

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



**Homeland  
Security**

AUDIT DATES			
<b>From:</b>	6/8/2021	<b>To:</b>	6/9/2021
AUDITOR INFORMATION			
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AGENCY INFORMATION			
<b>Name of agency:</b>	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
<b>Name of Field Office:</b>	Buffalo		
<b>Field Office Director:</b>	Thomas E. Feeley		
<b>ERO PREA Field Coordinator:</b>	(b) (6), (b) (7)(C)		
<b>Field Office HQ physical address:</b>	250 Delaware Ave, Floor 7, Buffalo, NY 14202		
<b>Mailing address: (if different from above)</b>	Click or tap here to enter text.		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
<b>Name of facility:</b>	Buffalo Service Processing Center (BSPC)		
<b>Physical address:</b>	4250 Federal Drive, Batavia, NY 14020		
<b>Mailing address: (if different from above)</b>	Click or tap here to enter text.		
<b>Telephone number:</b>	585-344-6500		
<b>Facility type:</b>	SPC		
<b>PREA Incorporation Date:</b>	11/26/2014		
Facility Leadership			
<b>Name of Officer in Charge:</b>	(b) (6), (b) (7)(C)	<b>Title:</b>	Officer in Charge
<b>Email address:</b>	(b) (6), (b) (7)(C)	<b>Telephone number:</b>	585-344-(b) (6), (b) (7)(C)
<b>Name of PSA Compliance Manager:</b>	(b) (6), (b) (7)(C)	<b>Title:</b>	Deportation Officer
<b>Email address:</b>	(b) (6), (b) (7)(C)	<b>Telephone number:</b>	716-364-(b) (6), (b) (7)(C)
ICE HQ USE ONLY			
<b>Form Key:</b>	29		
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## 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 Buffalo Service Processing Center (BSPC), formerly known as the Buffalo Federal Detention Facility (BFDF), was conducted on June 8-9, 2021, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C), and Assistant Program Manager, (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), and External Reviews and Analysis Unit (ERAU) during the audit report review process. The BSPC is an ICE operated facility with security and support service supplied by Akima Global Service (AGS) under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains male and female adult detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at BSPC are from the Dominican Republic, Jamaica, and El Salvador. BSPC is located in Batavia, New York.

ICE developed a contingency audit process to conduct PREA audits when operationally necessary or appropriate, e.g. a health pandemic. The process is divided into three phases: Pre-Audit, Remote Interviews, and On-Site Audit. During the Pre-Audit phase, the ERAU Team Lead contacts the facility to request submittal of facility documentation, completes a quality control review of the documentation, and uploads the documentation to SharePoint for the Auditor's review. As part of the initial document request, the Team Lead requests current rosters for detainees, staff, contractors, and volunteers, including any ICE staff assigned to the facility. Based on the size of the facility, the Auditor then selects the appropriate number of detainees, staff, volunteers, and contractors from the rosters to interview and supplemental documentation needed to confirm the facility's compliance with the PREA regulations. The second phase, Remote Interviews, consists of interviews (either through a virtual conference platform or conference line, the latter if the virtual platform is unavailable) with staff, detainees, volunteers, contractors, and outside investigative units and/or service providers. The third phase, the On-site Audit, is not scheduled until the environment is safe for the ICE federal staff, facility staff, detainees, and Auditors. This phase mirrors a traditional PREA audit with a facility tour, observation of facility practices, and follow-up from the prior phases, as needed. Exit briefings occur at the end of Phase Two and Three, during which compliance issues identified and potential recommendations are discussed, if warranted. The facility's compliance is not fully determined until the completion of the on-site audit phase.

Full compliance was contingent upon the on-site review of observations of the facility's operational practices during the facility tour, any additional documentation review, and interviews with staff and detainees to determine all subparts of the standard were appropriately handled per the standard's requirement and upon the Auditor's review of notes and information gathered during Phases One and Two of the contingency audit process. A second Auditor was utilized during Phase One and Two. Prior to Phase Three, the On-Site audit, the Auditor requested updated facility information and received additional documentation from the ERAU Team Lead and facility staff. The on-site audit consisted of a facility tour, supplemental interviews of staff and detainees, and review of follow-up documentation. This ICE PREA audit was originally scheduled for June 2020 and was postponed due to the health pandemic. The audit was changed to a contingency audit. The audit period review became May 2019 to June 7, 2021. This was the second PREA audit for BSPC.

Approximately four weeks prior to the audit, 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 through ERAU's SharePoint site. The main policy that provides facility direction for PREA is policy 4.5.12 - Sexual Abuse and Assault Prevention and Intervention (SAPPI). All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Lead Auditor for the interviews with staff and detainees.

The facility utilizes trained investigators to complete all allegations of sexual abuse. ICE reported eight sexual abuse allegations during the audit period with all eight closed. Each of these allegations were referred to ICE OPR. None were deemed criminal. Of the eight reported allegations, six were allegations of detainee-on-detainee and two were staff-on-detainee. With regard to the detainee-on-detainee allegations, four were determined to be unsubstantiated and two unfounded. There were two allegations against staff, one was unfounded, and the other was unsubstantiated. The Auditor completed an in-depth review of all eight of the sexual abuse allegations.

A total of 31 detainees from 24 different countries were interviewed. Of those interviewed, four had a history of victimization, one reported sexual abuse, one was disabled/wheelchair-bound, and one was housed in a special housing unit (not PREA-related). The Auditor also interviewed 21 random staff members, and the AGS Project Manager, facility's ICE Investigator, the AGS investigator, Intake Staff, Chief of Intake, Special Housing Unit Supervisor, Supervisory Detention and Deportation Officer (SDDO), Training Administrator, Human Resources (HR) Manager, Prevention of Sexual Abuse (PSA) Compliance Manager, ICE Health Services Corp (IHSC) Health Services Administrator (HSA), IHSC Nurse, IHSC Mental Health Coordinator, Grievance Officer, Facility Administrator, and Chaplain.

The entry briefing was held in the staff conference room with the ERAU Team Lead at 8:00 a.m. on Tuesday June 8, 2020. In attendance were:

(b) (6), (b) (7)(C) – Officer in Charge (OIC), ICE/ERO

(b) (6), (b) (7)(C) - Deportation Officer (DO), ICE/ERO

(b) (6), (b) (7)(C) - Supervisory Deportation and Detention Officer (SDDO), ICE/ERO

CDR (b) (6), (b) (7)(C) Commander (CDR) - HSA, IHSC, ICE/ERO

LCDR (b) (6), (b) (7)(C) - Program Manager, IHSC, ICE/ERO

(b) (6), (b) (7)(C) - Detention Service Manager (DSM), Oversight, Compliance, and Acquisition Division (OCAD)

(b) (6), (b) (7)(C) - DO, Custody Management Unit (CMU), ICE/ERO

Thomas Eisenschmidt - Certified PREA Auditor, Creative Corrections

(b) (6), (b) (7)(C) – Inspections and Compliance Specialist, DHS/ICE/OPR/ERAU

Brief introductions were made, and the Auditor provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Lead Auditor explained the audit process is designed to assess compliance through written policies and procedures and to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policies and procedures, observations made at the time of the facility tour, review of documentation, and the results of interviews with both staff and detainees.

The Auditor shared that he received no correspondence from any detainee or staff before the audit. The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific categories) including an alphabetic and housing listing of all detainees detained at the facility, lists of staff by duty position and shifts, and a list of volunteers/contractors on duty during the on-site audit.

On June 9, 2021, an exit briefing was held in the facility conference room. The Team Lead opened the briefing and then turned it over to the Auditor.

In attendance were:

(b) (6), (b) (7)(C) - Deputy Project Manager, AGS

(b) (6), (b) (7)(C) - OIC, ICE/ERO

(b) (6), (b) (7)(C) - DO, ICE/ERO

(b) (6), (b) (7)(C) - SDDO, ICE/ERO

CDR (b) (6), (b) (7)(C) Commander (CDR) HSA, IHSC, ICE/ERO

LCDR (b) (6), (b) (7)(C) - Program Manager, IHSC, ICE/ERO

(b) (6), (b) (7)(C) - DSM, OCAD

(b) (6), (b) (7)(C) - DO, ICE/ERO

(b) (6), (b) (7)(C) - DO, ICE/ERO

(b) (6), (b) (7)(C) - Project Manager, AGS

(b) (7)(C) - Lt. AGS

Thomas Eisenschmidt - Certified PREA Auditor, Creative Corrections

Kay Washington – Inspections and Compliance Specialist, DHS/ICE/OPR/ERAU

The Auditor spoke briefly about staff and detainee knowledge of the BSPC zero-tolerance policy. The Auditor informed those present of some of the preliminary findings. Specifically, it was too early in the process to formalize an outcome of the audit and the Auditor would need to discuss and review staff and detainee interviews. The Auditor explained the audit report process, timeframes, and thanked all present for their cooperation.

## SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2

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

Number of Standards Not Applicable: 2

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

Number of Standards Met: 33

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator  
§115.13 Detainee supervision and monitoring  
§115.15 Limits to cross-gender viewing and searches  
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient  
§115.21 Evidence protocols and forensic medical examinations  
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight  
§115.32 Other training  
§115.33 Detainee education  
§115.34 Specialized training: Investigations  
§115.43 Protective custody  
§115.51 Detainee reporting  
§115.52 Grievances  
§115.53 Detainee access to outside confidential support services  
§115.54 Third-party reporting  
§115.61 Staff reporting duties  
§115.62 Protection duties  
§115.63 Reporting to other confinement facilities  
§115.64 Responder duties  
§115.65 Coordinated response  
§115.66 Protection of detainees from contact with alleged abusers  
§115.67 Agency protection against retaliation  
§115.68 Post-allegation protective custody  
§115.71 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

§115.17 Hiring and promotion decisions  
§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

## 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 Auditor based compliance with this subpart based on the review of the policy 4.5.12 - Sexual Abuse and Assault Prevention and Intervention (SAAPI) that requires "the Buffalo Federal Detention Facility (BSPC) maintains a zero-tolerance policy for all forms of sexual abuse or assault. It is the policy of the BSPC to provide a safe and secure environment for all detainees, employees, contractors, and volunteers, free from the threat of sexual abuse or assault, by maintaining a Sexual Abuse and Assault Prevention and Intervention (SAAPI Program that ensures effective procedures for preventing, reporting, responding to, investigating and tracking incidents or allegations of sexual abuse or assault." The policy requires staff and detainees be informed and trained in ways to identify and subsequently prevent sexually assaultive behavior among detainees housed at this facility. The OIC verbally confirmed the policy was approved by the agency. The interviews with staff and detainees demonstrated their awareness to the facility's zero tolerance policy to all forms of sexual abuse and the methods to report sexual abuse.

(d): The facility has designated an ICE SDDO to oversee the facility's compliance efforts with the implementation of PREA as the PSA Compliance Manager at BSPC. Policy 4.5.12 requires that "the PSA Compliance Manager will serve as the facility point of contact for the local field office and ICE PSA Coordinator and must have sufficient time and authority to comply with facility sexual abuse and assault prevention and intervention policies and procedures." The interview with the PSA Compliance Manager indicated he reports directly to the OIC on all matters related to PREA and is the point of contact for the local ICE office. He also indicated he has sufficient time and authority to perform all PREA related responsibilities. The OIC also confirmed the PSA reports directly to him on all PREA related matters. During the site visit it appeared that the PSA Compliance Manager had sufficient time and authority to accomplish his duties.

### **§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): The Auditor based compliance with this subpart based on the review of the policy 4.5.12 that requires "BSPC ensure that it maintains sufficient supervision of detainees, through appropriate staffing levels and where applicable, video monitoring to protect detainee against sexual abuse." The PAQ and the interview with the OIC confirmed the staffing complement provided by AGS is 270 men and women staff and supplemented by a total of 190 video surveillance cameras strategically located throughout the facility to aid in supervision. He also stated that BSPC staffing levels for the supervision of the detainees are established prior to the contract agreement between ICE and the security staff contractor. He stated that staffing levels are based on direct supervision of the detainees. The Auditor reviewed the staffing plan for each shift and found the number of staff assigned was adequate for the operation and programming for that shift.

(b)(c): The Auditor based compliance with these subparts of the standard based on the review of the policy 4.5.12 that requires the facility "determine security needs based on a comprehensive staffing analysis and a documented comprehensive supervision guideline that is reviewed and updated at least annually. In determining adequate levels of detainee supervision and determining the need for video monitoring, the facility shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the findings and recommendations of sexual abuse incident review reports or other findings reflecting on facility security and detainee, the length of time detainees spend in agency custody, and any other relevant factors." The facility provided the staffing guidelines for each shift at BSPC for review. The OIC stated staffing is based on direct supervision that changes from shift to shift based on activities and programs that are operating. The OIC stated that staffing levels are based on direct supervision of the detainees, generally accepted detention/correctional practices; any judicial findings of inadequacy; the physical plant; detainee population; findings of incidents of sexual abuse; any recommendations of sexual abuse incident reviews; and any other relevant factors. He, along with the Shift Commanders, confirmed detainee supervision posts are never closed. The Auditor was provided the annual staffing review for 2020. The document addressed each of the subpart (c) standard requirements. During the site visit the Auditor observed, what appeared to be, adequate security staff supervising detainees.

(d): The Auditor based compliance with this subpart of the standard based on the review of policy 4.5.12 which requires "frequent unannounced security inspections shall be conducted to identify and deter sexual abuse of detainees." The policy further requires "Inspections will occur on night as well as day shifts, and staff are prohibited from alerting others that these inspections are occurring, unless such announcement is related to the legitimate operational functions of the facility." The supervisory interviews confirmed they are required to make daily rounds in every area of the facility that detainees are permitted access to. The OIC and Shift Commanders confirmed unannounced rounds are made throughout the facility on each shift and documented. These rounds are to be documented. The Auditors were provided copies of logbook entries demonstrating rounds by supervisors. Examples of officer post descriptions provided to the Auditors require rounds be conducted throughout the entire shift ensuring that safety and security measures are being adhered to. Furthermore, a random sampling of area logbooks was examined during the site visit; the Auditor found supervisor signatures documenting unannounced security rounds on each shift in these books.

### **§115.14 - Juvenile and family detainees.**

**Outcome:** Not Applicable (provide explanation in notes)

**Notes:**

The Pre-Audit Questionnaire (PAQ), and interviews conducted with the OIC and PSA Compliance Manager confirmed BSPC does not accept juveniles or family detainees. The personal observations by the Auditor also confirmed no juveniles being housed at BSPC.

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

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

#### **Notes:**

(b)(c)(d)(i): The Auditor based compliance with these subparts of the standard based on the review of policy 4.5.12 and policy 3.1.18 – Searches, that requires “pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Pat-down searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All pat-down searches by staff of the opposite gender shall be documented.” The policy also prohibits staff from “searching or physically examining a detainee for the sole purpose of determining the detainees’ genital characteristics. If the 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 medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private by a medical practitioner.” The OIC and PSA Compliance Manager confirmed no cross-gender pat searches were conducted at BSPC within the audit period and, if one were done, it would be documented. The Auditor interviewed both male and female random AGS security staff from each shift, 12 in total. Pat-search training and procedures were discussed with each of them, and the Auditor determined that the training was provided upon hiring and then annually thereafter. They also detailed for the Auditors the conditions under which a pat search may be performed, as outlined in policy and required by the standard. They specifically stated they are prohibited from searching any detainee for the sole purpose of determining their genital status. If they were required to have that information, the detainee would be brought to medical. The Auditor reviewed the PREA training and the search specific training curriculums demonstrating the subpart (i) and (j) standard requirements.

(e)(f): The Auditor based compliance with these subparts of the standard based on the review of policy 4.5.12 and policy 3.1.18 that requires “strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches shall be documented.” During interviews, both security and medical health care staff outlined for the Auditors the conditions under which a strip search and body cavity search may be performed at BSPC. Medical staff indicated that body cavity searches could not be performed by them to recover contraband, as IHSC staff are prohibited from performing any type of forensic examinations. Strip searches are performed when entering or leaving segregation by AGS staff. The search is documented on a form by AGS staff and a copy is sent to ICE. The Auditor observed the form that would be utilized if necessary during the on-site visit. The PAQ and interviews with the OIC and PSA Compliance Manager indicated BSPC neither authorized nor conducted any body cavity searches during the audit period. According to the random security staff interviews and the segregation supervisory Lieutenant, strip searches are permitted as a matter of routine for entering the segregation unit and for suspicion of contraband and must be documented per policy 3.1.18.

(g): The Auditor based compliance with this subpart of the standard based on the review of policy 4.5.12 that requires “detainees be able to shower, perform bodily functions and change clothing, without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with medical examination or monitored bowel movement. Staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing.” Random security and non-security staff confirmed the facility’s requirement to announce their presence every time they enter any area where detainees of the opposite gender may be showering, changing clothes, or performing bodily functions. During the site visit, the Auditor heard opposite gender staff announcing themselves prior to entering areas where detainees may be showering, changing clothes, or performing bodily functions. The Auditor interviewed random detainees and the majority confirmed staff of the opposite gender announce themselves prior to entering their living areas or areas where they may be showering or in a state of undress.

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

(j): The Auditor based compliance with this subpart of the standard based on the review of policy 4.5.12 that requires “all pat-down searches shall be conducted in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and policy, including officer safety.” The search curriculum is a class by itself that affords practical application. During the 12 random security staff interviews, each confirmed their training on searching cross gender, transgender, or intersex detainees in a professional and respectful manner.

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

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

#### **Notes:**

(a)(b): The Auditor based compliance with these subparts of the standard based on the review of policy 4.5.12 and policy 4.1.2 - Detainee Orientation that requires “upon admission to the BSPC, all detainees be notified of the facility’s zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee facility handbook, and provided with information about the facility’s SAAPI program.” The policies further require “the facility provide the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are limited English proficient (LEP), deaf, visually impaired, or otherwise disabled, as well as detainees who have limited reading skills. Procedures for LEP detainees or those with disabilities involve utilizing interpreter services or a Text Telephone (TTY) machine. The facility must maintain documentation of detainee participation in the instruction and orientation session.” According to four intake staff, the Chief of Intake, and PSA Compliance Manager interviews, each detainee arriving at BSPC receives the ICE Sexual Abuse and Assault Awareness pamphlet, the ICE National Detainee Handbook, and the Buffalo (facility-specific) handbook. The ICE Sexual Abuse and Assault Awareness pamphlet and Buffalo handbook are available in English and Spanish formats only. At the time of the on-site visit the facility had copies of ICE Sexual Abuse and Assault Awareness pamphlet in just Spanish and English. The ICE National Detainee Handbook is available in 11 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, and Vietnamese). After the on-site visit, the facility informed the Auditor they obtained the pamphlet in the other nine languages. According to intake staff, the two informational videos (PREA and Know Your Rights) run continuously in the intake area and in each housing unit; the videos are in English and Spanish. The intake staff interviews also confirmed that when confronted with a detainee that may be hearing impaired or deaf, information is provided to them in writing or through use of the text telephone (TTY). Those who are blind or with limited sight are provided individualized service by the intake staff to include reading information to the detainee if needed. The intake staff indicated when dealing with a detainee with low intellect or limited reading skills it would require referral to a supervisor, medical or mental health staff based on the detainee’s limitation. LEP detainees are provided assistance by staff through interpretative services, either through available staff or the ERO Language line. Thirty of the 31 random detainee interviews confirmed receiving information in a format that they understood; seven of those were LEP.

(c): The Auditor based compliance with this subpart of the standard based on the review of policy 4.5.12 that requires "in matters relating to allegations of sexual abuse, the facility shall employ effective expressive and receptive verbal communicating techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. The facility shall provide detainees with disabilities and LEP detainees with in-person or telephonic interpretation services that enable effective, accurate and impartial interpretation both receptively and expressively using any necessary specialized vocabulary." The policy further states "interpretation services shall be provided by someone other than another detainee unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." The 12 random security staff interviews, as well as the facility investigator, confirmed they were aware of the policy restrictions on the use of detainee interpreters, unless a detainee expresses a preference for another detainee to provide interpretation, and the agency determines that such interpretation is appropriate and consistent with DHS policy. A review of eight investigative case files indicated that in three instances, the detainee was provided interpretation through staff. The facility investigator confirmed detainees that are LEP, and where the facility does not have a Spanish speaking staff member on duty, the language line would always be used when conducting investigations.

### **§115.17 - Hiring and promotion decisions.**

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

#### **Notes:**

(a)(b)(e)(f): Review of Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0, require "the facility and agency, to the extent permitted by law, to refuse to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor or volunteer who may have contact with detainees, who has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard." The documents require all new hires, staff awaiting promotions, and all staff on an annual basis to complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form. The individual will respond directly to questions about previous misconduct as required per the standard and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The Division Chief of the OPR Personnel Security Unit (PSU), John Schwink, informed Auditors who attended training in Arlington, Virginia, in September 2018, that candidate suitability for all employment applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Applicants are questioned directly about any such previous misconduct both during their background check and during the job interview process and a positive response to any of those specific questions are grounds for unsuitability including material omissions or making false or misleading statements in the application. The AGS HR Manager confirmed the facility would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated that this information is provided through Work Force, an agency that AGS contracts with to maintain records. She also stated the facility would request information from prior institutions where the prospective candidate was previously employed and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire.

**DOES NOT MEET:** (b)-The hiring guidelines require, on an annual basis and upon every promotion, to complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form to comply with the standard requirements as outlined in (b). The Auditor reviewed 5 employee files, including a promotion, and could not find a completed self-declaration form in any of the files reviewed. The facility initiated the use of the self-declaration form during the on-site visit. The facility must provide copies of the Self-Declaration of Sexual Abuse/Sexual Harassment form for six employees (2 new hire, 2 current, and 2 promoted staff) to demonstrate compliance.

(c)(d): The Auditor determined compliance with these subparts after a review of Federal Statute 731.105 and ICE Directives 6.7.0 and 6.8.0 that require the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees prior to being allowed entrance into the facility. It further requires an updated background check be conducted every five years on all employees and unescorted contractors. The AGS HR Manager stated ICE completes all background checks for all staff and contractors prior to hiring and then every five years. Review of documentation provided by ICE's PSU Unit Chief confirmed that the 10 randomly selected employee's (five-AGS staff and five-ICE staff) background checks were performed prior to them reporting to work. Documentation also confirmed the due dates for the updated five-year background checks. The Auditor determined the provided background check information was compliant with the standard in all material ways.

### **§115.18 - Upgrades to facilities and technologies.**

**Outcome:** Not Applicable (provide explanation in notes)

#### **Notes:**

(a)(b): These subparts of the standard are not applicable based on the PAQ and the interview with the BSPC OIC who confirmed the facility has not expanded or modified the existing facility or updated video monitoring equipment since the previous audit in 2017.

### **§115.21 - Evidence protocols and forensic medical examinations.**

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

#### **Notes:**

(a): The Auditor determined compliance with this subpart of the standard after a review Policy 4.5.12 which outlines, "the BSPC Uniform Evidence Protocol that guarantees all individuals involved in any sexual assault incident ensure the chain of evidence is maintained." The policy further requires "taking steps to secure the scene, collecting clothing worn using standard precautions, collecting physical evidence using standard precautions, and searching the cells of involved offenders." The AGS facility investigator and ICE BSPC investigator confirmed each follows the evidence protocols provided in training and outlined in the policy to ensure the physical evidence needed for an administrative investigation is obtained and preserved. PREA allegations are investigated through OPR. The agency's policy 11062.2, SAAPI, outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS OIG, OPR, or the local law enforcement agency, ERO would assign an administrative investigation to be conducted. The Auditors found, after a thorough review of

eight investigative files, it appeared uniform evidence protocols were followed during the administrative investigations. The AGS security staff and IHSC medical staff indicated they are aware of the facility's evidence protocols and know the necessary steps to take during a report of sexual abuse.

(b)(d): The Auditors determined compliance to these standard subparts based on review of the memorandum of understanding (MOU) between the facility and RESTORE (Sexual Assault Services), a local advocacy group that leads the community response to sexual violence through advocacy and education by providing the safety, support, and validation that changes the lives of all those affected. The Auditor spoke with a staff member from RESTORE, who confirmed a qualified staff person from the organization would provide emotional support, crisis intervention, information, referrals if needed, and would accompany the victim through any forensics exams and investigative process. The facility reported eight sexual abuse investigations during the audit period. In review of the eight investigative files, the Auditor observed documentation indicating the alleged victims were offered victim advocacy services contact information. The facility AGS and ICE investigators confirmed that upon notification of every allegation, the detainee is first taken to medical, then he/she is provided this victim advocate information by both the investigator and medical staff. The investigative files document the alleged victim is provided this victim advocate information as well. The Auditor interviewed one detainee who alleged sexual abuse and confirmed being offered victim advocate information. The detainee did not disclose if the victim advocate was contacted.

(c): The Auditor based compliance with this subpart of the standard based on the review of policy 4.5.12 that requires "the facility in cases where evidentiary or medically appropriate, the facility administrator shall arrange for an alleged victim to undergo a forensic medical examination by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), where practicable. If a SANE or SAFE cannot be made available, the examination can be performed by other qualified health care personnel." The policy further requires "all services be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the allegation." The BSPC's medical department is managed and operated by IHSC staff, who are prohibited by policy to participate in sexual assault forensic medical examinations or evidence gathering. The HSA confirmed forensic examinations are conducted by the Erie County Medical Center (ECMC) by a trained SAFE or SANE practitioner and that BSPC staff, by policy, stabilizes the individual if necessary, in preparation for transport. The Auditor spoke with staff at the ECMC who confirmed that although there is no formal MOU with BSPC, the hospital would provide forensic services for detainees at the facility through their Buffalo Rising Against Violence, a DOJ funded SANE operation, at no cost to the detainee. The facility had no forensic examinations conducted during the audit period based on interviews with the PSA Compliance Manager, the HSA, review of the investigative files and review of the facility's PAQ.

(e): The Auditor based compliance with this subpart of the standard based on the review of policy 4.5.12 that requires "the facility in sexual abuse incidents secure and preserve evidence and safeguard information to the greatest extent possible consistent with established evidence protocols. The Genesee County Sheriff's Office Chief of Detectives (585) 345-3000 will be contacted by the OIC to begin a criminal investigation if warranted. Internal administrative investigations and disciplinary sanctions are pursued concurrently in a way that ensures non-interference with any criminal investigation." The policy further requires, "in the event the investigation is being conducted by a non-federal investigating agency, the facility shall request that the investigating agency follow the applicable requirements of this policy, including requirements related to evidence preservation and forensic examinations." The facility provided documentation that it requested the Sheriff Office comply with subparts (a) through (e) of this standard but has not heard back from them. None of the allegations of sexual assault at BSPC were determined to be criminal.

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

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

#### **Notes:**

(a)(b): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 requires that "all allegations of sexual abuse be investigated by qualified investigators and be referred to the Genesee County Sheriff's Office, who has the proper investigative authority for conducting all allegations of sexual abuse that are deemed to be criminal." The OIC and PSA Compliance Manager confirmed the BSPC policy requirements adhere to subparts (a)(b) requirements. Criminal investigations are referred to the Genesee County Sheriff, the agency with legal authority to conduct criminal investigations. The 4.5.12 policy also requires, "that upon the conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon completion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations will include preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse and assault involving the alleged perpetrator. Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." The PAQ indicated there were eight allegations of sexual abuse during the audit period. Six incidents were detainee-on-detainee allegations and two were staff-on-detainee allegations. None of the eight allegations were determined criminal. The Auditor reviewed all eight investigation files and determined they appeared to be completed in accordance with the standards and included direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses. The AGS and ICE Investigators were interviewed and found to be very knowledgeable concerning their responsibilities in the investigative process. ICE conducts administrative investigations for all allegations. The AGS Investigator assists with collecting video footage and allegation statements and provides them to the ICE Investigator who conducts the administrative investigation. The PSA Compliance Manager confirmed that all records associated with an allegation of sexual assault would be maintained for a minimum of 5 years beyond the release of the detainee or the employment of the staff member.

(c): . BSPC is an ICE facility and the agency investigative protocols can be found on the agency web site <https://www.ice.gov/detain/prea>. A review of the website confirms the sexual abuse investigation protocols are available to the public. These protocols are posted to ensure the public is informed about the investigative process explained to the public.

(d)(e)(f): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "all allegations of sexual abuse, when a staff member, contractor, or volunteer are involved, be promptly reported to the agency: Joint Intake Center (JIC); ICE OPR or the DHS OIG; and appropriate ICE FOD and, local law enforcement entity unless the complaint does not involve potentially criminal behavior. BSPC documents all required notifications on the form "Checklist for Responding to Allegations of Sexual Abuse or Assault at ICE Detention and Holding Facilities." The interviews with the facility's OIC and PSA Compliance Manager indicated all allegations are promptly reported to the JIC, the ICE OPR, or the DHS OIG, as well as the appropriate ICE FOD. The documentation observed in the eight investigative files further verified these notifications.



### **§115.31 - Staff training.**

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

**Notes:**

(a)(b)(c): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "training on the facility's SAAPI program be included in initial and annual refresher training for all employees. The review of the BSPC training curriculum includes instruction on: the facility's zero-tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal sexual behavior; the right of detainees and staff to be free from sexual abuse and from retaliation from reporting sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need to know in order to make decisions concerning the detainee-victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees; instruction on reporting knowledge or suspicion of sexual abuse and/assault and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault. All employees are required to sign and date the "PREA Training Certification" form at the conclusion of the training to document pre-service and annual in-service training." This certification states that "By signing and dating below I certify I have received training on: the agency's zero-tolerance policies for all forms of sexual abuse; the right of detainees and employees to be free from sexual abuse, and from retaliation for reporting sexual abuse; definitions and examples 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 such occurrences; procedures for reporting knowledge or suspicion of sexual abuse; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex (LGBTI), or gender nonconforming detainees; and the 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 purposes." The Auditors reviewed 15 random training files (ICE staff [1] and AGS staff [14]) and found each contained a signed certification form. The 12 random AGS staff and two ICE staff interviewed by Auditors confirmed each had received PREA pre-service and annual refresher training. Those interviewed also confirmed the instruction they received included the requirements outlined in subpart (a) of the standard. The interview with the AGS Training Administrator and review of the training curriculum confirmed the subpart (a) requirements are part of the information provided as well. The Training Administrator also confirmed that all staff assigned at BSPC received their annual refresher training in 2020 except for those out on long-term absence due to military leave. The Auditor indicated the facility exceeds the requirements of the standard as refresher training is provided annually, exceeding the requirement of refresher training every two years by the standard.

### **§115.32 - Other training.**

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

**Notes:**

(a)(b)(c): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "all volunteers and other contractors who have contact with detainees shall be trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention, and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees, however all volunteers and contractors who have any contact with detainees must be notified of ICE and the facility's zero-tolerance policy and informed how to report such incidents." The AGS Training Administrator confirmed all contractors receive the same PREA training the security staff receive and is documented by signature on the PREA Training Certification acknowledging they have received and understood the training. BSPC has 12 volunteers who are required to receive pre-service and annual refresher training on their responsibilities, under the agency's and facility's sexual abuse policy, to include definitions of prohibited acts, communication with LGBTI groups, means of reporting, and ensuring the nearest security staff person is notified if a detainee alleges sexual abuse to them. Two contractor training records were reviewed and included the signed statement having received the training. The Auditor was unable to interview any volunteers as none are allowed on site during the covid-19 pandemic but did review one of their training records that demonstrated a signed document acknowledging the individual received and understood the agency's sexual abuse training.

### **§115.33 - Detainee education.**

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

**Notes:**

(a)(b)(c): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "upon admission to the BSPC, all detainees be notified of the facility's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee handbook and provided with information about the facility's SAAPI program. Such information shall include at a minimum: the facility's zero-tolerance policy for all forms of sexual abuse or assault; the name of the facility PSA Compliance Manager, and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point of contact line officer, the DHS/OIG and the ICE/OPR investigation processes; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings and the right of a detainee who has been subjected to sexual abuse to receive treatment and counselling. The facility shall provide the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are LEP, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. During the intake process, detainees who are determined to be LEP or who may have a disability, i.e., hearing impaired, deaf, and blind, etc. will receive interpretive services and/or medical and/or mental health assistance throughout the process. The facility shall maintain documentation of detainee participation in the instruction session." Detainees arriving at BSPC are provided a National ICE Detainee Handbook, Buffalo (facility-specific) handbook, DHS-prescribed Sexual Abuse and Assault Awareness pamphlet, and are shown the two informational videos (PREA and Know Your Rights) that run continuously in the intake area and in each housing unit; the videos are in English and Spanish. The ICE National Detainee Handbook is available in 11 languages while the other documents are available in Spanish and English only. At the time of the site visit the facility had copies of the ICE Sexual Abuse and Assault Awareness pamphlet in just Spanish and English. After the on-site visit, the facility obtained the pamphlet in the other nine languages. The Auditors interviewed 31 detainees from 24 different countries with seven detainees were LEP, and all but one indicated they were provided documentation and information in a format each understood about the facility's SAAPI program.

(d): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "BSPC to post the DHS prescribed sexual assault awareness notice; the name of the PSA Compliance Manager; and the name of local organizations that can assist detainees who have been victims of sexual abuse on all housing unit bulletin boards." During the site visit, the Auditor observed the DHS prescribed notice, the name of the PSA Compliance Manager and the name of the victim advocate (RESTORE) in each of the detainee living areas. The random detainee interviews confirmed their knowledge of these postings in the living areas.

(e)(f): The Auditors determined compliance with these subparts of the standard after the interviews with four intake staff and the Chief of Intake who confirmed the intake process and what orientation materials each detainee receives upon arrival. Upon arrival, each detainee receives a medical screening, security screening to include paperwork and property inventory, and each is provided both the DHS prescribed ICE Sexual Abuse and Assault Awareness pamphlet and a copy of the ICE National Detainee Handbook. During the 31 detainee interviews, all but one confirmed they had received copies of these documents and signed for receipt of them. The Auditor randomly selected eight detainee files and reviewed signed documentation confirming receipt of both the ICE National Detainee Handbook and the Buffalo local facility handbook as part of the facility orientation.

#### **§115.34 - Specialized training: Investigations.**

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

#### **Notes:**

(a)(b): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "in addition to the general training, all facility staff responsible for conducting sexual abuse or assault investigations shall receive specialized training that covers at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross agency coordination in the investigation process. The facility must maintain written documentation verifying specialized training is provided to investigators pursuant to the requirement." Agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault that covers investigative techniques, evidence collections, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency offers another level of training, Fact Finders Training that 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; LGBTI, and disabled detainees; and an overall view of the investigative process. The agency provided training records of agency investigators to review for compliance with subpart (b) of the standard. Interviews with the OIC, the facility investigator, and Training Supervisor indicated required staff, three investigators at BSPC, have received specialized training for conducting sexual abuse investigations in accordance with the standard. Both ICE and AGS investigators have received the ICE OPR-Investigating Incidents of Sexual Abuse and Assault training. The Auditor was provided with certificates of completion for staff completing the specialized training. It was also determined the curriculum meets the standard requirements. The interviews conducted with the ICE and AGS investigators verified the completion of the training and indicated the training included interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. Each of the eight BSPC allegations were completed by a trained investigator.

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

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

#### **Notes:**

(a)(b): The Auditor determined compliance with these subparts of the standard after a review of IHSC Directive 03-01 Sexual Abuse and Assault Prevention and Intervention that requires "in addition to the general training provided to all employees, the agency shall provide specialized training to DHS or agency employees who serve as full and part-time medical practitioners or full and part-time mental health practitioners in immigration detention facilities where medical and mental health care is provided." The HSA confirmed the specialized training, provided by IHSC, covers all four elements outlined and required in subpart (b) of the standard; how to detect and assess signs of sexual abuse; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; and how and to whom to report allegations of sexual abuse. He also confirmed medical staff at BSPC are prohibited from conducting forensic examinations. If a forensic examination would be required, the detainee is sent to the ECMC where a SAFE/SANE will examine the victim. Interviews with medical and mental health staff indicated they received this additional specialized, and did so on an annual basis. The HSA confirmed all medical and mental health staff receive this training annually and are currently up to date. The HSA stated the required additional specialized training is provided through the Performance and Learning Management System (PALMS) and provided the Auditor with the curriculum topics covered in the training, that meet the subpart requirements. The Auditor randomly chose three medical training files and verified this training was received. The Auditor determined the facility exceeds the specialized training requirement as the standard only indicates the training is a one-time event and the facility requires it annually.

(c): The Auditor determined compliance with this standard subpart based on interviews with the OIC and PSA Compliance Manager who indicated the agency did review and approve the facility's policy and procedures for examining and treating victims of sexual abuse.

#### **§115.41 - Assessment for risk of victimization and abusiveness.**

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

#### **Notes:**

(a)(b)(c)(d): Policy 4.5.12 requires that "all detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior, and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until they have been classified and then they may be housed accordingly. The initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility." Interviews with intake staff and the Chief of Intake confirmed each detainee arriving at BSPC is assessed for vulnerability by the IHSC medical staff; however, this medical screening only addresses three of the nine subpart (c) requirements. Furthermore, the HSA indicted the assessment covers only the last six months, which does not meet the requirement of the standard to capture historical information. The majority of the detainees interviewed indicated they received what they believed was a classification within the first couple hours of arrival. The first day of the on-site visit, the PSA Compliance Manager was already providing guidance for the AGS intake staff to conduct an initial risk assessment on each detainee arriving at BSPC utilizing the 60/90-day reassessment document that addresses all nine of the subpart (c) requirements.

**DOES NOT MEET:** (c)(d)The facility's current assessment process does not capture all the required information of subpart (c)(d) nor does it capture a historical view past the last six months. The facility must develop a process to capture all the required information and ensure it does not restrict the

historical information captured to just the last six months. The facility needs to demonstrate that it is complying with the standard (c)(d) subparts while conducting initial risk assessments and update the policy on who, how, and what document will be used to complete it. The facility must provide an updated policy or directive that outlines the intake risk assessment process including the instrument they utilize to capture the required information including historical information beyond six months and staff responsible for the task. Staff training on the updated policy and/or directive for the new assessment process must be conducted and documentation provided for compliance review. The facility must also provide copies of ten risk assessments over a two month period to demonstrate an on-going process for standard compliance.

(e) The Auditor determined compliance with this subpart of the standard after review of policy 4.5.12 that requires reassessments of each detainee's risk of victimization or abusiveness occur between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The interview with the Classification Supervisor corroborated the reassessments requirements in the policy and indicated they are performed by the intake staff using a reassessment document. This reassessment document encompasses all of the requirements in (c). The Auditor was provided copies of completed reassessment forms (2-reassessments) performed within the reassessment time frame as required. The Auditor reviewed five investigative files and the each of these detainees' detention files and found vulnerability reassessments completed on detainees completed within the 24 hour requirement specified in the Performance-Based National Detention Standards (PBNS) which BSPC is required to comply with.

(f): The Auditor determined compliance with this subpart of the standard after review of policy 4.5.12 that "prohibits detainees from being punished for refusing to answer, or for not disclosing complete information in response to questions asked about: whether the detainee has a mental, physical or developmental disability, identifies as LGBTI or gender non-conforming, experienced prior sexual victimization, or has any concerns about his physical safety." The Classification Officer and the four intake officers confirmed detainees are not disciplined for refusing to answer any of the questions asked during the assessment.

(g): The Auditor determined compliance with this subpart of the standard after review of policy 4.5.12 that requires, "the facility implement appropriate controls on the dissemination of responses to questions asked related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees." The policy further requires sensitive information be limited to staff on a need-to-know basis only for the purpose of treatment, programming, housing, and security and management decisions. The Classification Officer confirmed appropriate controls are placed on all detainee records, and information including reassessments are maintained in the detainee's detention file and secured in the records room file cabinet, which is under double lock and key.

#### **§115.42 - Use of assessment information.**

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

#### **Notes:**

(a): Policy 4.1.1, Detainee Admission Procedures, and policy 4.5.12 requires, "the facility assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger." The Classification Officer indicated detainee assignments are made on an individual basis after reviewing the detainees' vulnerability assessment and Record of Deportable/Inadmissible Alien (Form I-213) document. He stated that all classification determinations outlined in subpart (a) are made on an individualized basis, taking into account these available documents to ensure the safety of each detainee. Since the initial vulnerability assessment does not cover all the requirements of 115.41(c), the determinations made by the Classification Officer are not completed in accordance with subpart (a), which requires the facility to use the information from the risk assessment under 115.41 to inform assignment of detainees to housing, recreation, and other activities, and voluntary work. The agency shall make individualized determinations about how to ensure the safety of each detainee.

**DOES NOT MEET:-** The facility is not accurately completing the risk assessment under 115.41; therefore, the risk assessment is not utilized to make informed assignment of detainees to housing, recreation and other activities, and voluntary work. The agency must make individualized determinations about how to ensure the safety of each detainee utilizing the risk assessment. The facility must develop a process to make informed assignments from the risk assessment that includes all pertinent information from 115.41(c). The facility must provide copies of ten risk assessments over a two month period with the individualized detainee determinations for housing, recreation and other activities, and voluntary work to ensure the safety of each detainee. The facility must provide staff refresher training on the policy and standard requirements on making individualized determinations to ensure the safety of the detainee and provided documentation of the training for compliance review.

(b)(c): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "when making assessment and housing decisions for a transgender or intersex detainee, the facility shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his gender and self-assessment of safety needs shall always be taken into consideration as well. The facility's placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee." The policy states, "When operationally feasible, transgender and intersex detainees shall be given the opportunity to shower separately from other detainees." The PSA Compliance Manager indicated depending on the housing unit the transgender or intersex detainee is assigned to, showering would be arranged at times when other detainees were not in the shower, like at count times. The facility does accept transgender detainees, but according to the PSA Compliance Manager, the facility has not had a transgender detainee assigned to BSPC in over three years.

#### **§115.43 - Protective custody.**

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

#### **Notes:**

(a)(b)(c)(e): The Auditor determined compliance with these subparts of the standard after a review of policy 3.4.2, Administrative Segregation and policy 3.4.4, Protective Custody Operations, that require "the use of administrative segregation to protect detainees with special vulnerabilities, including detainees vulnerable to sexual abuse or assault, to those instances where reasonable efforts have been made for the least amount of time practicable, and when no other viable housing option exists, and as a last resort. Vulnerable detainees who have been placed in administrative segregation for protective custody should not be held there beyond 30 days and shall have access to programs, services, visitation, counsel, and other services available to the general population to the maximum extent possible." These policies further require, "victims and vulnerable detainees be

housed in a supportive environment that represents the least restrictive housing option possible and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. This placement should take into account any ongoing medical or mental health needs of the victim." The policies also require, "BSPC to notify the appropriate ICE FOD whenever a detainee is placed in administrative segregation due to vulnerability to sexual abuse or assault for 72 hours or longer. If access to programs, privileges, education, or work opportunities is restricted, the facility shall document the reason for it." The Auditor interviewed the BSPC Segregation Lieutenant, who indicated that segregation is not normally used to house victims or potential victims of sexual assault unless the detainee requests it. The OIC indicated segregation would not be used to protect a vulnerable detainee and that alternative housing would be utilized, including the use of the facility medical beds. He also stated that if the use of segregation were ever used for any victim or vulnerable detainee, he would notify the FOD within 72 hours. He also stated that segregation has not been utilized within the audit period to house any victim or vulnerable detainee. The OIC approved all policies used at BSPC.

(d): The Auditor determined compliance with this subpart of the standard after a review of policy 3.4.2 that requires "the OIC/AOIC assign a supervisor to be responsible for investigating the circumstance of the detainee's placement in segregation, within 72 hours to determine whether segregation is still warranted." The policy further requires "a multi-disciplinary committee of facility staff, including facility leadership, medical and mental health professionals, and security staff shall meet weekly to review all detainees currently housed in the facility's Special Housing Unit (SHU). During the meeting, the committee shall review each detainee individually to ensure all staff are aware of the detainee's status, current behavior, and physical and mental health, and to consider whether any change in status is appropriate. Upon the request of the Field Office Director, the facility administrator shall permit ICE/ERO personnel to participate in the weekly meetings either in person or by teleconference. The review authority will consider any alternatives available and what, if any, assistance could be provided the detainee to facilitate their return to the general population." The Segregation Lieutenant confirmed the segregation policy and practice. The OIC indicated segregation would not be used to protect a vulnerable detainee. He also indicated if it were to be used, the review process outlined in policy 3.4.4 and 3.2.4 would be utilized. He also stated that segregation has not been utilized within the audit period to house any victim or vulnerable detainee. The one detainee interviewed who alleged sexual abuse indicated he was never placed in segregation as a result of his allegation or vulnerability.

### **§115.51 - Detainee reporting.**

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

#### **Notes:**

(a)(b): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 and the Buffalo detainee handbook that requires "detainees have multiple ways to privately and if desired, anonymously report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting them." The policy outlines reporting options for detainees: to any staff, during sick call, through the grievance office, to BSPC administrators, calling the facility's 24-hour toll-free notification telephone numbers, through their family members, and through the contact information each detainee is provided upon arrival and posted throughout the facility. The ICE National Detainee Handbook and Buffalo handbook have reporting information for the DHS OIG and the Detainee Reporting Information Line (DRIL). The Auditor checked the reporting line (DRIL in three different housing locations and found them operational with no need for detainee PIN to make the call. The PSA Compliance Manager and random staff interviews informed the Auditor that consular office information and reporting information is provided to detainees in the orientation materials distributed at intake and on posters throughout the facility. This information was observed posted in unit living areas and in the holding area during the site visit. The random detainee interviews confirmed this reporting information is provided upon arrival and posted in the detainee living areas. All but one of the 31 detainees randomly interviewed confirmed their knowledge of how to report any incidents and indicated that reporting information is provided to them and posted throughout the facility. The Auditors also confirmed through the review of the eight randomly chosen detainee files that the orientation/intake materials were inclusive of this reporting information and signed for receipt of them, as indicated in 115.33.

(c): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "staff take seriously all statements from detainees claiming to be victims of sexual abuse or assault and shall respond supportively and non-judgmentally and accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." The PSA Compliance Manager, facility investigator, and facility PAQ confirmed that of the eight reported PREA allegations during the audit period, one was reported through the DRIL, and the remaining seven were reported to security staff. The investigator informed the Auditor that in each case, where the incident was presented to staff verbally, the staff documented it in writing or had the detainee document it in writing. The Auditor interviewed random staff who confirmed the BSPC policy requirement that they are to accept and immediately report all allegations of sexual abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors. The eight case file reviews demonstrated written allegations of sexual abuse were properly documented.

### **§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): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 and policy 3.5.6, Detainee Grievance Procedures, that require "formal grievances related to sexual abuse and assault may be filed at any time during, after, or in lieu of lodging an informal grievance or complaint and with no time limit imposed on when a grievance may be submitted. Decisions on grievances shall be issued within 5 days of receipt and appeals shall be responded to within 30 days." These policies further require, "Emergency grievances are those involving an immediate threat to the welfare or safety of a detainee. Processing for emergency grievances will begin with the initial determination by the receiving staff member that the issue raised is life threatening. Emergency grievances may be given directly to the GO [Grievance Officer], Shift Supervisor or the OIC. Medical emergency grievances shall be brought to the immediate attention of proper medical personnel for medical assessment. Emergency Grievances concerning sexual abuse or assault will immediately be forwarded to the OIC/AOIC through the chain of command. All grievances related to sexual abuse and the facility's decision on any such grievance be forwarded to the FOD." The Auditor interviewed the acting Grievance Officer who confirmed the PSA Compliance Manager and OIC are immediately notified of all allegations of sexual abuse made through the grievance office. He also stated allegations of sexual abuse are treated as an "emergency" grievance and that all medical emergencies are brought immediately to the proper medical personnel for assessment. All findings on this type of grievance are responded to within five days of receipt and responses to an appeal of the grievance decision are responded to within 30 days. The interview with the PSA Compliance Manager confirmed once notified of the grievance, she notifies, as required, the OIC of the allegation who then notifies the FOD. None of the eight allegations within the audit period were made through the grievance process.

(f) The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 and review of the Buffalo local facility handbook that indicate, "detainees may obtain assistance from another detainee, the housing officer or other facility staff, family members or legal

representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties.” Random staff interviews confirmed their knowledge of the assistance requirements noted both in policy and the local detainee handbook. The acting Grievance Officer detailed and confirmed the policy requirement as well.

### **§115.53 - Detainee access to outside confidential support services.**

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

**Notes:**

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires “BSPC to utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse and assault perpetrators to most appropriately address victim needs.” The policy further requires, “the facility attempt to enter into a MOU with a community service provider or national organization to provide legal advocacy and confidential emotional support services for immigrant victims of sexual abuse.” BSPC entered into an MOU with RESTORE in 2018 with no sunset date. This community victim advocate agency provides emotional support and crisis intervention service to victims of abuse regardless of when it occurred. The Auditor spoke with a representative of this agency and confirmed the MOU, and the services RESTORE provides to BSPC. The representative from RESTORE indicated that RESTORE not only provides support to all victims of sexual assault but they also accept reports of sexual abuse. The representative stated that RESTORE is a mandatory reporting agency and informs the detainee prior to accepting any allegations that information will be forwarded back to the facility. The representative further indicated that RESTORE has not been used by the facility in any capacity within the audit period. Detainee victims of sexual abuse are provided with this advocate information, which was confirmed during the interview with the detainee who alleged to have been sexually assaulted. The PSA Compliance Manager confirmed that all contact with RESTORE is confidential and unmonitored at BSPC. Telephone contact is made to RESTORE without the detainee providing their PIN number to make contact. The review of the eight investigative case files documented victim advocate services were offered to the detainee. The extent to which the telephones are monitored is found in the Buffalo detainee handbook and noted on the housing unit bulletin boards.

### **§115.54 - Third-party reporting.**

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

**Notes:**

The Auditor determined compliance with the standard after a review of policy 4.5.12 that requires “third party reports of sexual abuse of detainees being housed at the BSPC can be reported directly to the facility lobby officer during visitation hours. The lobby officer will immediately notify the OIC/AOIC or first line supervisor when a third-party report of sexual abuse is received. Third party reports of sexual abuse can also be made by calling the facility’s main number (585-344-6500).” The lobby has SAAPI posters in plain view of visitors with information on how to report sexual abuse on behalf of a detainee. The ICE National Detainee Handbook and the Buffalo handbook provide information for the reporting of sexual abuse by third parties. The ICE website, <https://www.ice.gov/prea>, has reporting information on behalf of a detainee as well. These resources are available to the public. The PSA Compliance Manager and Investigator confirmed BSPC had one allegation reported through the DRIL within the audit period.

### **§115.61 - Staff reporting duties.**

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

**Notes:**

(a)(b)(c): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires “all staff to immediately report: any knowledge, suspicion, or information, regarding an incident or allegation of sexual abuse occurring at the facility; any retaliation against detainees or staff who reported or participated in an investigation about sexual abuse or assault; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.” The policy also states “ICE employees at the BSPC follow the chain of command by reporting to their first line SDDO who will in turn report directly to the OIC/AOIC. All contract personnel will report directly to their first line supervisors who in turn will report directly to the OIC/AOIC.” The OIC/AOIC at the BSPC indicated they have an open-door policy on reporting incidents of a serious nature (i.e. an incident or allegation of sexual abuse) which do not require the standard chain of command to be followed. All staff are required to report sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee victim’s welfare, and for law enforcement/investigative purposes. As previously noted, this policy was reviewed and approved by the OIC. The 12 random staff interviews confirmed their knowledge of the BSPC reporting requirements outlined by the policy and that these requirements are reinforced in their PREA training they receive annually. The staff interviews also confirmed their knowledge of reporting sexual abuse outside their chain of command directly to the OIC, if needed. The Auditor also reviewed the training curriculum for pre-service and annual refresher training and found the reporting information and requirements detailed in the curriculum as required by the standard. The PSA Compliance Manager, facility Investigator, and the facility’s PAQ confirmed that of the eight reported PREA allegations during the audit period, seven were reported to security staff. The Investigator informed the Auditor that in each case, where the incident was presented to staff verbally, the staff documented it in writing or had the detainee document it in writing. The seven case file reviews demonstrated allegations of sexual abuse were properly reported and documented by staff.

(d): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires “if the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person statute, the facility shall report that information to the FOD so that ICE can report the allegation to the designated State or local services agency under applicable mandatory reporting laws.” BSPC does not house juveniles or family detainees. The PAQ and interviews with the OIC and the PSA Compliance Manager confirmed if any vulnerable adult was ever the victim of a sexual assault at BSPC, the facility would notify the Sheriff and the FOD as it does with every allegation. The facility has not had any incidents involving a vulnerable adult as there were no vulnerable adults housed at BSPC during the audit period.

### **§115.62 - Protection duties.**

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

**Notes:**

The Auditor determined compliance with the standard after a review of policy 4.5.12 that requires “if a facility staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee.” The Auditors questioned 12 AGS security staff, 2 ICE staff, the PSA Compliance Manager and the OIC about this type of situation, and all of them responded that the detainee’s safety and well-being would be their primary concern in any situation where the detainee would be in substantial risk of sexual abuse/assault. Each of their responses indicated that their primary response would be to immediately locate the detainee and remove him/her from

danger and then contact their supervisor. The OIC and PSA Compliance Manager confirmed BSPC had no known detainees at substantial risk of imminent sexual abuse within the audit period.

#### **§115.63 - Reporting to other confinement facilities.**

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

**Notes:**

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "Upon receiving an allegation that a detainee was sexually abused or assaulted while confined in another facility, the facility administrator shall notify the Field Office Director and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation. The facility administrator shall notify the detainee in advance of such reporting. The facility shall document that it has provided such notification. A facility receiving such notification shall ensure the allegation is referred for investigation and reported to the Field Office Director." The OIC and PSA Compliance Manager indicated that BSPC has received no allegations of sexual abuse from detainees at BSPC having occurred in other facilities, and if they had, they would notify the facility and the FOD by email within 72 hours of being notified. They also confirmed BSPC had not received any reported allegations of sexual abuse reported back to them by another facility allegedly having occurred at BSPC.

#### **§115.64 - Responder duties.**

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

**Notes:**

(a): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "first responder staff take immediate action to separate any detainee who alleges that he/she has been sexually abused or assaulted from the alleged assailant, and shall refer the detainee for a medical examination and/or a clinical assessment for potential negative symptoms. The first security staff member to respond to a report of a sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect evidence." The policy also requires "if the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder shall: request the alleged victim and abuser not to take any action that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating." During the review of the eight investigative files, the Auditor determined the responding security staff member(s) followed the protocols as required by the situation and as outlined in the policy. The interviews with the 12-security staff confirmed their responsibilities as responders to incidents of sexual abuse. Each of them detailed their handling of any sexual abuse allegation. These responses were exact requirements outlined in the subpart and required policy protocols.

(b): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "if the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and notify security staff." The OIC and investigator confirmed five of the eight allegations made during the audit period, were made to security staff with one reported through the DRIL and two to non-security staff. Two interviews conducted with non-security staff confirmed if an allegation of sexual abuse was made to them, that they would secure the detainee and notify the closest security staff person.

#### **§115.65 - Coordinated response.**

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

**Notes:**

(a)(b): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "the facility use a coordinated, multidisciplinary team approach to sexual abuse, such as a Sexual Assault Response Team (SART), to include a medical practitioner a mental health practitioner, a facility administrator, an investigator from the assigned investigative entity, and representatives from outside entities that provide relevant services and expertise (advocate)." The PSA Compliance Manager confirmed that SART's primary duties include responding to reported incidents of sexual abuse; responding to victim assessment and support needs; ensuring policy and procedures are enforced to enhance detainee safety; and participating in the development of practices and/or procedures that encourage prevention of sexual abuse. The Auditor reviewed eight investigative files and found each documented the multidisciplinary and coordinated responses (Medical, Mental Health, Investigator, etc.) at BSPC in the response to the sexual abuse allegations.

(c)(d): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires that "if a victim is transferred between detention facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential for medical or social services (unless the victim requests otherwise in the case of a transfer to a non-ICE facility). If the receiving facility is unknown to the sending facility, the sending facility shall notify the FOD, so that he or she can notify the receiving facility." The OIC, PSA Compliance Manager, and the PAQ confirmed that BSPC had no detainee make an allegation of sexual abuse prior to being transferred to another facility by ICE that would have required this notification. If they had, the OIC and PSA Compliance Manager both stated the policy and notification process would have been followed with the FOD notification and medical notifications.

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

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

**Notes:**

The Auditor determined compliance with the standard after a review of policy 4.5.12 that requires "staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." The BSPC policy denotes "Staff (employees, contractors and volunteers). The PSA Compliance Manager and OIC indicated if any employee (AGS or ICE, contractor, or volunteer) was the subject of a sexual abuse allegation he/she would be removed from all detainee contact until the investigation was completed. BSPC had two allegations of sexual abuse made against staff during the audit period. The Auditor was provided separation notices prohibiting the employee from any detainee contact until the completion of the investigations.

#### **§115.67 - Agency protection against retaliation.**

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

**Notes:**

(a)(b)(c): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "staff, contractors, and volunteers shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. The facility shall employ multiple

protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations." The policy further states "for at least 90 days following a report of sexual abuse or assault, the facility, in concert with ICE, shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff, and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments by staff." The PSA Compliance Manager at BSPC has been designated as the monitor for staff and detainee retaliation. During his interview, he confirmed he monitors the detainee for at least 90 days during which time he meets with the detainee and monitors any detainee disciplinary reports, housing changes or requests and questions him/her on issues they may be experiencing or concerned about. He also stated his staff monitoring for retaliation continues for at least 90 days and may be extended longer, if needed. The staff retaliation monitoring would include investigation into negative performance reviews, time off refusals, and change of duties or reassignment requests. Retaliation monitoring documentation was provided on the detainees who reported sexual abuse. The monitoring continued for 90 days unless the detainee was released. The PSA Compliance Manager confirmed BSPC has had no cases of retaliation reported by a detainee or staff member within the last 12 months. The review of the eight investigative files confirmed monitoring was performed for at least 90 days unless the detainee was released.

#### **§115.68 - Post-allegation protective custody.**

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

#### **Notes:**

(a)(b)(c)(d): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 and policy 3.4.4 that require "victims and vulnerable detainees be housed in a supportive environment that represents the least restrictive housing option possible and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault, and shall not be held for longer than five days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee." The policy also requires that "a detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until the completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee." The policy also states that "the facility shall notify the appropriate ICE Field Office Director whenever a detainee victim, or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hours." The Auditor interviewed the Segregation Lieutenant who indicated that segregation is never used for victims or potential victims of sexual assault unless the detainee requests it. The OIC indicated segregation would not be used to protect a vulnerable detainee or victim and that some form of alternative housing would be utilized, like the use of medical beds. He also stated that if the use of segregation were ever used for that purpose, he would notify the FOD within 72 hours and comply with the provision of the policy. The OIC approved all policies used at BSPC.

#### **§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): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "the facility coordinate with ICE and other appropriate investigative entities to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse." The policy further requires "all investigations must be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators. Administrative investigations are conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The ICE OPR will typically be the appropriate investigative office within DHS, as well as the DHS OIG in cases where the DHS OIG consents conducting the investigation." The Auditor interviewed both the facility ICE investigator and the AGS investigator. According to the AGS investigator, his role is to gather staff reports of the allegations, secure any video footage, and provide support to the ICE investigator, if needed. The ICE investigator confirmed he conducts the facility administrative investigations after OIG, OPR, and local law enforcement has either concluded their investigation or declined the investigation. He also confirmed administrative investigations are conducted on every allegation. As previously noted the Auditor reviewed eight investigative files. Each investigation was performed by a trained investigator and appeared to be prompt, thorough and objective.

(c)(e)(f): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "administrative investigations be conducted on all allegations of sexual abuse to include the following procedures: preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators and witnesses; reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect or witness without regard to the individuals status as detainee, staff or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph and an effort to determine whether actions or failures to act at the facility contributed to the abuse." The policy further requires that "the documentation of each investigation by written report shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings and the departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." The ICE investigator and the PSA Compliance Manager confirmed documentation of such reports are maintained for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. The ICE Investigator confirmed an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. The PSA Compliance Manager affirmed when the outside law enforcement agency, Genesee County Sheriff's Office, investigates allegations of sexual abuse, the facility cooperates to the fullest and remains informed through verbal or written communication.

#### **§115.72 - Evidentiary standard for administrative investigations.**

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

#### **Notes:**

The Auditor determined compliance with the standard after a review of policy 4.5.12 that states "the facility uses no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated" for administrative investigations conducted by the AGS Investigator. Agency SAAPI policy (11062.2) states, "Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse or assault, and may not be terminated solely due to the departure of the alleged abuser or victim from the employment or control of ICE." Upon review of the eight investigative files, it appeared to the Auditor that a preponderance of the evidence was the standard used in determining the outcome of the investigations. Interviews with the AGS investigator and PSA Compliance Manager verified the facility will not impose any standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated.

**§115.73 - Reporting to detainees.**

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

**Notes:**

The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "following an investigation conducted by the facility into a detainee's allegation of sexual abuse, the facility shall notify the FOD of the results of the investigation and any responsive actions taken so that the information can be reported to ICE headquarters and to the detainee." During the review of eight investigative files, the Auditors found the detainee notification document in each. Five of the notification forms were signed by the detainee and three forms had a notation that the detainee had been released prior to the conclusion of the investigation.

**§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): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "staff shall be subject to disciplinary or adverse action, up to and including removal from their position for substantiated allegations of sexual abuse or for violating ICE or facility sexual abuse rules, policies, or standards." This policy was reviewed and approved by the OIC. There were two allegations of sexual abuse involving staff during the audit period. One of the allegations was determined unfounded and the other investigation was unsubstantiated. The Auditor was provided with documentation of the two staff removals from contact with the detainees when the allegation was made and until the investigation was concluded. The OIC confirmed any staff member that violates the zero-tolerance policy would be removed from Federal Service. All violations would be reported to the FOD by him.

(c)(d): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "the facility report all incidents of substantiated sexual abuse by staff and all removal of staff or resignations in lieu of removal for violations of sexual abuse policies, to appropriate law enforcement agencies unless the activity was clearly not criminal. The facility shall also report all such incidents of substantiated abuse, removals, or resignations in lieu of removal to the FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such information to any relevant licensing bodies to the extent known." The OIC confirmed staff are subject to discipline for violations of the department's sexual abuse policies and termination is the presumptive disciplinary sanction for a staff member who has engaged in sexual abuse. He also indicated removals or resignations for violations of agency or facility sexual abuse policies would be appropriately handled with notification to the FOD and forwarded to any relevant licensing bodies by the facility to the extent known. He also stated that no staff had been terminated or disciplined within the audit period for violation of the zero-tolerance policy. There were no staff-on-detainee cases found to be substantiated, resulting in staff being subjected to disciplinary or adverse action, up to and including removal from their position.

**§115.77 - Corrective action for contractors and volunteers.**

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

**Notes:**

(a)(b)(c): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall also report such incidents to the FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies to the extent know." The OIC stated any contractor or volunteer found to have violated any part of their zero-tolerance policy would face immediate removal from the facility and prohibited from future contact with any detainee. He also confirmed there were no reported incidents requiring the removal of a contractor or volunteer within the previous 12 months and, if there were, they would be reported to the FOD, Genesee County Sheriff, and any licensing body.

**§115.78 - Disciplinary sanctions for detainees.**

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

**Notes:**

(a)(b)(c)(d)(e)(f): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 and policy 3.3.1, Detainee Discipline, that require detainees be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault." The policies also require that "the sanctions be commensurate with the nature and circumstances of the abuse committed; the detainee's disciplinary history; the sanctions imposed for comparable offenses by other detainees with similar histories; the discipline be intended to encourage the detainee to conform to rules and regulations in the future." Policy 3.3.1 documents the facility's disciplinary system with levels of reviews, appeals, procedures, and documentation procedures that considers whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Policy 4.5.12 requires the facility not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. This policy also requires a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The OIC and PSA Compliance Manager confirmed BSPC follows both policies when dealing with detainee misconduct. None of the detainee-on-detainee allegations were found to be substantiated resulting in the detainee disciplinary process being utilized.

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

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

**Notes:**

(a)(b)(c): Policy 4.5.12 requires "if the screening required in standard 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall take appropriate action to ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow up as appropriate." This policy further states "when a referral for medical follow-up is initiated the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." The HSA confirmed the referral for medical or mental health follow-up is typically accomplished on the same day the referral is made but always within the standard and policy time requirements. She also confirmed medical asks each detainee on the admission assessment about prior victimization, and if the detainee answers in the affirmative,



the computerized question is checked and a referral to mental health for an appointment is automatically made. If the situation requires immediate attention, the detainee is seen immediately, otherwise the detainee is seen in accordance with policy and procedures. The Auditor interviewed four detainees who reported prior victimization, and each indicated they were offered medical/mental health services. As noted in 115.41, the facility was not conducting full vulnerability assessments beyond the couple questions medical was asking. The facility initiated a new process to conduct the full initial assessment for risk during the site visit but the Auditor has not received evidentiary documentation of that new process yet. Furthermore, as the medical screening form currently stands, it does ask about prior victimization, but the referral is only made if the victimization occurred within the last six months.

**DOES NOT MEET:** Detainees are only being offered a referral if the report sexual victimization was within the past six months. If the assessment pursuant to 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate, regardless of when the incident was reported to have occurred; therefore, the facility must implement a process that ensures detainees who meet this criteria are referred regardless of when the incident occurred. The facility must provide an updated process, policy or directive that outlines a detainee who has reported sexual victimization including historical beyond the last six months is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. Staff training on the updated process, policy and/or directive for the new process must be conducted and documentation provided for compliance review. The facility must also provide copies of ten risk assessments and medical or mental health notes where a detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up over a two month period to demonstrate an on-going process for standard compliance.

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

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

#### **Notes:**

(a)(b): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." The policy further states "all treatment services, both emergency and ongoing shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The services provided to victims are to be consistent with the community level of care." The facility provided the Auditors with medical records and investigative files for the alleged eight victims of sexual assault reported during the audit period. The review of these files confirmed each of the alleged victims were immediately brought to the medical unit and evaluated by medical staff. The HSA indicated victims would have access to medical examinations and crisis services, consistent with community standards, and at no cost to the detainee regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The interview with the detainee who alleged sexual assault confirmed he was brought to medical immediately and was never charged for any initial or follow-up services related to the allegation.

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

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

#### **Notes:**

(a)(b)(c)(d)(f): The Auditor determined compliance with these subparts of the standard after a review of policy 4.5.12 that requires "the facility offer medical and mental health evaluation and as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention and shall provide such victims with medical and mental health services consistent with the community level of care." The policy further requires, "the evaluation and treatment of such victims shall include follow up service; treatment plans; and when necessary, referrals for continued care following their transfer to, or placement in other facilities, or their release from custody." The policy also details, "any detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy related medical services and timely access to all lawful pregnancy related medical services." The HSA confirmed the medical and mental health services at BSPC are consistent with the community level of care and all treatment would be provided without cost to the detainee victims regardless of if he/she names the abuser or cooperates with any investigation arising out of the incident. The Auditor reviewed eight investigative files documenting detainees, who alleged sexual abuse, were seen by medical and mental health staff. The interview with the detainee who alleged sexual assault confirmed he was brought to medical immediately and was never charged for any initial or follow-up services related to the allegation.

(e): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "victims be provided tests for sexually transmitted infections as medically appropriate." The HSA confirmed the facility follows the 4.5.12 policy requirements and indicated that the medical and mental health departments at BSPC are able to provide on-site crisis intervention services and testing for sexually transmitted infections and other infectious diseases and if necessary, they could provide prophylactic treatment to detainees if needed.

(g): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "the facility attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." None of the eight allegations during the audit period were determined to be substantiated. The mental health practitioner confirmed the facility would see any abusive detainee and offer services.

#### **§115.86 - Sexual abuse incident reviews.**

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

#### **Notes:**

(a): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "the facility conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For any substantiated or unsubstantiated allegation, the facility shall prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and assault. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response." Both the report and response shall be forwarded to the FOD, or his or her designee for transmission to the ICE PSA Coordinator. The PSA Compliance Manager stated the incident review team is composed of ICE administrators, the PSA Compliance Manager, AGS administrators, an investigator and a medical or mental health staff person and completes an incident reviewing in writing on all sexual abuse allegations. The Auditors reviewed eight investigative files and found an

incident review for all of the files conducted within 30 days of the investigation being completed. There were no recommendations for improvement made in any of these completed incident reviews.

(b): The DHS Sexual Abuse or Assault Incident Review form utilized at BSPC indicates the team is required to determine if the assault or abuse was motivated by race; ethnicity; gender identity; LGBTI identification; status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The incident reviews completed on this form included the review of each of these elements and were included in the eight investigative files the Auditor reviewed.

(c): The Auditor determined compliance with this subpart of the standard after a review of policy 4.5.12 that requires "all department heads meet annually with the OIC/AOIC to conduct a review of all investigations of sexual abuse or assault. Each SAPPI file will be examined and discussed to ensure proper policy and protocols are in place, working and being adhered to. At the conclusion of the annual review, BSPC shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. The results and findings of the annual review written response shall be provided to the Buffalo FOD, or his or her designee for transmission to the ICE PSA Coordinator." The PSA Compliance Manager provided the Auditors with the annual review completed in October 2020, with no recommended changes, and indicated it was distributed to the Facility Administrator, FOD, and Corporate 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): The Auditor determined compliance with this standard after a review of policy 4.5.12 that requires "the facility maintain in a secure area all case records associated with claims of sexual abuse or assault, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post release treatment if necessary." The PSA Compliance Manager confirmed all investigative files and related data abuse is securely maintained in his office under double lock and key, with access restricted to only staff with a need to review. He indicated the records are retained for at least five years after release of the staff or detainee from BSPC unless federal, state, or local law requires otherwise.

#### **§115.201 - Scope of audits.**

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

**Notes:**

- (d): The Auditor was allowed access to the entire facility while on-site and able to interview staff and detainees about sexual safety during the contingency process and the on-site visit.
- (e): The Auditor was able to revisit areas of the facility and to view all relevant documentation as requested.
- (i): Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
- (j): Audit notices were posted and observed throughout the facility in English and Spanish. The Auditor received no staff or detainee correspondence.

### **AUDITOR CERTIFICATION**

Update Audit Findings Outcome Counts by Clicking Button:

**Update Outcome Summary**

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

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

*Thomas Eisenschmidt*

8/2/2021

**Auditor's Signature & Date**

**(b) (6), (b) (7)(C)**

8/3/2021

**PREA Assistant Program Manager's Signature & Date**

**(b) (6), (b) (7)(C)**

8/3/2021

**PREA Program Manager's Signature & Date**

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



**Homeland  
Security**

**AUDITOR INFORMATION**

<b>Name of Auditor:</b>	Thomas Eisenschmidt	<b>Organization:</b>	Creative Corrections, LLC.
<b>Email address:</b>	(b) (6), (b) (7)(C)	<b>Telephone number:</b>	315-730- (b) (6), (b) (7)(C)

**PROGRAM MANAGER INFORMATION**

<b>Name of PM:</b>	(b) (6), (b) (7)(C)	<b>Organization:</b>	Creative Corrections, LLC.
<b>Email address:</b>	(b) (6), (b) (7)(C)	<b>Telephone number:</b>	772-579- (b) (6), (b) (7)(C)

**AGENCY INFORMATION**

<b>Name of agency:</b>	U.S. Immigration and Customs Enforcement (ICE)
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**FIELD OFFICE INFORMATION**

<b>Name of Field Office:</b>	Buffalo
<b>Field Office Director:</b>	Thomas E. Feeley
<b>ERO PREA Field Coordinator:</b>	(b) (6), (b) (7)(C)
<b>Field Office HQ physical address:</b>	250 Delaware Ave, Floor 7, Buffalo, NY 14202
<b>Mailing address: (if different from above)</b>	

**INFORMATION ABOUT THE FACILITY BEING AUDITED**

**Basic Information About the Facility**

<b>Name of facility:</b>	Buffalo Service Processing Center (BSPC)
<b>Physical address:</b>	4250 Federal Drive, Batavia, NY 14020
<b>Mailing address: (if different from above)</b>	
<b>Telephone number:</b>	585-344-6500
<b>Facility type:</b>	SPC

**Facility Leadership**

<b>Name of Officer in Charge:</b>	(b) (6), (b) (7)(C)	<b>Title:</b>	Officer in Charge
<b>Email address:</b>	(b) (6), (b) (7)(C)	<b>Telephone number:</b>	585-344- (b) (6), (b) (7)(C)
<b>Facility PSA Compliance Manager</b>			
<b>Name of PSA Compliance Manager:</b>	(b) (6), (b) (7)(C)	<b>Title:</b>	Supervisory Detention and Deportation Officer
<b>Email address:</b>	(b) (6), (b) (7)(C)	<b>Telephone number:</b>	585-344- (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.

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Buffalo Service Processing Center (BSPC), formerly known as the Buffalo Federal Detention Facility (BFDF), was conducted on June 8-9, 2021, by U.S. Department of Justice (DOJ) and U.S. DHS certified PREA Auditor, Thomas Eisenschmidt, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C), and Assistant Program Manager, (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), and External Reviews and Analysis Unit (ERAU) during the audit report review process. The BSPC is an ICE operated facility with security and support service supplied by Akima Global Service (AGS) under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains male and female adult detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at BSPC are from the Dominican Republic, Jamaica, and El Salvador. BSPC is located in Batavia, New York.

During the audit, the Auditor found the BSPC met 33 standards, had 2 standards (115.31, 115.35) that exceeded, had 2 standards (115.14, 115.18) that were non-applicable, and 4 non-compliant standards (115.17, 115.41, 115.42, and 115.81). As a result, the facility was placed under a corrective action period to address the non-compliant standards, which has now been completed and the facility is found compliant with all standards.

In September 2021, November 2021, and in January 2022, the Auditor was provided the ICE PREA Corrective Action Plan (CAP), through ERAU, and reviewed to determine compliance with the four standards that did not meet compliance during the PREA audit site visit and documentation review. The final supplied documentation was reviewed by the Auditor on January 27, 2022. The review of this documentation confirmed that all four standards are compliant in all material ways.

## PROVISIONS

**Directions:** After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence relied 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. 17 - Hiring and promotion decisions

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

#### Notes:

(a)(b)(e)(f): Review of Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0, require "the facility and agency, to the extent permitted by law, to refuse to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor or volunteer who may have contact with detainees, who has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard." The documents require all new hires, staff awaiting promotions, and all staff on an annual basis to complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form. The individual will respond directly to questions about previous misconduct as required per the standard and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The Division Chief of the OPR Personnel Security Unit (PSU), (b) (6), (b) (7)(C), informed Auditors who attended training in Arlington, Virginia, in September 2018, that candidate suitability for all employment applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Applicants are questioned directly about any such previous misconduct both during their background check and during the job interview process and a positive response to any of those specific questions are grounds for unsuitability including material omissions or making false or misleading

statements in the application. The HR Manager confirmed the facility would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated that this information is provided through Work Force, an agency that AGS contracts with to maintain records. She also stated the facility would request information from prior institutions where the prospective candidate was previously employed and any candidate or staff member providing false, misleading, or incomplete information would be subject to dismissal or withdrawal of an offer to hire.

**DOES NOT MEET (b):** The hiring guidelines require, on an annual basis and upon every promotion, to complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form to comply with the standard requirements as outlined in subpart (b). The Auditor reviewed 5 employee files, including a promotion, and could not find a completed self-declaration form in any of the files reviewed. The facility initiated the use of the self-declaration form during the site visit. The facility must provide copies of the Self-Declaration of Sexual Abuse/Sexual Harassment form for six employees (2 new hire, 2 current, and 2 promoted staff) to demonstrate compliance.

**CORRECTIVE ACTION:** On September 14, 2021, the Auditor accepted the "MEMORANDUM FOR: Administration and Training Department" dated June 15, 2021, and the PREA Self-Declaration Form. The memorandum indicates the PREA Self-Declaration Form will be completed by all employees annually during the facility's annual refreshing training. The facility provided signed copies of the PREA Self-Declaration Form of Sexual Abuse/Sexual Harassment for six employees (2 new hire, 2 current, and 2 promoted staff) to demonstrate compliance. The facility is compliant with the standard in all material ways.

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

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

#### **Notes:**

(a)(b)(c)(d): Policy 4.5.12 requires that "all detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until they have been classified and then they may be housed accordingly. The initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility." Interviews with intake staff and the Chief of Intake confirmed each detainee arriving at BSPC is assessed for vulnerability by the IHSC medical staff; however, this medical screening only addresses three of the nine subpart (c) requirements. Furthermore, the HSA indicated the assessment covers only the last six months, which does not meet the requirement of the standard to capture historical information. The majority of the detainees interviewed indicated they received what they believed was a classification within the first couple hours of arrival. The first day of the on-site visit, the PSA Compliance Manager was already providing guidance for the AGS intake staff to conduct an initial risk assessment on each detainee arriving at BSPC utilizing the 60/90-day reassessment document that addresses all nine of the subpart (c) requirements.

**DOES NOT MEET (c)(d):** The facility's current assessment process does not capture all the required information of subpart (c)(d), nor does it capture a historical view past the last six months. The facility must develop a process to capture all the required information and ensure it does not restrict the historical information captured to just the last six months. The facility needs to demonstrate that it is complying with the standard (c)(d) subparts while conducting initial risk assessments and update the policy on who, how, and what document will be used to complete it. The facility must provide an updated policy or directive that outlines the intake risk assessment process including the instrument they utilize to capture the required information including historical information beyond six months and staff responsible for the task. Staff training on the updated policy and/or directive for the new assessment process must be conducted and documentation provided for compliance review. The facility must also provide copies of ten risk assessments over a two-month period to demonstrate an on-going process for standard compliance.

**CORRECTIVE ACTION:** The Auditor received the CAP update on November 23, 2021, addressing the training and the responsibilities for the staff assigned to processing detainees upon arrival. The Auditor was also provided an updated post order for the processing staff position. The risk assessment form was updated but still did not address all the subpart (c)(d) requirements. The standard remained non-compliant based on the fact the Admission PREA Vulnerability Assessment Questionnaire allowed the detainee to opt out of the assessment prior to the victimization question required under subpart (c) being asked. The CAP documents received by the Auditor on January 27, 2022, removed the opt out ability for the detainee, and addressed both the subpart (c)(d) requirements. The facility provided completed risk forms as required. The facility is now compliant with the standard in all material ways.

### §115. 42 - Use of assessment information

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

**Notes:**

(a): Policy 4.1.1, Detainee Admission Procedures, and policy 4.5.12 requires, "the facility assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger." The Classification Officer indicated detainee assignments are made on an individual basis after reviewing the detainees' vulnerability assessment and Record of Deportable/Inadmissible Alien (Form I-213) document. He stated that all classification determinations outlined in subpart (a) are made on an individualized basis, taking into account these available documents to ensure the safety of each detainee. Since the initial vulnerability assessment does not cover all the requirements of 115.41 (c), the determinations made by the Classification Officer are not completed in accordance with subpart (a), which requires the facility to use the information from the risk assessment under 115.41 to inform assignment of detainees to housing, recreation, and other activities, and voluntary work. The agency shall make individualized determinations about how to ensure the safety of each detainee.

**DOES NOT MEET (c)(d):** The facility is not completing the risk assessment under 115.41 (c)(d); therefore, the risk assessment is not utilized to make informed assignments of detainees to housing, recreation and other activities, and voluntary work. The agency must make individualized determinations about how to ensure the safety of each detainee utilizing the risk assessment. The facility must develop a process to make informed assignments from the risk assessment that includes all pertinent information from 115.41 (c)(d). The facility must provide copies of ten risk assessments over a two-month period with the individualized detainee determinations for housing, recreation and other activities, and voluntary work to ensure the safety of each detainee. The facility must provide staff refresher training on the policy and standard requirements on making individualized determinations to ensure the safety of the detainee and provided documentation of the training for compliance review.

**CORRECTIVE ACTION:** The Auditor received the CAP update on November 23, 2021. The risk assessment form was updated but still did not address all the subpart (c)(d) requirements allowing staff to make informed decisions about detainee's housing, recreation and other activities, and voluntary work to ensure the safety of each detainee. The CAP documentation received by the Auditor on January 27, 2022, addressed the subpart (c)(d) requirements and the facility provided completed risk forms as required. The facility is now compliant with the standard in all material ways.

### §115. 81 - Medical and mental health assessments; history of sexual abuse

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

**Notes:**

(a)(b)(c): Policy 4.5.12 requires "if the screening required in standard 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall take appropriate action to ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow up as appropriate." This policy further states "when a referral for medical follow-up is initiated the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." The HSA confirmed the referral for medical or mental health follow-up is typically accomplished on the same day the referral is made but always within the standard and policy time requirements. She also confirmed medical asks each detainee on the admission assessment about prior victimization, and if the detainee answers in the affirmative, the computerized question is checked and a referral to mental health for an appointment is automatically made. If the situation requires immediate attention, the detainee is seen immediately, otherwise the detainee is seen in accordance with policy and procedures. The Auditor interviewed four detainees who reported prior victimization, and each indicated they were offered medical/mental health services. As noted in 115.41, the facility was not conducting full vulnerability assessments beyond the couple questions medical was asking. The facility initiated a new process to conduct the full initial assessment for risk during the site visit, but the Auditor had not received evidentiary documentation of that new process when the interim report was issued. Furthermore, as the medical screening form currently stands, it does ask about prior victimization, but the referral is only made if the victimization occurred within the last six months.

**DOES NOT MEET (a):** Detainees are only being offered a referral if the reported sexual victimization was within the past six months. If the assessment pursuant to 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate, regardless of when the incident was reported to have occurred; therefore, the facility must implement a process that ensures detainees who meet this criteria are referred regardless of when the incident occurred. The facility must provide an updated process, policy or directive that outlines a detainee who has reported sexual victimization including historical beyond the last six months is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. Staff training on

the updated process, policy and/or directive for the new process must be conducted and documentation provided for compliance review. The facility must also provide copies of ten risk assessments and medical or mental health notes where a detainee was referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up over a two-month period to demonstrate an on-going process for standard compliance.

**CORRECTIVE ACTION:** The Auditor received the CAP update on November 23, 2021, indicating the facility and IHSC medical policies were changed to reflect any detainee identified under PREA concerns by the facility during intake is referred directly to medical and mental health services regardless of the timeframe of the incident. To assist in the facility's ability to capture the historical information regarding sexual abuse beyond six months, the facility has edited its Admission PREA Vulnerability Assessment Questionnaire to not reference a time frame. This form was updated on November 15, 2021, to now show "Prior to arriving to the facility, has anyone forced or threatened you to engage in sexual activity, or have you experienced sexual victimization at any time in your life?" All new and previous detainees identified using this form are directly referred to medical/mental health services regardless of any medical intake responses. In addition, any medical history beyond the six-month time frame is also included in the medical/mental health encounters, if provided by the detainee. The standard remained non-compliant based on the fact the Admission PREA Vulnerability Assessment Questionnaire allowed the detainee to opt out of the assessment prior to the victimization question required under subpart (c) being asked. The Auditor also noted the facility would need to provide an example of the new form being utilized once this issue was resolved. The CAP documents received by the Auditor on January 27, 2022, removed the opt out ability for the detainee and the facility provided completed risk forms and medical documentation supporting the subpart requirements. The facility is now compliant with the standard in all material ways.

**§115. Choose an item.**

**Outcome:** Choose an item.

**Notes:**

**§115. Choose an item.**

**Outcome:** Choose an item.

**Notes:**

**AUDITOR CERTIFICATION:**

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

Thomas Eisenschmidt  
**Auditor's Signature & Date**

February 25, 2022

(b) (6), (b) (7)(C)  
**Assistant Program Manager's Signature & Date**

February 28, 2022

(b) (6), (b) (7)(C)  
**Program Manager's Signature & Date**

February 28, 2022