HSA revealed that the IHSC staff utilize the electronic health record template when conducting the intake screening and that the electronic medical record template utilizes a drop down box that dictates if sexual abuse occurs within the last six months, the resident is to be referred to BHPs for evaluation. In explaining the drop-down box, she further indicated that if a resident experienced sexual abuse outside the six months a referral to BHPs staff was not required. The Auditor reviewed the electronic records and confirmed that residents who indicated that they experienced sexual abuse outside the six-month margin are in fact excluded from a referral to BHPs staff.

Does Not Meet: Agency IHSC staff utilize a drop-down box, located on the electronic medical record, that limits reporting sexual victimization within the last six months to determine if a referral to BHP is appropriate. The utilization of this drop-down box eliminates those residents who report sexual victimization outside the 6-month margin from being referred to BHPs staff as required by the standard. The agency must review the electronic medical record template for possible changes or develop other methods to allow staff to become compliant with the standard by referring all residents who report sexual victimization to BHPs staff and not just those who experienced victimization within the last six months.

(b/c): BFRC policy LOP 00-02 dictates that IHSC staff complete a medical intake screening form that reviews the PREA assessment tool components. Interviews with the acting HSA and intake staff, confirm that medical sees the resident upon intake. The policy further states that BHPs staff will see any referrals from IHSC staff due to being a "high risk" for sexual assaultive behaviors, sexual victimization, and/or abusiveness within 24 hours or the next scheduled business day. An interview with mental health staff confirms that they interview all new residents within 24 hours of admission. The Auditor reviewed the one allegation investigation and further confirmed that both medical and mental health staff met with the alleged victim and the alleged perpetrator within the requirements of the standard.

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

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

Notes:

(a/b): IHSC policy 03-01 and BFRC policy 28.010 (SAAPI) require an alleged victim of sexual abuse to be seen by a health care provider for a medical evaluation. When necessary, the alleged victim will be transferred to an outside healthcare facility, PSHSJ Hospital for the required level of care. IHSC 03-01 further states that IHSC staff provide crisis intervention services, including emergency contraception, sexually transmitted infections testing, and prophylactic treatment to all victims without cost. In interviews with IHSC medical and mental health staff it was confirmed that the level of care is consistent with professionally standards of care and are offered regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

§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/g): IHSC policy 03-01 states that IHSC staff will offer medical and mental health evaluations and treatment where appropriate to all victims of sexual abuse. The evaluation and treatment will include follow-up services and treatment plans and when necessary, a referral for continued care following a transfer or release. Victims will be offered testing for sexually transmitted infections and offered pregnancy tests, as medically appropriate. All services will be provided without cost to the detainee. In interviews with IHSC medical and BHPs staff it was confirmed that the level of care is consistent with professionally standards of care and are offered regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. A review of the one allegation investigation further confirmed compliance of medical care until the resident left the facility in a few days after the incident. In an interview with BHPs staff it was confirmed that they would conduct a mental health evaluation of all know resident abusers within 60 calendar days or sooner of learning such abuse history and offer treatment deemed as appropriate. Per IHSC policy 03-01 all refusals for medical and mental health services will be documented. A review of the one allegation investigation further confirmed compliance with all subparagraphs of the standard.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a/b/c): BFRC policy 28.010 (SAAPI) dictates that the PSA Compliance Manager 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 PSA Compliance Manager considers whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The Auditor reviewed the one allegation investigation and determined that the incident review was completed as required. Interviews with the Executive Director and PSA Compliance Manager further confirmed that incident reviews are conducted as required by the standard. BFRC policy 28.010 further dictates that 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 and that if the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report with the results and findings of the annual review provided to the facility administrator, Field Office Director, and the agency PSA Compliance Manager. Reviews for years ending 2017 and 2018 were provided to the Auditor prior to the on-site audit. The negative report for year ending 2019 was completed and forwarded on-site to the AFOD who forwarded that reported to the agency PREA Coordinator.

§115.87 - Data collection.

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

Notes:

(a): BFRC policy 28.010 states that the Executive Director shall maintain all case records associated with claims of sexual abuse, including incident reports, investigation reports, resident information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling for five years. The Executive Director confirmed the facility maintains these documents locked in her office with access on a need to know basis only. The Auditor observed the filing of case records during the on-site tour and confirmed compliance.

§115.201 - Scope of audits.

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

Notes:

(d)(e)(i)(j) During the PREA audit of the BFRC, the Auditor was able review all policies, memos, and other documents required to make assessments on PREA compliance. All areas of the facility were observed during the on-site portion of the audit. Interviews with staff and residents were accommodated in private areas, and the Auditor was able to interview staff from all shifts. The Auditor observed notices of the DHS PREA Audit posted throughout the facility to include the resident housing area, both in English and Spanish. The Auditor received no detainee or staff correspondence prior to the on-site audit.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	35
Number of standards not met:	4
Number of standards N/A:	0
Number of standard outcomes not selected (out of 41):	0

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

Sabina A. Kaplan 5/11/2020

Auditor's Signature & Date

(b) (6), (b) (7)(C) 5/11/2020

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 5/11/2020

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Sabina Kaplan	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	914-474-(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
Field Office Director:	Simona Flores
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 Family Residential Center		
Physical address:	1040 Berks Road Leesport, PA 19107		
Mailing address: *(if different from above)*			
Telephone number:	610-396-0310		
Facility type:	IGSA		
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-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Line Supervisor
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	610-396-(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.

On February 4-6, 2020, the Prison Rape Elimination Act (PREA) on-site of the Berks Family Residential Center (BFRC) located in Leesport, Pennsylvania was conducted by the U. S. Department of Justice (DOJ) and U. S. Department of Homeland Security (DHS) certified PREA Auditor, Sabina Kaplan for Creative Corrections, LLC. The purpose of the audit was to determine compliance with the DHS PREA Standards. The PREA audit was the second DHS PREA audit of the facility. The Auditor was provided guidance and oversight during the audit report writing and review process by the ICE PREA Program Manager, Barbara King, and Assistant ICE PREA Manager Mark Stegemoller, both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight of the ICE PREA Audit process and liaison with the ICE External Reviews and Analysis Unit (ERAU) during the audit report review process.

On February 6, 2020, the last day of the on-site visit, the Auditor conducted an exit-briefing and discussed her preliminary findings. The ERAU Team Lead, (b) (6), (b) (7)(C), and facility staff provided additional documentation during the on-site portion of the audit. Although neither required by the standards nor a normal auditor practice to give facilities additional time to provide documentation after an audit has concluded, the Auditor continued to request further information from the facility and ERAU Team Lead for compliance determination. However, the additional documentation provided was insufficient, and as such, the facility's findings were as follows: of the 41 standards reviewed, the Auditor found two standards (115.31 Staff Training and 115.32 Other Training) exceeded the requirements of the standard; zero standards were not applicable; four standards were deficient (115.34 Specialized Training Investigations, 115.41 Assessment for Risk of Victimization and Abusiveness, 115. 42 Use of Assessment Information, and 115.81 Medical and Mental Health Screenings; History of Sexual Abuse); and the remaining 35 standards complied with the requirements of the standards.

The ERAU Team Lead sent the Notification of PREA Corrective Action Plan required with a copy of the interim PREA Audit Report to ERO, notifying them of the 11/9/20 CAP end date.

On 5/18/20, the Auditor received the ICE PREA Corrective Action Plan (CAP) from the ERAU Team Lead for BFRC. The ERO developed the CAP with the facility, and the plan addressed the five standards that did not meet compliance during the PREA audit on-site visit and documentation review. The Auditor reviewed the CAP and concurred with the proposed recommendations for achieving compliance with the five deficient standards. Throughout the corrective action period, the Auditor did not receive any responsive documentation to review for compliance; the first and final submission of responsive documentation was received on the CAP period end date on November 9, 2020. Per the DHS PREA regulations, the Auditor cannot accept any documentation after the regulatory 180-day CAP period ends. The Auditor reviewed the compliance documentation submitted on November 9, 2020, and determined the facility has not met full compliance with all four standards: 115.34 Specialized Training Investigations, 115.41 Assessment for Risk of Victimization and Abusiveness, 115. 42 Use of Assessment Information, and 115.81 Medical and Mental Health Screenings; History of Sexual Abuse.

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. 34 - Specialized training: Investigations

Outcome: Does not Meet Standard

Notes:

(a/b): The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as Office of Detention Oversight staff and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault that covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP, Lesbian, Gay, Bi-sexual, Transgender, Intersex, (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the ICE SharePoint to document compliance with the standard. BFRC reported one allegation of sexual abuse during the previous 12 months. In review of the investigation packet on JICMS and the records of agency investigators on the ICE SharePoint, the Auditor determined the listed investigator was not specially trained as required by the standard.

Does not meet: Per Sub paragraph (a) of standard 115.34, all investigations into alleged sexual abuse must be conducted by qualified investigators. The ICE investigator on record who completed the one allegation of sexual abuse reported at BFRC during the audit period was not listed on the agency training record located on the ICE SharePoint nor were they able to provide their training record upon request. The agency must provide specialized training to all staff required to conduct investigations. The investigator must complete specialized training.

Corrective Action Taken:
The agency did not provide the Auditor with the requested documentation indicating the investigator receiving the required investigative training. In addition, the Auditor reviewed the agency investigator training records on November 9, 2020 and determined that the investigator did not complete the investigative training. Based on the lack of required documentation provided and review of the agency investigator training records, the Auditor has determined that 115.34 remains non-compliant.

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

Outcome: Does not Meet Standard

Notes:

(a/b/c/d): BFRC policy 28.010 (SAAPI) states that IHSC will identify potential residents with risk and immediately notify BFRC with instructions for care, and once notified of a resident's history of sexual abuse or assault, reasonable efforts will be made to accommodate the temporary placement of the resident. BFRC policy Local Operating Procedure (LOP) 00-02 PREA Victimization and/or Abuse Initial Assessment and Reassessment Monitoring dictates that during the screening process, BFRC shall consider whether the resident has a mental, physical or developmental disability; the age of the resident; the physical build and appearance of the resident; whether the resident has been previously incarcerated or detained; the nature of the residents criminal history; whether the detainee has self-identified as LGBTI or gender nonconforming; whether the resident has any convictions for sex offenses against an adult or child; whether the resident has self-identified as having previously experienced sexual victimization;, the residents own concerns about his or her physical safety; the residents own perception of vulnerability and/or fear of being detained at the facility; and any identified heightened needs for supervision, additional safety precautions and/or separation from certain other residents. Residents are classified as soon as possible upon arrival and before assignment to general population. New residents are kept separate from the general population by maintaining them in the intake area until the classification process is completed. Generally, residents are classified the same day of their arrival. Exceptions occur when new residents are admitted during the late-night hours in which classification occurs the next day; however, all residents are classified within twelve hours. The intake area was inspected during the tour. The intake area provides privacy for residents when undressing and using the restroom. The medical staff conducts interviews in a private office while the children are monitored by line staff in an activity area. PREA posters were prominently displayed in English and Spanish. The intake process and applicable policies were reviewed. Intake staff were interviewed and confirmed the timeline for processing new residents. In an interview with the acting HSA, she indicated that residents new to the facility were interviewed. According to interviews with the AFOD and Executive Director, all residents of BFRC are screened by ICE for prior incidents of criminal behavior prior to being accepted into the facility. Once cleared of having a prior criminal history, the facility screens for each of the remaining criteria to assess for the risk of sexual victimization as outlined in the standard. This information is acquired through information received from the IHSC intake screening and the background information received from ICE prior to the arrival of the resident. The IHSC initial screening considers prior sexual abuse victimization and prior acts of sexual abuse. It also asks the resident if they currently feel they are in danger of sexual abuse. The facility did not provide any documentation as to what is specifically considered by ICE prior to resident assignment at BFRC, nor does it address the resident's sexual identity. The Auditor reviewed four intake assessment forms and determined the forms lacked the substance needed to meet the standard.

Does Not Meet: Residents are not screened as required by the subsections of provision (c) of the standard. The facility did not make available a copy of the Risk Classification Assessment (RCA), the ICE screening prior to intake to the facility that is utilized with the IHSC

Screening Tool to determine if all the required subsections of provision (c) of the standard is met. The facility's documentation shared with the Auditor relied solely on the IHSC Intake Screening form that does not include insight regarding the age or physical build of the resident. In addition, the IHSC Screening form does not inquire whether the resident had been previously incarcerated or detained, the nature of the resident's criminal history, and whether the resident has self-identified as LGBTI or gender nonconforming. As the facility does not ascertain whether the resident was previously incarcerated or detained, they lack knowledge regarding the possibility that they may be at risk of being sexually abusive. The facility must screen residents on all the subsections of provision (c) of the standard.

Corrective Action Taken:
On November 9, 2020, the Auditor received the facility's CAP response with supporting documentation that did not remedy the deficient standard. The Auditor required the facility to provide supporting evidence to substantiate compliance with standard 115.41(c). The Auditor required the facility to provide an updated screening form to ensure all detainees are assessed in accordance with the regulatory requirement. In addition, the facility was required to provide documentation that all staff who conduct intake screenings have received training on the new form. The facility's initial response in the CAP misquoted the standard indicating "Per federal guidance listed in 115.41(e) an agency shall conduct such initial classification within 30 days of the inmate's confinement." The provision noted is a requirement of the Department of Justice (DOJ) PREA standards (115.41) and not that of the DHS PREA standards (115.41). The Auditors response was as follows: "The facility must develop and implement an intake screening form that encapsulates all subsections of the standard. In addition, the facility must provide this new screening form to the Auditor and provide documentation that all staff who conduct intake screenings have received training on the new form." Per the facility's CAP response, the facility's target implementation date was July 31, 2020.

On November 10, 2020, the ERAU Section Chief forwarded to the Auditor six completed risk screening forms, provided by the facility, which were properly developed as required by standard. Upon reviewing the initial six intake risk assessments provided, all intake screening forms were from the same family and had a Detention Center Admission (DCA) date of November 6, 2020. There is no indication on the form, other than the Director's sign-off date of November 10, 2020, which the Auditor notes is outside the CAP period timeframe, to document that the screening was conducted on intake as required by the standard.

In addition, none of the initial screenings included the staff person's name who conducted the initial assessment; therefore, the Auditor could not ascertain from the submitted documentation that the person responsible for the screening was properly trained on how to accurately complete them. Although the facility provided training sign off documentation for 12 of the 20 staff they indicated were responsible for conducting the screenings, the training form did not confirm all staff responsible for conducting initial risk assessments have reviewed and understand their responsibilities for completing the newly implemented initial risk assessment procedures.

In conclusion, although the facility developed and implemented an intake screening form that encapsulates all subsections of the standard, the facility did not provide the Auditor with the required documentation to confirm that the screening is done upon intake. In addition, the facility did not provide documentation, in either an email, or a signed acknowledgment training form, that confirm all staff they designated could potentially complete the initial risk assessment received the necessary training and understand their responsibilities. Finally, the initial risk screening forms submitted did not include the date and time to confirm the screening was completed within 12 hours of addimission nor the signature of who completed the form; therefore, the Auditor could not determine if the author of the form was trained as required by the CAP. Based on the lack of required documentation provided, the Auditor has determined that 115.41(c) remains non-compliant.

§115. 42 - Use of assessment information

Outcome: Does not Meet Standard

Notes:

(a): BFRC policy 02-02 states that IHSC staff will complete a medical intake screening form that considers whether the resident has a mental, physical or developmental disability; the age of the resident; the physical build and appearance of the resident; whether the resident has been previously incarcerated or detained; the nature of the residents criminal history; whether the resident has self-identified as LGBTI or gender nonconforming; whether the resident has any convictions for sex offenses against an adult or child; whether the resident has self-identified as having previously experienced sexual victimization; the residents own concerns about his or her physical safety; and the residents own perception of vulnerability and/or fear of being detained at the facility. Any identified heightened needs for supervision, additional safety precautions and/or separation from certain other residents, and any significant findings will be referred to all appropriate stakeholders (i.e. IHSC medical staff, ERO, custody senior management and IHSC Behavioral Health Unit) via email, as well as custodial staff, to accommodate appropriate housing arrangements. The policy neglects the elements of the standard that include recreation and other activities, and volunteer work. In addition, the facility does not consider the resident's physical characteristics (build and appearance), age, previous incarceration or detainment, alleged offense and criminal history, whether the detainee is perceived to be LGBTI or is gender non-conforming required by 115.41. Interviews with the acting HSA, Executive Director, and PSA Compliance Manager revealed that medical does not share information as required by policy LOP 02-02 or the standard.

Does Not Meet: Interviews with the Acting HSA, AFOD, and the Executive Director confirmed that information at screening isn't always shared with the appropriate stakeholders as dictated by BFRC policy and the standard. The facility must ensure information obtained from the risk assessment is shared with the appropriate staff so that it will be effectively utilized to determine resident housing, recreation, and other activities, and volunteer work.

Corrective Action Taken:
On November 9, 2020, the Auditor received the facility's CAP response with supporting documentation that did not remedy the deficient standard. The Auditor required the facility to provide supporting evidence to substantiate compliance with standard 115.42. The Auditor's response was as follows: "The facility must develop and implement a procedure that the screening intake form, developed in corrective action related to 115.41(c), is used to inform all assignments of residents to housing, recreation, and other activities, and volunteer work.

The facility must provide this procedure to the Auditor and provide documentation that all staff who make housing, recreation and other activities, and volunteer work decisions have received training on the new procedure. In addition, the facility needs to provide documentation from the 10 samples from 115.41 through this process with a sample of a detainee identified for special housing needs, if applicable, and that this information was shared with need to know staff as directed by the revised policy." Per the facility's CAP response, the facility's target implementation date was July 31, 2020. On November 10, 2020, the ERAU Section Chief forwarded to the Auditor six completed risk screening forms, provided by the facility, which were properly developed as required by standard; however, the form included only a section on housing and did not encapsulate recreation and other activities, and volunteer work decisions, as required by the standard. The facility did not provide an updated procedure or training documentation for any staff responsible for making housing, recreation and other activity decisions.

In conclusion, the Auditor was not provided with a revised procedure for utilizing the initial risk screening tool to make all housing, recreation and other activities, and volunteer work decisions. In fact, the implemented initial risk screening form only encapsulates housing decisions for detainees. In addition, the facility did not submit training documentation for all staff making housing, recreation and other activities, and volunteer and work decisions on the revised procedure. Also, the facility did not provide to the Auditor documentation of the 10 samples from 115.41 through this process with a sample of a detainee identified for special housing needs, if applicable, and that this information was shared with need to know staff as directed by the revised policy. Based on the lack of required documentation provided, the Auditor has determined that 115.42(a) remains non-compliant.

§115. 81 - Medical and mental health assessments; history of sexual abuse
Outcome: Does not Meet Standard
Notes:

(a): BFRC policy LOP 00-02 states that during intake, any detainee who is assessed and determined to be a "high risk" potential for sexual assaultive behaviors, sexual victimizations, and/or abusiveness will be referred to Behavioral Health Providers (BHPs) as soon as possible via telephone encounter or in electronic health records. It further states that BHPs shall schedule an appointment and evaluate the resident within 24 hours or the next scheduled business day. Interview with the acting HSA revealed that the IHSC staff utilize the electronic health record template when conducting the intake screening and that the electronic medical record template utilizes a drop down box that dictates if sexual abuse occurs within the last six months, the resident is to be referred to BHPs for evaluation. In explaining the drop-down box, she further indicated that if a resident experienced sexual abuse outside the six months a referral to BHPs staff was not required. The Auditor reviewed the electronic records and confirmed that residents who indicated that they experienced sexual abuse outside the six-month margin are, in fact, excluded from a referral to BHPs staff.

Does Not Meet: Agency IHSC staff utilize a drop-down box, located on the electronic medical record, that limits reporting sexual victimization within the last six months to determine if a referral to BHP is appropriate. The utilization of this drop-down box eliminates those residents who report sexual victimization outside the 6-month margin from being referred to BHP staff as required by the standard. The agency must review the electronic medical record template for possible changes or develop other methods to allow staff to become compliant with the standard by referring all residents who report sexual victimization to BHP staff and not just those who experienced victimization within the last six months.

Corrective Action Taken:
On November 9, 2020, the Auditor received the facility's CAP response with supporting documentation that did not remedy the deficient standard. The Auditor required the facility to provide documentation that the medical record template was updated, or that the facility developed other methods to allow staff to become compliant with the standard, i.e., by referring all residents who report sexual victimization and not just those who experienced victimization within the last six months. The facility's target implementation date was July 31, 2020. On November 10, 2020, the ERAU Section Chief forwarded to the Auditor six completed risk screening forms, provided by the facility, which were properly developed as required by standard 114.41 (c), however the form does not indicate that all detainees who answer yes to prior victimization will be referred to a qualified medical or mental health for follow-up as appropriate as required by standard 115.81. The ERAU Section Chief also provided the Auditor with a facility provided (b) (7)(E) [redacted] navigates to a request for the six months encapsulated in the current medical record drop-down box be updated to capture the detainee's entire history. After numerous attempts, the Auditor was unable to open the link. In addition, a request from the Detention Evaluation and Analysis Division (DEAD) to have the subject of the link forwarded as a hard copy was not answered. Therefore, the Auditor could not confirm the requested update to the medical electronic record system.

The Auditor was not provided with a readable request reflecting that the medical electronic record system be updated to capture the detainee's entire sexual abuse history and not just the last six months. The facility submitted to the Auditor six completed risk screening forms which were properly developed as required by standard 114.41 (c); however, the form does not indicate that all detainees who answer "yes" to prior victimization will be referred to a qualified medical or mental health for follow-up, as appropriate, as required by standard 115.81. Based on the lack of required documentation provided, the Auditor has determined that 115.81(c) remains non-compliant.

§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.

Sabina Kaplan December 16, 2020
Auditor's Signature & Date

(b) (6), (b) (7)(C) December 16, 2020
ICE PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) December 17, 2020
ICE PREA Program Manager's Signature & Date