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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Robin M. Bruck	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Chicago Field Office		
Field Office Director:	Ladeon Francis		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	101 W Ida B Wells Drive, Chicago, Il 60605		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Chase County Detention Center		
Physical address:	307 S Walnut Street, Cottonwood Falls, KS 66845		
Mailing address: *(if different from above)*	PO Box 639, Cottonwood Falls, KS 66845		
Telephone number:	620-273-7054		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	620-273-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manger
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	620-273-(b) (6), (b) (7)(C)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found Chase County Detention Center (CCDC) met 10 standards, had 0 standards that exceeded, had 1 standard that was non-applicable, and had 30 non-compliant standards. As a result of the facility being out of compliance with 30 standards, the facility entered into a 180-day corrective action period which began on April 04, 2023, and ended on October 01, 2023. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Not Met: 30

§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
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and mental health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews

The facility submitted documentation, through the Agency, for the CAP on April 28, 2023, through October 1, 2023. The Auditor reviewed the CAP documentation and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on October 1, 2023. In a review of the submitted documentation, to demonstrate compliance with the deficient standards, the Auditor determined compliance with 23 of the standards, and found that 7 standards continued to be non-complaint based on submitted documentation or lack thereof.

Number of Standards Met: 23

§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
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.43 Protective custody
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§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.64 Responder duties
§115.65 Coordinated response
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.78 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

Number of Standards Not Met: 7

§115.31 Staff training
§115.33 Detainee education
§115.35 Specialized training: Medical and Mental Health care
§115.42 Use of assessment information
§115.67 Agency protection against retaliation
§115.81 Medical and mental health assessments; history of sexual abuse
§115.86 Sexual abuse incident reviews

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence replied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit. Failure to comply with any part of a standard provision shall result in a finding of "Does not meet Standard" for that entire provision, unless that part is specifically designated as Not Applicable.

§115. 13 - Detainee supervision and monitoring

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

Notes:

(a)(b)(c): CCDC Policy #14 states, "The facility shall provide sufficient staff to ensure that detainee supervision is performed in a manner that will deter and prevent sexual abuse. The use of electronic monitoring devices will be in place to assist and document events. Assigned staff are to make security checks of all areas of responsibility on an irregular basis and unannounced security inspections on all shifts." The facility reported 41 staff employed at the facility who may have recurring contact with detainees, which includes 28 security DOs (16 male and 12 female), 4 transport officers, 3 administrative staff, and 3 medical staff, and 3 full-time ICE staff. According to the PAQ, security custody staff work two 12-hour shifts, 0600-1800 and 1800-0600. During an interview with the JA, the Auditor confirmed the facility utilizes a staff-detainee ratio to maintain sufficient supervision of the detainees. He reported that he strives to maintain a 7/1 ratio. In addition, the JA indicated the facility utilizes video monitoring in its efforts to protect detainees against sexual abuse. During the on-site audit, the Auditor observed appropriate staffing levels within the facility. The facility has a total of [redacted] strategically located throughout the facility. Video cameras are operated 24 hours a day, 7 days a week and have PTZ functionality. The Control Officer post is manned 24 hours a day, 7 days a week and has line of sight into 7 of the housing units. The (b) (7)(E) is visually monitored with the use of the video monitoring system and continual security inspections but cannot be physically seen by the Control Officer. The Auditor observed the control officer site lines and confirmed there are no blind spots within the housing units. The Auditor observed the facility comprehensive detainee supervision guidelines (Post Orders) and confirmed the guidelines were reviewed and updated in April 2022. Interviews with the JA and PSA Compliance Manager confirmed the facility considers generally accepted detention and correctional practices; the physical layout of the facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents; the findings and recommendations of sexual abuse incident reviews; the length of time the detainees spend in the Agency custody; and any judicial findings of inadequacy when determining the adequate levels of detainee supervision and the need for video monitoring. However, the JA further indicated that the facility did not have an actual staffing plan but strives to maintain a 7/1 ratio of staff to detainee.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. In an interview with the JA, it was confirmed that the facility does not have a staffing plan but strives to maintain a 7/1 staff ratio. To become compliant, the facility must provide the Auditor with documentation to confirm when determining adequate staffing levels at CCDC, and the need for video monitoring, that the facility took into consideration: the physical layout of each holding facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the findings and recommendations of sexual abuse incident review reports; or any other relevant factors, including but not limited to the length of time detainees spend in Agency Custody.

Corrective Action Take (c): The facility submitted a staffing plan which confirms when determining adequate staffing levels and the need for video monitoring CCDC considers the physical layout of each holding facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the findings and recommendations of sexual abuse incident review reports; or any other relevant factors, including but not limited to the length of time detainees spend in CCDC. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

(d): CCDC Policy #14 states, "Assigned staff are to make security checks of all areas of responsibility on an irregular basis, and unannounced security inspections on all shifts." A review of CCDC Policy #14 confirmed it did not include the requirement that staff are prohibited from alerting others that unannounced security inspections are being conducted. The Auditor reviewed the facility control logs and could not differentiate the PREA unannounced security inspections from normal security inspections conducted at the facility on each shift. During interviews with the JA and the PSA Compliance Manager, it was indicated all security staff are required to perform security inspections during the day and night shifts. However, interviews with the JA and the PSA Compliance Manager could not confirm these inspections are PREA unannounced security inspections conducted specifically to deter detainee sexual abuse. In addition, interviews with the DOs could not confirm that staff are prohibited from alerting others that these security inspections are occurring.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The Auditor reviewed the facility control logs and could not differentiate the PREA unannounced security inspections from the standard security inspections conducted at the facility on each shift. During interviews with the JA and PSA Compliance Manager, it was indicated that all security staff are required to perform security inspections during the day shift and the night shift. However, interviews with the JA and the PSA Compliance Manager could not confirm these security inspections are PREA unannounced security inspections conducted specifically to deter detainee sexual abuse. In addition, interviews with the DOs could not confirm staff are prohibited from alerting others that these security inspections are occurring. To become compliant, the facility must develop and implement a procedure to conduct frequent unannounced security inspections to identify and deter sexual abuse of detainees. The procedure shall include requiring supervisors to document the unannounced security inspections to confirm PREA unannounced security inspections are being conducted. Once implemented, the facility shall document training of all custody supervisors on the new procedure, including instruction regarding the purpose of the unannounced security inspections. In addition, the facility must implement a procedure that prohibits staff from notifying others that the unannounced security inspections are being conducted. Once implemented the facility must document training of all security line staff and supervisors on the new procedure.

Corrective Action Taken (d): The facility updated and submitted policy Chapter #14, SAAPI, which requires assigned staff are to make security checks of all areas of responsibility on an irregular basis, and unannounced security inspections on all shifts. A review of updated policy Chapter #14 further confirms it requires unannounced security inspections will be conducted with the goal of deterrence of detainee sexual abuse and staff are prohibited from alerting others that unannounced security inspections are being conducted. The facility submitted a staff training roster which confirms all applicable staff have received training on updated policy Chapter #14, SAAPI. Upon review of all submitted documentation, the Auditor now finds the facility in compliance with subsection (d) of the standard.

§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:

(g): CCDC Policy #14 states, "The Chase County Detention Center shall ensure that the detainees may shower, perform bodily functions, 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." During the on-site audit, the Auditor observed the male staff announcing, "Male on the floor", when entering a female unit. The Auditor interviewed two female DOs. One reported she announces every time she enters the unit and the other officer stated she knocks on the door prior to entering the unit; however, the Auditor did not observe the female staff announcing themselves as they entered the housing units. The Auditor interviewed 20 detainees, of which 3 female detainees confirmed all male staff announce themselves when they enter the unit; and all male detainees reported female staff do not announce themselves when entering the unit; however, they are aware they are in the unit due to their voices being heard. In addition, all 20 detainees interviewed stated, to their knowledge, no staff has seen them naked in the shower, using the bathroom, or changing their clothes.

Does Not Meet (g): The facility is not in compliance with subsection (g) of the standard. The Auditor interviewed two female DOs. One reported she announces every time she enters the unit and the other officer stated she knocks on the door prior to entering the unit; however, the Auditor did not observe the female staff announcing themselves as they entered the housing units. In addition, all male detainees interviewed reported female staff do not announce themselves when entering the male housing units. To become compliant, the facility must retrain all female staff, to include the administrative female staff, of the requirement to announce their presence prior to entering housing units that include detainees of the opposite gender. The facility shall provide the Auditor with documentation of the training received.

Corrective Action Taken (g): The facility submitted an "Effective Communication" training curriculum and a staff training roster which confirmed all applicable staff have received training on the "Effective Communication" curriculum which includes "Officers must announce their presence to the inmate and detainee population. Whenever you enter a pod, officers are to say their specified gender when entering. For example, "Male in the pod" or "Female in the pod". Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (g) of the standard.

§115. 16 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): CCDC Policy #14 states, "The facility will take appropriate steps to ensure that detainees with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. This includes but not limited to 1) detainees who are deaf or hard of hearing; 2)

those who are blind or have low vision; 3) those who have intellectual, psychiatric problems; 4) those with speech disabilities." During interviews with seven DOs, it was reported that if a detainee was LEP, communication would be established with the use of the language line or with the assistance of Google Translate. However, the facility did not submit documentation to confirm the use of the language line or Google Translate, nor did the Auditor observe their use while on-site. Interviews with seven DOs further indicated that if a detainee is deaf or hard of hearing, staff would have the detainee read the information. In addition, during the interviews with two DO's the Auditor confirmed they have the ability to speak and translate in American Sign Language. However, the Auditor could not confirm the facility utilizes these services or any other services specifically for those detainees who are deaf or hard of hearing. In interviews with the seven DOs, it was further indicated if a detainee had difficulty reading, had an intellectual, psychiatric, or speech disability, they would speak with them on the same levels they would with their grandchildren or children, in a kind and patient manner, ensuring they understand. In an interview with the PSA Compliance Manager, it was indicated that information is given to the detainees through the facility handbook and during orientation, both of which are available in English and Spanish only. In addition, the PSA Compliance Manager indicated that the facility handbook and ICE National Detainee Handbook, are located on the housing unit kiosks in English and Spanish. This was confirmed through observation by the Auditor. The auditor could not confirm that the DHS-prescribed Sexual Assault Awareness Information (SAAI) pamphlet was available in the 15 most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) as the facility had uploaded the 2021 ICE National Detainee Handbook on the kiosk, which does not include nine of the recently published languages. In addition, the Auditor observed the orientation video on the kiosks in English and Spanish only. During the on-site audit, the Auditor further observed PREA information, including the ICE National Detainee Handbook, the DHS-prescribed SAA notice, the DHS Office of Inspector General (OIG) contact information, and the SOS Flyer. However, the Auditor observed the bulletin boards are secured, on the wall a little higher than an average height person, and information was printed on pages that were approximately 4x5, which an average height detainee with good eyesight would have difficulty reading. During interviews with 20 detainees, 11 English speaking detainees reported they were given information regarding sexual abuse, how to stay safe, and how to report an incident of sexual abuse; and 9 detainees, including 7 LEP detainees, reported they were not given any PREA information during the intake process; however, they were aware there was PREA information located on the housing unit kiosks. In addition, all seven LEP detainees reported that staff have not communicated with them using the language line or Google Translate, and if communication is necessary, another detainee is utilized to interpret for them. The Auditor reviewed 10 detainee files, all contained documentation that the detainee had received the PREA Orientation, the facility handbook, and the ICE National Detainee Handbook. The documentation could not confirm that they received the information in a manner that they would understand.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. During interviews with seven DOs, it was reported that if a detainee was LEP, communication would be established with the use of the language line or with the assistance of Google Translate. However, the facility did not submit documentation to confirm the use of the language line or Google Translate, nor did the Auditor observe their use while on-site. Interviews with seven DOs further indicated that if a detainee is deaf or hard of hearing, staff would have the detainee read the information. In addition, during the interviews with two DO's the Auditor confirmed they have the ability to speak and translate in American Sign Language. However, the Auditor could not confirm the facility utilizes these services or any other services specifically for those detainees who are deaf or hard of hearing. During interviews with 20 detainees, 11 English speaking detainees reported they were given information regarding sexual abuse, how to stay safe, and how to report an incident of sexual abuse; and 9 detainees, including 7 LEP detainees, reported they were not given any PREA information during the intake process; however, they were aware there was PREA information located on the housing unit kiosks. In addition, all seven LEP detainees reported that staff have not communicated with them using the language line or Google Translate, and if communication is necessary, another detainee is utilized to interpret for them. During the on-site audit, the Auditor further observed PREA information, including the ICE National Detainee Handbook, the DHS-prescribed SAA notice, the DHS Office of Inspector General (OIG) contact information, and the SOS Flyer. However, the Auditor observed the bulletin boards are secured, on the wall a little higher than an average height person, and information was printed on pages that were approximately 4x5, which an average height detainee with good eyesight would have difficulty reading. The Auditor could not confirm that the DHS-prescribed Sexual Assault Awareness Information (SAAI) pamphlet was available in the 15 most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) as the facility had uploaded the 2021 ICE National Detainee Handbook on the kiosk, which does not include nine of the recently published languages. To become compliant, CCDC must provide detainees access to the ICE National Detainee Handbook, in all the 14 most prevalent languages encountered by ICE, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese. In addition, the facility must make available the DHS-prescribed SAAI pamphlet, in the 15 most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) to all detainees. In addition, the facility must implement a practice of providing PREA information to LEP and

deaf or hard of hearing detainees in a manner they understand. Once developed, all intake staff must receive documented training on the new procedures and the facility must present the Auditor with 10 detainee files that includes detainees who speak languages, other than English or Spanish to confirm that detainees have access to the information in a language they understand. In addition, if applicable, the facility must provide the Auditor with five detainee files consisting of detainees who are deaf or hard of hearing to confirm they are getting the PREA information in a format they understand.

Corrective Action Taken (a)(b): The facility submitted a link to the Agency website which confirms the facility is able to download the ICE National Detainee Handbook in the 14 most prevalent languages encountered by ICE. The facility submitted 10 PREA orientation forms signed by detainees which confirm the detainees received the DHS-prescribed SAA Information pamphlet in a manner they could understand to include the use of ERO translation services and disability accommodations. Based on the Auditor's review of 10 submitted PREA orientation forms, signed by detainees, which confirm the detainees received the DHS-prescribed SAA Information pamphlet in a manner they could understand to include the use of ERO translation services and disability accommodations, the Auditor no longer requires documentation to confirm all intake staff received training on the new procedures. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

(c): The Auditor reviewed all policies submitted by the facility and confirmed the facility did not submit a policy that prohibits the use of minors, alleged abusers, detainees who witnessed the alleged abuse or detainees who have a significant relationship with the alleged abuser from providing interpreter services; or that allows the use of another detainee in matters related to sexual abuse should the detainee express a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. In interviews with seven DOs, all DOs indicated that if the victim or witness requested translation by another detainee, they would allow it unless the interpreter is the abuser or someone with a significant relationship with the abuser. None of the DOs interviewed indicated that the use of another detainee would only be utilized after the Agency determines that such interpretation is appropriate and consistent with DHS policy or that detainees who witnessed the alleged abuse may not be used for interpretation.

Does Not Meet (c): The facility is not in compliance with subsection (c) of this standard. In interviews with seven DOs, all DOs indicated that if the victim or witness requested translation by another detainee, they would allow it unless the interpreter is the abuser or someone with a significant relationship with the abuser. None of the DOs interviewed indicated that the use of another detainee would only be utilized after the Agency determines that such interpretation is appropriate and consistent with DHS policy or that detainees who witnessed the alleged abuse may not be used for interpretation. To become compliant, the facility must implement a practice that allows a detainee to use another detainee to provide interpretation for a victim of sexual abuse provided the Agency determines the interpretation is appropriate and consistent with DHS policy and prohibits the use of any detainee who witnessed the alleged abuse to be used for interpretation. Once implemented, the facility must train all custody supervisors and DOs of the new practice and provide documentation that the training has been received.

Corrective Action Taken (c): The facility submitted updated policy Chapter #14, SAAPI, which requires in matters related to sexual abuse, ICE detainee victims may use another detainee to provide interpretation if requested by the victim and the Agency determines such interpretation is appropriate and consistent with DHS policy. The facility submitted a staff training roster which confirms all applicable staff have received training on updated policy Chapter #14, SAAPI. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115. 17 - Hiring and promotion decisions
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d)(e): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government serve undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have

engaged in such activity. CCDC Policy #14 states, "The Facility will not hire or promote anyone who may have contact with detainees and will not enlist the services of any contractor who may have contact with detainees. 1) Who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or 2) who has been convicted of engaging or attempting to engage in sexual activity in the community 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. 3) All new staff will be asked if there has ever been an allegation of PREA made against them. The facility will perform a criminal backgrounds records check before hiring new employees or enlisting the service of contractors who may have contact with detainees." A review of CCDC Policy #14 confirms it does not contain the requirement material omissions regarding misconduct, or the provision of materially false information is grounds for termination or withdrawal of an offer of employment. During interviews with the JA and PSA Compliance Officer, the Auditor confirmed the facility does not enlist the services of contractors. All persons with detainee contact are facility staff or ICE staff. In an interview with the PSA Compliance Manager, who also functions as the HRM, it was indicated that criminal background checks are completed on all prospective employees to determine if the person is suitable for employment. In addition, the PSA Compliance Manager indicated that perspective applicants are asked during the initial interview process if they have ever engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or if they have been convicted of engaging or attempting to engage in sexual activity facilitated by force, or of implied threats of force, or coercions, or if the victim dd not consent or was unable to consent or refuse, or who has been civilly or administratively adjudicated to have engaged in such activity and if there is an affirmative response the applicant would not be hired. However, the questions are asked verbally; and therefore, no documentation is maintained to determine compliance. The PSA Compliance Manager further indicated that all promotional candidates are asked in an interview about any previous misconduct prior to being promoted and all prior institutional employers are contacted and asked if the prospective employee is eligible for re-hire and the reasons for leaving the previous employment; however, prior institutional employers are not asked about substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. During interviews with seven DOs, one DO indicated she believed she had been asked the questions during her interview and the remaining six reported they were not asked or do not remember being asked questions regarding previous sexual misconduct as described in subsection (a) of the standard and were not aware of a continuing duty to disclose sexual misconduct. There have not been any staff promotions during the audit period. The Auditor reviewed 10 randomly selected employee files. All files, except for two food service employees with no contact with detainees confirmed background checks were conducted prior to the employee being hired. The facility is not an immigration only facility, and therefore is not required to complete background investigations, every five years for staff who have contact with detainees. Additionally, the Auditor could not confirm the facility imposes a continually affirmative duty to disclose any such misconduct. The Auditor submitted a Background Investigation for Employees and Contractors form to the OPR PSO Unit to include the three ICE employees assigned to the facility to verify the completion of the background process. OPR PSO confirmed the background investigation status of all Agency employees submitted were completed. An interview with the SDDO confirmed there have not been any promotions of ICE staff at the facility during the audit period. During an interview with the JA, he confirmed the facility does not enlist the services of contractors or volunteers, who may have reoccurring contact with detainees. No documentation was provided to the Auditor to confirm material omissions regarding misconduct, or the provision of materially false information is grounds for termination or withdrawal of an offer of employment. During the on-site audit, the Auditor confirmed there were no contractor or volunteers working in the facility.

Does Not Meet (a)(b)(e): The facility is not in compliance with subsections (a), (b), and (e) of the standard. The PSA Compliance Manager indicated that perspective applicants are asked during the initial interview process: if they have ever engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution; or if they have been convicted of engaging or attempting to engage in sexual activity facilitated by force, or of implied threats of force, or coercions, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity and if there was an affirmative response answer the applicant would not be hired. However, the questions are asked verbally; and therefore, no documentation is maintained to determine compliance. During interviews with seven DOs, one DO it was indicated she believed she had been asked about previous sexual misconduct during her interview and the remaining six reported they were not asked or do not remember being asked questions regarding previous sexual misconduct as described in subsection (a) of the standard. In addition, the PSA Compliance Manager indicated all prior institutional employers are contacted and asked if the prospective employee is eligible for re-hire and the reasons for leaving the previous employment; however, past institutional employers are not asked about substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. During interviews with seven DOs, or through review of personnel records, the Auditor could not confirm the facility imposes a continually affirmative duty to disclose any such misconduct or material omissions regarding misconduct, or the provision of materially false information was grounds for termination or withdrawal of an offer of employment. The Auditor reviewed 10 randomly selected employee files. To become compliant, the facility must implement a practice that requires and informs staff they have a continuing affirmative duty to report any misconduct involving sexual abuse. The new procedure must also include the requirement material omissions regarding misconduct, or the provision of materially false

information would be grounds for termination or withdrawal of an offer of employment. Once implemented the facility shall train all HR staff on the new procedures. In addition, the procedure must ensure the facility inquires and refrains from hiring, promoting or enlisting the services of any employee, contractor or volunteer who may have contact with detainees, who has: engaged in sexual abuse in a prison, jail, holding facility, confinement facility, juvenile facility, or other institution; been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or been civilly or administratively adjudicated to have engaged in the activity described above. Once implemented, the facility must provide documentation that confirms the procedure ensures the facility inquires and refrains from hiring, promoting or enlisting the services of any employee, contractor or volunteer who may have contact with detainees, who has: engaged in sexual abuse in a prison, jail, holding facility, confinement facility, juvenile facility, or other institution; been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or been civilly or administratively adjudicated to have engaged in the activity described above, staff have a continuing duty to report any pervious misconduct, and that material omissions regarding misconduct, or the provision of materially false information would be grounds for termination or withdrawal of an offer of employment. In addition, the facility must train all HR staff on the new procedures and document that the training was received.

Corrective Action Taken (a)(b)(e): The facility submitted updated policy Chapter #14, SAAPI, which requires and informs staff they have a continuing affirmative duty to report any misconduct involving sexual abuse. A review of updated policy Chapter #14, SAAPI, further confirms material omissions regarding misconduct, or the provision of materially false information would be grounds for termination or withdrawal of an offer of employment. In addition, a review of updated policy Chapter #14, SAAPI, confirms the facility inquires and refrains from hiring, promoting or enlisting the services of any employee, contractor or volunteer who may have contact with detainees, who has: engaged in sexual abuse in a prison, jail, holding facility, confinement facility, juvenile facility, or other institutions; been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or been civilly or administratively adjudicated to have engaged in the activity described above. The facility submitted a staff training roster which confirms HR staff have received training on updated policy Chapter #14, SAAPI. The facility submitted an updated PREA Employment Questionnaire which confirms the updated PREA Employment Questionnaire includes employees, contractors, and volunteers and notifies HR staff the form is to be used when hiring or utilizing the services of a contractor or volunteer. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (e) of the standard.

§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)(b)(c)(d): The Agency's Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (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 ICE ERO 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 Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." CCDC Policy #14 states, "The facility is responsible for investigating allegations of sexual abuse and shall follow a uniform evidence protocol. 1) All clothing and bedding will be collected. These items will be placed in paper evidence bag and labeled according to procedure. 2) All evidence will be turned over the Investigator. 3) Victims will be scheduled for an examination and/or treatment as necessary." A review of CCDC Policy #14 confirms it does not include the requirements: the protocol shall be developmentally appropriate for juveniles where applicable and developed in coordination with DHS; how to best utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, information, and referrals; the presence of his or her outside or internal victim advocate if requested by the detainee including any available victim advocacy services offered by a hospital conducting the forensic exam such as support during a forensic exam and investigatory interviews. In addition, a review of CCDC Policy #14 confirms it does not include the requirements facilities shall offer all detainees who experience sexual abuse access to forensic medical examinations with the victim's consent and without cost to the detainee and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident or examinations shall be performed by a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forensic Examiner (SAFE) or a qualified medical practitioner if a SAFE or SANE is not available. In interviews with the JA and PSA Compliance Manager, it was confirmed all criminal allegations would be investigated by the Chase County Sheriff's Office (CCSO). In an interview with the facility RN, it was indicated that if a detainee is sexually assaulted, the detainee would be transported to Newman Regional Health for a SANE Exam and victim advocate services would be provided by SOS. The Auditor reviewed a

Memorandum of Understanding (MOU) between CCDC and Newman Regional Health. The MOU is in effect from November 28, 2022, through December 31, 2023. According to the MOU, CCDC services to be rendered include CCDC will transport the related party(ies) to the Newman Region health for sexual assault examination and assessment of care. Newman Regional Health services include an appropriate SANE who will complete an assessment with evidence collection and completed rape kit. The hospital will coordinate, as needed, with any investigation and provide reports to the facility regarding necessary treatment and findings. SANE exams are at no cost to the victim of a sexual abuse. During the on-site audit, utilizing a detainee phone, the Auditor spoke with an advocate from SOS who indicated in the event a forensic exam was required, advocacy services would be provided to the victim during the forensic exam. The advocate further indicated SOS would provide emotional support, crisis intervention, information and referrals that may be needed; however, the SOS advocate could not articulate how they would be notified of the incident or the steps that would be taken to provide the services to the detainee; and therefore, the Auditor could not determine that procedures have been established to provide a victim advocate, if the victim requests they be made available, if a sexual abuse were to occur. There were five allegations of sexual abuse reported at CCDC during the audit period. One case included staff-on-detainee and four cases involved detainee-on-detainee. The Auditor reviewed five sexual abuse allegation investigation files and determined that uniform evidence procedures, to include ensuring detainees do not destroy usable evidence, were followed during the administrative investigations. The facility does not house juvenile detainees.

Does Not Meet (a)(b)(c)(d): The facility is not in compliance with subsections (a), (b) and (c) of the standard. The facility has not provided the Auditor with the required protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions to determine compliance. As the facility did not provide the required protocol, the Auditor could not confirm the requirements of subsections (b), (c), (d), are included in the protocol. The elements include how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address the victim's needs. The procedures shall include outside victim advocates services following an incident of sexual abuse. The facility shall attempt to make available to the victim a victim advocate from the local rape crisis center to provide the victim advocate services, if not available the agency shall provide these services by making available a qualified staff member from a community-based organization or a qualified staff member. The outside or internal victim advocate shall provide emotional support, crisis intervention, information and referrals. As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by the hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. To become compliant, the facility must develop a protocol, in conjunction with DHS, that includes all elements how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address the victim's needs. The procedures shall include outside victim advocates services following an incident of sexual abuse. The facility shall attempt to make available to the victim a victim advocate from the local rape crisis center to provide the victim advocate services, if not available the agency shall provide these services by making available a qualified staff member from a community-based organization or a qualified staff member. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals. As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by the hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. The facility shall provide the established protocol to the Auditor to confirm compliance with all elements of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content. If applicable, the facility must provide the Auditor with all sexual abuse investigation files that occurred during the corrective action period (CAP) period.

Corrective Action Taken (a)(b)(c)(d): The facility submitted updated policy Chapter #14, SAAPI, which requires the facility makes available to a detainee victim of sexual abuse a victim advocate from a rape crisis center, which can provide valuable expertise, and support in the areas of crisis intervention and counseling to most appropriately address the victims' needs. A review of updated Chapter #14, SAAPI, further requires if adequate health care services are not available, to include outside victim advocates services following an incident of sexual abuse, to make available to the victim a victim advocate from the local rape crisis center to provide emotional support, crisis intervention, information, and referrals, and if requested by the victim provide the presence of his or her outside or internal victim advocate during a forensic exam and investigatory interviews, the facility will consult with the ICE FOD to secure additional assistance. The facility submitted a staff training roster which confirms applicable staff have received training on updated policy Chapter #14, SAAPI. The facility submitted one sexual abuse allegation investigation file which confirmed all required elements of subsections (a), (b), (c), and (d) of standard 115.21 were followed by the assigned facility Investigator during the course of the investigation. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), (c), and (d) of the standard.

(e): The facility is responsible to conduct all administrative investigations of sexual abuse. All criminal investigations are conducted by the CCSO. Interviews with the JA and PSA Compliance Manager indicated that the facility has not requested the CCSO to follow all requirements of standard §115.21 (a)-(d).

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. Interviews with the JA and the PSA Compliance Manager indicated that the facility has not requested the CCSO to follow all requirements of standard §115.21 (a)-(d). To become compliant, the facility shall request the CCSO to follow all requirements of standard §115.21 (a)-(d).

Corrective Action Taken (e): The facility provided an MOU with the CCSO which confirms CCSO agrees to follow the requirements of subsections (a) – (d) of standard 115.21. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (e) of the standard.

§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)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that, "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." CCDC Policy #14 states, "The facility shall develop written procedures for administrative investigations, including provision requiring a.) Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data: b.) Interviewing alleged victims, suspected perpetrators, and witnesses. c.) Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; d.) Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; e.) An effort to determine whether actions or failures to act at the facility contributed to the abuse; f.) Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and g.) Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." In addition, "The Jail Administrator will notify the Chase County Sheriff's Office of the abuse immediately. The Chase County Sheriff's Office will conduct the investigation, maintain all records, and will coordinate all actions with the probable cause of a criminal act being committed, the report will be forwarded to the Chase County Prosecuting Attorney for consideration of formal charges. All allegations or suspicion of sexual abuse will be investigated and reported in a timely manner." CCDC Policy #14 further states, "The Jail Administrator will notify the Chase County Sheriff's Office of the abuse immediately. The Chase County Sheriff's Office will conduct the investigation, maintain all records, and will coordinate all actions with the probable cause of a criminal act being committed, the report will be forwarded to the Chase County Prosecuting Attorney for consideration of formal charges. All allegations or suspicion of sexual abuse will be investigated and reported in a timely manner." An initial review of the PREA allegation spreadsheet indicated that there were five allegations of sexual abuse reported during the audit period. In addition, the PREA allegation spreadsheet indicated all five cases were closed and all five cases were determined to be unfounded by the facility investigator. The review of the PREA allegation spreadsheet further confirmed the ICE OPR was notified of all the allegations; however, one case did not have a date the ICE JIC was notified, noting, "JICMS not notified." Of the five cases included on the PREA allegation spreadsheet, four included a detainee-on-detainee allegation and one included a staff-on-detainee allegation. All cases were determined to be unfounded by the facility investigator. There were no cases referred for prosecution. During the on-site audit, the Auditor reviewed five sexual abuse allegation investigation files and confirmed an administrative investigation had been completed on all five allegations. However, during the review, two of the allegations appeared to include the elements consistent with sexual contact as per DHS PREA standard definitions. The Auditor confirmed that neither allegation had been referred to local law enforcement for a criminal investigation as per the facility policy and subsection (d) of the standard. In an interview with the PSA Compliance Manager/Investigator, it was confirmed the allegations were not referred to local law enforcement, as required by the facility policy and the standards as the facility determined there was no evidence of the allegations occurring.

Does Not Meet (a)(b)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (d), (e) and (f) of the standard. The facility has not established the required protocol to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority as required in subsection (a) of the standard. As the facility does not have a protocol, the requirements of subsections (b), (d), (e), and (f) that require what is included in the protocol is also non-compliant. An initial review of the PREA allegation spreadsheet indicated that there were five allegations of sexual abuse reported during the audit period. In addition, the PREA allegation spreadsheet indicated all five cases were closed and all five cases were determined to be unfounded by the facility investigator. The review of the PREA allegation spreadsheet further confirmed the ICE OPR was notified of all the allegations; however, one case did not have a date the ICE JIC was notified noting "JICMS not notified." During the on-site audit the Auditor reviewed four sexual abuse allegation investigation files and confirmed two of the allegations included elements consistent with sexual contact as per PREA definitions; however, neither allegation had been referred to local law enforcement for a criminal investigation as per CCDC Policy #14 and subsection (d) of the standard. In an interview with the PSA Compliance Manager/Investigator, it was confirmed that the allegations were not referred to local law enforcement, as the facility determined there was no evidence of the allegations occurring. To become compliant, the facility must develop a protocol that includes all elements of subsections (b), (d), (e), and (f) of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content. If applicable, the facility must submit all closed sexual abuse allegation investigations with confirmation that the facility notified ICE OPR, the ICE JIC, the appropriate ERO FOD, and if clearly not criminal local law enforcement of the reported allegation.

Corrective Action Taken (a)(b)(d)(e)(f): The facility submitted updated policy Chapter #14, SAAPI, which includes clear direction to staff on how to report an incident of detainee sexual abuse. A review of updated policy Chapter #14, SAAPI, further confirms the documentation and maintenance of all reports and referrals of allegations of sexual abuse for at least five years. The facility submitted a staff training roster which confirms all applicable staff have received training on updated policy Chapter #14, SAAPI. The facility submitted one sexual abuse allegation investigation file which occurred following implementation of the updated practice. The facility submitted an email which confirms the one sexual abuse investigation that occurred following implantation of the updated practice was reported to the SDDO, ICE OPR, the ICE JIC, and the appropriate ERO FOD; however, the allegation of sexual abuse was not criminal in nature; and therefore, the facility was not mandated to report the allegation to the local law enforcement agency. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), (d), (e) and (f) of the standard.

Does Not Meet (c): During a review of the Agency and the facility website, it was confirmed that the Agency website (www.ice.gov) does include the required Agency protocol; however, a review of the CCDC website (www.chasejail.com/PREA) confirmed CCDC Policy #14 and a dedicated investigative protocol are not included.

Corrective Action Taken (c): The facility submitted an email which indicated the CCDC investigative protocol was published on the facility website (www.chasejail.com/PREA). The Auditor reviewed the facility website (www.chasejail.com/PREA) and confirmed the CCDC protocol had been published as required by subsection (c) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115. 31 - Staff training
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): CCDC Policy #40, "Staff Training" states, "The agency shall train, or require the training of all employees who may have contact with immigration detainees, and the facility staff, to be able to fulfill their responsibilities under this part, including training on: 1) the agency and the facility's zero-tolerance policies for all forms of sexual abuse; 2) the right of detainees and staff to be free from sexual and from retaliation for reporting sexual abuse; 3) definitions and examples of prohibited and illegal sexual behavior; 4) recognition of situations where sexual abuse may occur; 5) recognition of physical, behavioral, and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; 6) how to avoid inappropriate relationships with detainees; 7) how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; 8) procedures for reporting knowledge or suspicion of sexual abuse; and 9) 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 or investigative purposes." The Auditor reviewed the facility PREA training curriculum and confirmed the training does not include: the agency's zero tolerance of all forms of sexual abuse; definitions of prohibited behaviors; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on examples of prohibited and illegal behaviors; recognition of situations where sexual abuse may occur; recognition of physical, behavioral and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; how to avoid an inappropriate relationship with a detainee; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, 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 or investigative purposes. In addition to the facility on-site PREA training, staff is required to complete PREA training through the Detention and Online Training Academy (DACOTA), which includes Prison Rape Elimination Act (PREA): A Legal Proactive Approach to PREA. The facility did not provide the Auditor with the on-line training curriculum to determine if all elements of the standard are included in the on-line training. An interview with the facility Training Director indicated that all staff have received PREA training. The Training Director maintains and excel spreadsheet to keep track of all those that need to complete training. During interviews with seven DOs, it was confirmed they are required to attend PREA training every year. The facility PAQ indicated there are 32 staff employed at the facility, who may have recurring contact with detainees. The Auditor reviewed a PREA sign-in sheet and confirmed all 32 staff attended PREA training in 2022.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed the facility PREA training curriculum. The training did not include the agency's zero tolerance of all forms of sexual abuse; definitions of prohibited behaviors; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on examples of prohibited and illegal behaviors; recognition of situations where sexual abuse may occur; recognition of physical, behavioral and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; how to avoid an inappropriate relationship with a detainee; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, 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 or investigative purposes. In addition to the facility on-site PREA training, staff is required to complete PREA training through DACOTA, which includes Prison Rape Elimination Act (PREA): A Legal Proactive Approach to PREA. The facility did not provide the Auditor with the on-line training curriculum to determine if all elements of the standard are included in the on-line training. To become compliant, the facility must provide the Auditor with a copy of the training curriculum for DACOTA to confirm it is compliant with the requirements of subsection (a) of the standard. If it is not, the facility must revise the training curriculum to include all elements of subsection (a) of the standard. Once revised, the facility shall provide the Auditor with documentation that all staff have completed 2023 PREA training utilizing the revised curriculum.

Corrective Action Taken (a): The facility submitted the DOCOTA training curriculum which confirms it does not include the Agency's zero tolerance policy, the right of detainees and staff to be free from retaliation for reporting sexual abuse, and how to communicate effectively and professionally with detainees including detainees who identify as lesbian, gay, bisexual, transgender, intersex, or gender nonconforming. The facility submitted an updated PREA lesson plan which includes the Agency's zero tolerance policy, the right of detainees and staff to be free from retaliation for reporting sexual abuse, how to communicate effectively and professionally with the detainees including detainees who identify as lesbian, gay, bisexual, transgender, intersex, or gender nonconforming. The facility submitted a training bulletin which confirms custody staff have received the updated training; however, the standard requires all staff and contract staff, including transport officers, medical, administration, and kitchen staff, have received the required training. The facility submitted a memorandum to Auditor indicating all staff including CO, Medical, and Administration have reviewed and understand the updated policy Chapter #14, SAAPI; however, the Auditor required all staff to be trained in all elements of standard 115.31 to include the Agency's zero tolerance policy, the right of detainees and staff to be free from retaliation for reporting sexual abuse, and how to communicate effectively and professionally with the detainees including detainees who identify as lesbian, gay, bisexual, transgender, intersex, and gender nonconforming which was added to the updated PREA lesson plan. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (a) of the standard.

§115. 33 - Detainee education

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(e): CCDC Policy #14 states, "During the intake Transactions detainees shall receive information explaining the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse and sexual harassment. The detainee receives information regarding the "zero tolerance" during the detainee screening process in booking. PREA statement are places in detainees living area, c. All detainees must sign in and acknowledge they understand the policy prior to their assignment to a cell/pod. The record of their acknowledgement of the policy is then stored in their detainee history in TEAM." CCDC Policy #4 "Admission and Release" states, "Each newly admitted inmate/detainee will be oriented to the facility through written material on the facility policies, rules, prohibited acts, and procedures all included in the facility handbook and on zero-tolerance PREA policy." The Auditor reviewed the facility PREA Orientation document, which states, "We have a zero-tolerance policy. If you have any questions or concerns, please speak with the jail staff. If you have any allegations of sexual assault or sexual abuse, please contact the PREA

Coordinator (name inserted) either email with a Grievance, General Request, and/or by asking staff to speak with the PREA Coordinator." However, a review of the PREA Orientation document confirms it does not include the following information: prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting including a staff member other than an immediate point-of-contact line officer, the DHS OIG and the ICE JIC; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to received treatment and counseling. Interviews with the PSA Compliance Manager and seven DOs, trained in the booking process, indicated the PREA Orientation document is given to all detainees during the booking process. If a detainee is LEP, the document is provided in a language that they can understand by using Google Translation. Interviews with seven DOs further indicated if a detainee is deaf or hard of hearing, the document is printed with the use of Google Translation, in a language they can read. If a detainee has limited reading skills or is blind, the document is read to them in a language that they can understand, utilizing Google Translation. If a detainee has intellectual, psychiatric, or speech disabilities, the seven DOs reported they would deliver the material to them as they would their children or grandchildren to ensure they understand the document. Interviews with three Spanish speaking detainees indicated the PREA Orientation document was provided in Spanish, and if they had questions or did not understand, a Spanish speaking detainee assisted with explaining the document. Interviews with 13 English speaking detainees confirmed the PREA Orientation was provided in English, in which they could understand; however, it was not provided in their preferred language. During the on-site audit, the Auditor did not observe the DHS-prescribed SAAI pamphlet, available in 15 of the most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) available to the detainees in the intake area. However, the Auditor observed the facility Inmate/Detainee Handbook, the ICE National Detainee Handbook, a PREA video, and the PREA Orientation are available to the detainees on the housing unit kiosks in both English and Spanish. The ICE National Detainee Handbook contained the DHS-prescribed SAAI pamphlet in nine languages (Arabic, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi and Spanish). However, the newly published languages (Bengali, Romanian, Russian, Turkish, Ukrainian, Vietnamese) were not available. The Auditor reviewed 10 detainee files and confirmed the PREA Orientation document had been utilized and signed by each of the detainees. However, the Auditor could not confirm the completion of an orientation program for detainees whose preferred language was not English or Spanish.

Does Not Meet (a)(b)(e): The facility is not in compliance with subsections (a), (b), and (e) of this standard. The PREA Orientation document does not include all required elements of this standard. The document does not include prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting including a staff member other than an immediate point-of-contact line officer, the DHS OIG and the ICE JIC; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to received treatment and counseling. The Auditor could not confirm the document is provided in a format that is accessible to all detainees nor does the facility distribute to the detainee during the orientation process a copy of the DHS-prescribed SAA Information pamphlet in a manner they could understand. During the on-site audit the Auditor observed the facility handbook, the ICE National Detainee Handbook, and the PREA orientation video on the housing unit kiosks in English and Spanish only. To become compliant, the facility must develop and implement a PREA Orientation that informs the detainees of each element required in subsection (a) of the standard in a language that they understand. Once implemented, the PREA Orientation shall be made available to all detainees in a language they understand. The facility must make available and distribute during the orientation process the DHS-prescribed SAAI pamphlet available in the most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian). In addition, the facility shall provide the Auditor with 10 detainee files, which include detainees who do not speak English or Spanish are getting the facility orientation program, which includes: the Orientation document, facility Inmate/Detainee handbook, the DHS-prescribed SAAI pamphlet; and the orientation video in a manner that they can understand, including the use of Google Translation services.

Corrective Action Taken (a)(b)(e): The facility submitted updated policy Chapter #14, SAAPI, which requires, "facility orientation program notify and inform detainees about the Agency and facility zero-tolerance policies for all forms of sexual abuse, instruction on prevention and intervention strategies, definitions and examples of detainee-on-detainee sexual abuse, staff on-detainee sexual abuse and coercive sexual activity, an explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of contact line officer (e.g., the compliance manager or a mental health specialist), the DHS Office of Inspector General, and the Joint Intake Center, information about self-protection and indicators of sexual abuse, prohibition against retaliation, including an explanation that reporting sexual abuse 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 counseling." Updated policy Chapter #14, SAAPI, requires the facility to

provide a copy of the DHS-prescribed SAA Information pamphlet and the ICE National Detainee Handbook to all detainees in a manner and language they can understand. The facility submitted booking forms which confirm the detainee's booking date and when the detainee received the ICE National Detainee Handbook and facility handbook. In addition, the facility submitted three detainee files for detainees who do not speak English or Spanish which confirmed detainees received the DHS-prescribed SAA Information pamphlet in a manner they could understand. A review of the detainee files further confirmed the use of ERO interpretation services for those detainees who required the PREA education be interpreted in a manner they could understand. The facility submitted a memorandum to Auditor indicating the facility has implemented a practice to ensure detainees who are disabled are provided PREA information during the intake process; however, the facility did not provide documentation to confirm what practice was implemented. The facility submitted a memorandum to the Auditor indicating the facility has provided a copy of a packet to confirm all required elements of the standard are included in the packet distributed during intake; however, the facility did not provide a copy of the packet or documentation to confirm the facility has implemented a practice to ensure the PREA information included in the orientation video is provided during the intake process in a manner all detainees can understand. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsections (a) and (b) of the standard.

(d)(f): During the on-site audit, the Auditor observed the DHS-prescribed SAA notice, with the name of the PSA Compliance Manager, posted on only a few of the housing unit bulletin boards. In addition, the Auditor observed the SOS brochure that can assist detainees who have been victims of sexual abuse. The flyer appeared to be a flyer that is intended for child victims. After discussions with the PSA Compliance Manager, the facility obtained the adult version of the flyer. However, prior to the exit brief, the Auditor could not confirm it had been posted on all housing unit bulletin boards. The Auditor observed the ICE National Detainee Handbook, which contains information about reporting a sexual abuse, is available to the detainees on the facility kiosk in the housing units. However, the handbook is only available in English and Spanish.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. During the on-site audit, the Auditor observed the DHS-prescribed SAA notice, with the name of the PSA Compliance Manager, posted on only a few of the housing unit bulletin boards. In addition, the Auditor observed the SOS brochure that can assist detainees who have been victims of sexual abuse. The flyer appeared to be a flyer that is intended for child victims. After discussions with the PSA Compliance Manager, the facility obtained the adult version of the flyer. However, the Auditor could not confirm prior to the exit interview that the flyer had been posted on all housing unit bulletin boards. To become compliant, the facility shall post the DHS-prescribed SAA notice, with the name of the PSA Compliance Manager; and information regarding SOS on all housing unit bulletin boards and submit documentation the signage has been posted.

Corrective Action Taken (d): The facility submitted images which confirm the facility has posted the DHS-prescribed sexual assault awareness notice, with the name of the PSA Compliance Manager, and information regarding SOS on all housing unit bulletin boards. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (d) of the standard.

§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): ICE Directive 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, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on ICE OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. CCDC Policy #14 states, "In addition to the general training provided to all employees pursuant to §115.31, the facility shall ensure that, to the extent the facility itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement setting." The facility PAQ indicated the facility has two investigators who have received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed two training certificates indicating the investigators completed the PREA: Investigating Sexual Abuse in a Confinement Setting through National Institute of Corrections. The Auditor is familiar with this training and has confirmed all elements are included in the training. The Auditor reviewed the facility general PREA training documentation and confirmed both investigators had received the

training pursuant to §115.31. However, during interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each investigator struggled with basic investigative questions, to include but not limited to the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. The Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. During interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each investigator struggled with basic investigative questions, to include but not limited to the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. In addition, the Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training. To become compliant, the facility must retrain the two facility investigators to confirm they are knowledgeable in the information provided in the training. In addition, the facility must submit documentation to confirm the training was received. If applicable the facility must provide copies of all sexual abuse allegation investigation files that occurred during the CAP period to confirm the facility Investigators who complete the investigations have received specialized training to do so.

Corrective Action Taken (a): The facility submitted the training curriculum for Administrative Investigations of Jail/Corrections Officer Misconduct which confirms it includes investigating sexual abuse in a confinement setting and effective cross-agency coordination. The facility submitted training records which confirm facility Investigators were retrained utilizing the provided curriculum. The facility submitted one sexual abuse allegation investigation file which occurred during the CAP period which confirms the investigation was conducted by a specially trained investigator. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 35 - Specialized training: Medical and mental health care

Outcome: Does not Meet Standard

Notes:

(b)(c): CCDC Policy #14, states, "The facility shall ensure that all full and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in a) how to detect and assess signs of sexual abuse and sexual harassment; b) how to preserve physical evidence of sexual abuse; c) how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and d) how and to who, to report allegations of suspicions of sexual abuse and sexual harassment." During an interview with the SDDO, the Auditor confirmed the facility policy has been approved by the Agency. In an interview with the facility RN, it was indicated that medical staff are required to attend training every year through the National Coalition of Correctional Health Care. She reported this training covers the specialized training required for this standard. However, the facility did not submit a copy of the training curriculum or certificates of training completion to determine compliance.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of this standard. The facility did not provide the training curriculum for the specialized training received through the National Coalition of Correctional Health Care to determine if all elements required under this standard are contained in the curriculum. In addition, the facility did not provide documentation that confirmed the required training was received by medical staff. To become compliant, the facility must submit a copy of the National Coalition of Correctional Health Care curriculum to determine all elements required are included in the training. If it does not, the facility must provide a curriculum that includes all elements of subsection (b). In addition, the facility must provide documentation that all medical staff have received the training.

Corrective Action Taken (b)(c): The facility submitted a PREA Resource Center Specialized training curriculum for Medical and Mental Health staff which confirms it includes all elements required by subsection (b) of the standard. The facility provided a training roster which confirms medical staff have received contractor and support training; however, the PREA training received by medical staff predates the compliant curriculum; and therefore, the Auditor could not confirm all medical and mental health staff have received training on the standard's requirements how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse and sexual harassment, and how and to who, to report allegations of suspicions of sexual abuse and sexual harassment. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsections (b) and (c) of the standard.

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

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

Notes:

(a)(b)(c)(d)(g): CCDC Policy #14 states, "All Detainees shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other detainees or sexually abusive toward other detainees." CCDC Policy #5 "Classification System" states, "All inmate/detainees shall be classified upon arrival and before being admitted into the general population. All facility staff assigned to classification duties shall be adequately trained in the facility's classification process. Any inmate/detainee who cannot be classified because of missing information at the time of processing shall be kept separated from the general population. Once the needed information is obtained, classification shall be expedited, and the inmate/detainee may be housed in the general population if warranted." CCDC Policy #14 further states, "Staff shall use facts and other objective, credible evidence documented in the inmate/detainee's file, criminal history checks during the classification process, Relevant considerations include current offense(s), past offense(s), escapes(s), institutional disciplinary history, documented violent episodes and incidents, medical information, and a history of victimization while in detention." The PSA Compliance Manager confirmed all detainees are classified by the ICE Field Office prior to arrival at the facility by completing the Risk Classification Assessment (RCA) and are screened upon arrival to CCDC utilizing the Intake Assessment at Booking document. The Auditor reviewed the RCA and confirmed it takes into consideration whether the detainee has a mental, physical, or developmental disability; the age of the detainee; whether the detainee has been previously incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has self-identified as LGBTI or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. In addition, the Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include if the detainee has mental, physical, or developmental disabilities; if the detainee has been previously incarcerated or detained; or whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. The PSA Compliance Manager further confirmed detainees are given a housing assignment within the first few hours of booking; however, they are housed within the booking holding cells, with one other detainee, for several days before they are moved to the assigned housing unit due to ICE covid protocol. During the on-site audit, the Auditor was unable to observe a detainee being processed, as no detainees arrived at the facility while the Auditor was on-site. However, the Auditor was able to review a video recording of a detainee being process into the facility. During the review of the video, the Auditor was able to confirm another detainee was present to interpret and/or explain the Intake Assessment at Booking form to an incoming detainee thus exposing the detainee's responses to the initial risk assessment to be assessable to other detainees to exploit the information to the detainee's detriment by staff or other detainees. The Auditor reviewed 12 detainee files and confirmed each file contained the completed RCA and the signed Intake Assessment at Booking form completed during the booking process. During interviews with 20 detainees, all detainees reported translation services, and/or, help in completing the Intake Assessment at Booking form was provided by another detainee.

Does Not Meet (g): The facility is not in compliance with subsection (g) of the standard. During the on-site audit, the Auditor was able to review a video recording of a detainee being process into the facility. As the Auditor was viewing the video, the Auditor was able to confirm there was another detainee present to interpret and/or explain the Intake Assessment at Booking form to an incoming detainee, thus exposing the detainee's responses to the initial risk assessment to be assessable to other detainees to exploit the information to the detainee's detriment by staff or other detainees. During interviews with 20 detainees, all detainees reported translation services, and/or help in completing the Intake Assessment at Booking form was provided by another detainee. To become compliant, the facility must implement appropriate controls on the dissemination within the facility of responses to questions asked to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees, including but not limited to utilizing another detainee during the booking process to translate, and/or help the incoming detainee complete the Intake Assessment at Booking form. Once implemented, the facility must train all applicable staff on the new procedure and submit documentation that the training was received. In addition, the facility must provide the Auditor with 15 detainee files consisting of detainees whose preferred language is other than English or Spanish to confirm compliance with subsection (g) of the standard.

Corrective Action Taken (g): The facility submitted an Admission and Release training curriculum which confirms it requires staff not to use trustees (detainees) to translate on intake, to use the language line, and when using the language line, document the ID of the interpreter (name and identification number), and note that an interpreter was used. The facility submitted a training roster that confirms all applicable staff were trained on the Admission and Release training curriculum. The facility submitted an email which confirms the one sexual abuse investigation file that occurred during the CAP period was reported to the SDDO, ICE OPR, the ICE JIC, and the appropriate ERO FOD. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (g) of the standard.

(e): CCDC Policy #5 states, "Each inmate/detainee's classification will be reviewed at regular intervals, when required by changes in the inmate/detainee's behavior or circumstances, or upon discovery of additional, relevant information." In an interview with the facility PSA Compliance Manager, it was indicated that detainees are reassessed for risk of victimization and abusiveness between 60 to 90 days from the date of the initial assessment and when warranted. The Auditor reviewed the facility Inmate/Detainee Reclassification form. The form inquires if the detainee had been involved in an incident and if the detainee acts out when asked to do something. The form does not address the detainee's risk of victimization or abusiveness. The Auditor reviewed 12 detainee files and confirmed 3 files contained documentation of the reassessment between 60 to 90 days of the initial assessment; 3 files indicated no reassessment was completed in the required timeframe; and 6 files indicated the reassessment had not been completed but was in the 90-day timeframe. In addition, the Auditor reviewed five sexual abuse allegation investigation files and confirmed none of the files included a reassessment of the detainee victim after an incident of sexual abuse.

Does Not Meet (e): The facility is not in compliance with subsection (e) of this standard. The Auditor reviewed the facility Inmate/Detainee Reclassification form. The form inquires if the detainee had been involved in an incident and if the detainee acts out when asked to do something. The form does not address the detainee's risk of victimization or abusiveness. The Auditor reviewed 12 detainee files, and of the 6 files that required a reassessment be conducted, 3 files did not contain documentation that a reassessment had been conducted during the 90-day timeframe. In addition, the Auditor reviewed five sexual abuse allegation investigation files and confirmed none of the files indicated the facility had conducted a reassessment of the detainee victim after an incident of sexual abuse. To become compliant, the facility must implement a practice that ensures all detainees are reassessed for risk of abusiveness or victimization between 60 to 90 days of the initial assessment, and if warranted based upon receipt of additional relevant information or following an incident of abuse or victimization. In addition, the facility must provide documentation that all classification staff and facility Investigators are trained on the new procedure. If applicable, the facility must provide the Auditor with 10 detainee files that include reassessments of detainee's risk of victimization and abusiveness between 60 to 90 days of the initial assessment. In addition, the facility must provide the Auditor with all sexual abuse allegation investigation files that occurred during the CAP period to confirm the detainee victim was reassessed for risk of sexual victimization after an incident of sexual abuse.

Corrective Action Taken (e): The facility submitted updated policy Chapter #14, SAAPI, which requires the facility reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment and at any other time if warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The facility submitted a blank updated reassessment form which confirms the updated reassessment form requires detainees be reassessed for risk of abusiveness or victimization between 60 to 90 days of the initial assessment, and if warranted based upon receipt of additional relevant information or following an incident of abuse or victimization. The facility submitted a training bulletin and a staff roster which confirm all applicable staff have received training on the standards requirement to ensure all detainees are reassessed for risk of abusiveness or victimization between 60 to 90 days of the initial assessment, and if warranted based upon receipt of additional relevant information or following an incident of abuse or victimization. The facility submitted a memorandum to the Auditor confirming a practice to reassess detainee victims following an incident of sexual abuse was implemented following the one sexual abuse allegation investigation occurring during the CAP period; and therefore, the Auditor no longer requires the facility submit documentation to confirm the detainee victim included in the one sexual abuse allegation investigation file which occurred during the CAP period was reassessed following the reported incident of sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (e) of the standard.

§115. 42 - Use of assessment information
Outcome: Does not Meet Standard
Notes:

(a): CCDC Policy #14 states, "The Facility shall use information from the risk screening required by 115.41 to inform housing, bed, education, and program assignments with the goal of keeping separate those detainees at high risk of being sexually victimized from those at high risk of being sexually abusive." During an interview, the PSA Compliance Manager indicated that each detainee is provided the Intake Assessment at Booking document to assess the detainee and that the form is completed by the detainee during the booking process. The Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include if the detainee has mental, physical or developmental disabilities; if the detainee has been previously incarcerated or detained; or whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; and therefore, the initial risk assessment is not compliant with the requirements of §115.41 (c). The PSA Compliance Manager further indicated all detainees are classified by the ICE Field Office prior to arrival at the facility and that detainees are given a housing assignment within the first few hours of booking; however, the PSA Compliance Manager could not articulate the facility's practice regarding the consideration of the information obtained during the initial risk assessment screening in determining housing, recreation, work, and voluntary programming.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. During an interview the PSA Compliance Manager indicated that each detainee is provided the Intake Assessment at Booking document to assess the detainees and that the form is completed by the detainee during the booking process. The Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include if the detainee has mental, physical, or developmental disabilities; if the detainee has been previously incarcerated or detained; or whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; and therefore, the initial risk assessment is not compliant with the requirements of §115.41 (c). The PSA Compliance Manager further indicated all detainees are classified by the ICE Field Office prior to arrival at the facility and that detainees are given a housing assignment within the first few hours of booking; however, the PSA Compliance Manager could not articulate the facility's practice regarding the consideration of the information obtained during the initial risk assessment screening in determining housing, recreation, work and voluntary programming. To become compliant, the facility must establish and implement a procedure to ensure that information gained from the risk assessment is compliant with standard §115.41 subsection (c). In addition, the facility must implement a practice that requires the facility to use the information gained during the initial PREA risk screening to determine detainee housing, recreation, and other activities. The facility shall train all applicable staff on the new procedures and submit documentation to the Auditor to confirm the training was received. The facility must submit 10 detainee files to confirm information gained from the updated initial risk assessment was considered in determining the detainee's housing, recreation and other activities, and voluntary work assignment.

Corrective Action Taken (a): The facility submitted updated policy Chapter #14, SAAPI, which requires the facility take into consideration, to the extent the information is available, all elements of subsections (c) and (d) of standard 115.41 to assess detainees for risk of sexual victimization. A review of updated policy Chapter #14, SAPPI, further confirms staff are required to use the information from the risk assessment pursuit to standard 115.41 to inform assignment of detainees to housing, recreation and other activities, and voluntary work. The facility submitted a staff training roster which confirms applicable staff have received training on updated policy Chapter #14, SAAPI. The facility submitted a memorandum to the Auditor which indicates the facility did not have any detainees who were processed through intake following implementation of an updated risk form; however, the memorandum did not confirm there were no detainees reviewed for recreation and other activities, and voluntary work assignments. The facility submitted a memorandum to the Auditor which indicates the facility provided an updated initial risk assessment form; however, the facility provided an updated reassessment form to be compliant with 115.41 (e) and did not provide an updated initial risk assessment form which includes all elements of subsection (c) of standard 115.41; and therefore, the Auditor could not confirm the facility is utilizing information received from a compliant risk assessment to assess detainees for risk of sexual victimization or abusiveness to determine recreation and other activities, and voluntary work assignments. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility is not in compliance with subsection (a) of the standard.

(b): During an interview the PSA Compliance Manager indicated that each detainee is provided the Intake Assessment at Booking document to assess the detainees and that the form is completed by the detainee during the booking process. The Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. In interviews with the PSA Compliance Manager and seven DOs, it was confirmed the question is not asked of any detainee. During an interview with the facility RN, it was confirmed medical staff would be consulted regarding housing decisions for a transgender/intersex detainee. In addition, medical staff would consult with Crosswinds, the mental health provider, in determining the most suitable placement, that would ensure his/her safety needs and the security needs of the facility; however, without learning the detainee's gender self-identification, the facility cannot consider the information when making an assessment for housing decisions or able to consider the effects that a housing placement may have on the health and safety of a transgender/intersex detainee. During the on-site audit, the Auditor could not determine through interviews with staff that housing decisions of a transgender/intersex detainee would not be based solely on the identity documents or physical anatomy of the detainee. The facility has not knowingly housed a transgender/intersex detainee; and therefore, has not conducted a reassessment of a transgender or intersex detainee to review any threats to safety experienced by the detainee.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. The facility does not inquire whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. Without learning the detainee's gender self-identification, the facility cannot consider the information when making an assessment for housing decisions or able to consider the effects that a housing placement may have on the health and safety of a safety of a transgender/intersex detainee consistent with the safety and security of on the facility. The facility must also implement a practice that requires the facility reassess all transgender and intersex detainees twice each year to review any threats to safety experienced by the detainee.

Corrective Action Taken (b): The facility submitted updated policy Chapter #14, SAAPI, which requires placement and programming assignments for transgender or intersex detainees be reassessed at least twice each year to review any threats to safety experienced by the detainee. The facility submitted an updated Intake Assessment at Booking form which includes asking the detainee if he/she self-identifies as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. Upon review of all submitted documentation, the Auditor now finds the facility in compliance with subsection (b) of the standard.

§115. 43 - Protective custody

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

Notes:

(a)(b)(c)(d)(e): CCDC Policy #15 "Special Management Unit" (SMU) states, "An inmate/detainee will be place in "protective custody" status in Administrative Segregation only when there is documentation that it is warranted and that no reasonable alternatives are available." Additionally, it states, "Detailed records will be maintained on the circumstances related to an inmate/detainee's confinement in an SMU, through required permanent SMU logs and individual inmate/detainee records. Administrative Segregation-generally, these inmate/detainees shall receive the same privileges as are available to inmate/detainees in the general population, depending on any safety and security considerations for inmate/detainees, facility staff and security." The Auditor reviewed a memorandum to the file which states, "we have had no one in protective custody in the reporting period." During an interview with the SDDO, the Auditor confirmed that CCDC Policy #15 was developed in consultation with ICE ERO. A review of Policy #15 confirmed it does include written procedures that require: a supervisory staff member to conduct a review within 72 hours of a detainee's placement in administrative segregation; an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter; or that placement in protective custody shall not ordinarily exceed a period of 30 days. In an interview with the JA, it was confirmed detainees vulnerable to sexual abuse or assault would only be placed into administrative segregation after all reasonable efforts had been made to provide other appropriate housing. The JA further indicated detainees would have access to the same privileges (i.e., programs, visitation, counsel and other services available to the general population) as those in general population. In addition, the JA indicated that the facility would notify ICE immediately if a detainee is placed into administrative segregation based on vulnerability to sexual abuse. During the on-site audit the Auditor confirmed through observation there were no detainees housed in administrative segregation based on vulnerability to sexual abuse.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. In a review of CCDC Policy #15 the Auditor confirmed the facility does not have written procedures that requires a supervisory staff member to conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter; or that placement in protective custody shall not ordinarily exceed a period of 30 days. To become compliant, the facility must in consultation with the ERO FOD update CCDC Policy #15 to include the requirements of supervisory staff to conduct a review within 72 hours of a detainee's placement in administrative segregation, an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter, and that placement in protective custody shall not ordinarily exceed a period of 30 days. Once developed the facility must provide the Auditor with a copy of CCDC Policy #15 with documentation that the policy was updated in consultation with the ERO FOD. Once implemented the facility must train all security supervisors on the requirements of updated CCDC Policy #15 and provide the Auditor with documentation that confirms the training was received. If applicable, the facility must submit to the Auditor any detainee files that include a detainee being placed in protective custody due to being vulnerable to sexual abuse.

Corrective Action Taken (d): The facility submitted updated policy Chapter #14, SAPPI, which requires supervisory staff conduct a review within 72 hours of a detainee's placement in administrative segregation, an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter. A review of submitted updated policy Chapter #14, SAPPI, further confirms a detainee's placement in protective custody due to be vulnerable to sexual abuse shall not ordinarily exceed a period of 30 days. The facility submitted a SMU Training curriculum and a training roster which confirm all security supervisors were trained on updated policy Chapter #14, SAAPI. The facility submitted a copy of updated policy Chapter #14, SAAPI, signed by the ERO FOD which confirms updated policy Chapter #14, SAAPI, was developed in consultation with the ICE FOD having jurisdiction over the facility. The facility submitted a memorandum to the Auditor which confirms there have been no detainees placed in protective custody during the CAP

period due to being vulnerable to sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

§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): CCDC Policy #14 states, "The facility shall provide multiple internal ways for detainees to privately report sexual abuse and sexual harassment or violations of those responsible for such incidents. 1) detainees may report sexual abuse and sexual harassment by using the form to report to the administrative staff or externally mailing to family member who can contact the Jail Administrator; 2) detainee can report sexual abuse and sexual harassment directly to detention and/or medical staff; 3) detainees have access to phone and any contact a family member to have them report the allegation to the Jail Administrator." [sic] CCDC Policy #14 further states, "Detainees have access to phone and any contact a family member to have them report the allegation to the Jail Administration." [sic] In review of the facility Inmate/Detainee Handbook, the Auditor confirmed detainees are instructed on the following ways to report an alleged sexual abuse: write a letter reporting sexual misconduct to the ICE AFOD, Deputy FOD, or the FOD; file an inmate/detainee grievance form; or write to the DHS OIG. During the on-site audit, the Auditor observed on housing unit bulletin boards information that advised detainees how to contact the DHS OIG, to confidentially and, if desired, anonymously, report an incident of sexual abuse; the ICE Detainee Reporting and Information Line (DRIL) posters; and signage that advised the detainee how to contact their consulate official and SOS. Utilizing the detainee telephone in the units, the Auditor tested each line. The phone calls made to the DHS OIG were not successful. The Auditor was Instructed the call would be answered in the order it was received and was informed it would be a fifteen-minute wait; however, the call immediately began to ring and then went silent. The Auditor remained on the line for an additional five minutes before hanging up. A test call made to the ICE DRIL was successful. However, the Auditor inquired if the call was of an actual detainee reporting sexual abuse, what steps would be taken. The person on the line did not know and placed the Auditor on hold for approximately five minutes. Once the person returned on the line, she informed the Auditor she would take the information and report it to headquarters. Interviews with the JA and PSA Compliance Manager indicated that detainees are provided multiple ways to report sexual abuse. However, no documentation was submitted that confirms detainees are notified they may report retaliation for reporting an incident of sexual abuse, staff neglect, or violations of staff responsibilities that may have contributed to an incident. In addition, the PSA Compliance Manager indicated detainees can report an allegation of sexual abuse through SOS. SOS is not part of the facility or the Agency. During an interview with a staff member at SOS, the Auditor confirmed SOS would not take a report of sexual abuse, but their services are to provide detainees who have suffered sexual abuse with advocacy services, crisis intervention, and counseling.

Does Not Meet (a)(b): The facility is not in compliance with subsection (a) and (b) of the standard. CCDC Policy #14 does not include the requirement that detainees may report retaliation for reporting an incident of sexual abuse, any staff neglect, or violations of responsibilities that may have contributed to the incident. The Auditor attempted a test call to DHS OIG and was advised the call would be answered in the order it was received and that it would be a fifteen-minute wait. However, the call immediately began to ring and then went silent. In an interview, the PSA Compliance Manager indicated detainees can report an allegation of sexual abuse through SOS. However, during an interview with a staff member at SOS, the Auditor confirmed SOS would not take a report of sexual abuse and that their services are to provide detainees who have suffered sexual abuse with advocacy services, crisis intervention, and counseling. To become compliant, the facility must develop and implement policy and procedure to ensure that in addition to reporting sexual abuse, detainees have multiple ways to privately report retaliation for reporting sexual abuse, staff neglect, or violations of responsibilities that may have contributed to an incident of sexual abuse. Once implemented, the facility must train all staff and provide the Auditor with documentation that confirms the training was completed. In addition, the facility must provide detainees at least one way to report an allegation to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request, including but not limited to, working telephones that enable a detainee to contact the DHS OIG. Once implemented, the facility must provide the Auditor with documentation that confirms the new procedure was implemented. In addition, the facility must provide documentation that facility telephones are in working order to allow detainees access to the DHS OIG to report an allegation of sexual abuse, retaliation for reporting an incident of sexual abuse, staff neglect, or violations of staff responsibilities that may have contributed to an incident to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request.

Corrective Action Taken (a)(b): The facility submitted updated policy Chapter #14, SAAPI, which confirms the facility will provide detainees with access to outside victim advocates for emotional support services related to sexual abuse, the facility provides multiple ways for detainees to report staff violations of responsibilities that may have contributed to the

incident, and detainees may report retaliation for reporting an incident of sexual abuse or any staff neglect that may have contributed to the abuse. The facility submitted an email from an ICE DDO which confirmed the ICE DDO was able to contact a named person at the DHS OIG. The facility provided a training bulletin and a staff roster which confirm a sampling of all staff have received training on the standard's requirement to ensure detainees have multiple ways to privately report retaliation for reporting sexual abuse, staff neglect, or violations of responsibilities that may have contributed to an incident of sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

(c): The Auditor reviewed CCDC Policy #14 and confirmed it does not include the provision for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. Interviews with facility DOs confirmed they are required to accept all reports of sexual abuse verbally, in writing, anonymously or by a third party, and document all such reports.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of CCDC Policy #14 confirms it does not include the provision for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. To become compliant, the facility shall revise CCDC Policy #14 to include the requirement for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. Once revised all staff shall be trained on updated Policy #14 and the facility must submit documentation to confirm that staff have received the training.

Corrective Action Taken (c): The facility submitted updated policy Chapter #14, SAAPI, which requires facility staff accept reports made verbally, in writing, anonymously, and from third parties, and shall promptly document verbal reports. The facility submitted a training bulletin and a staff roster which confirm a sampling of all staff have received training on the requirement staff must accept reports made verbally, in writing, anonymously, and from third parties, and shall promptly document verbal reports. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115. 52 - Grievances

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

Notes:

(a)(b)(c)(d)(e)(f): CCDC Policy #14 states, "There is no time limit to submit grievance on an allegation of sexual abuse or assault" and "all allegations we be [sic] investigated immediately." CCDC Policy #14 further states, "Emergency Grievances that involve an immediate threat to an inmate/detainee's health, safety or welfare shall be identified and handled in a time-sensitive manner. Staff shall respond to emergency grievances in and [sic] expeditious manner. Once staff who is approached by the inmate/detainee determines that he or she is in fact raising an issue requiring urgent attention, emergency grievance procedures shall apply. The protocol for emergency grievance procedures shall bring the matter to the immediate attention of a Supervisor or the Administrator, even if it is later to be determined that it is not a true emergency, and the grievance is subsequently routed through normal non-emergency channels." Additionally, "All medical grievances will be received by the medical department within 24 hours or the next business day." CCDC Inmate/Detainee handbook states, "An inmate/detainee may file a grievance only for himself but will be given the opportunity to obtain assistance from another inmate/detainee in filing a grievance" and "any inmate/detainee who does not accept the decision of the Jail Supervisor may appeal to the Jail Administrator within 5 days of receiving the decision of the Jail Supervisor. The Jail Administrator will provide the inmate/detainee with a written decision within five days of receiving the appeal." An interview with the PSA Compliance Manager, who acts as the facility grievance officer, indicated detainees can file a grievance at any time through the housing unit kiosk. The detainee is not required to participate in the informal grievance process and can immediately file a formal grievance and any time limits imposed for filing a grievance are removed if the grievance involves a sexual abuse or assault. The grievance officer further indicated, a detainee can file an appeal to the JA, and it will be answered within five days, and if a medical emergency grievance is received, it will be immediately forwarded to the facility RN for an assessment. In addition, the grievance officer indicated if a grievance is received that involve an immediate threat to the detainee's health or safety, he/she would be immediately removed from the threat and the threat would be investigated. Although the facility handbook states a detainee may request the assistance of another detainee in filing the grievance, the PSA Compliance Manager confirmed the detainee may also request the assistance of facility staff, a family member or his/her attorney. An interview with the facility RN indicated that all sexual abuse grievances would be treated as a medical emergency and would be brought to her attention and if required she would see the detainee immediately. During the interview with the grievance officer, the Auditor could not confirm that all grievances related to sexual abuse and the facility's decision in respect to such grievance would be sent to the appropriate ICE FOD at the end of the grievance process. The facility PAQ indicated that the facility has not received any grievances regarding an

allegation of sexual abuse during the audit period. The Auditor reviewed five allegation of sexual abuse investigation files and confirmed none of the allegations were reported through the grievance system.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. During an interview with the grievance officer, the Auditor could not confirm that the facility would send all grievances related to sexual abuse and the facility's decision with respect to such grievances to the appropriate ICE FOD at the end of the grievance process. To become compliant, the facility shall develop and implement a procedure to ensure that all sexual abuse related grievances shall be forwarded to the ICE FOD at the end of the grievance process. In addition, the facility must train all grievance staff on the new procedure and submit documentation that the training was received. If applicable, the facility must submit copies of all grievances that include an allegation of sexual abuse and the corresponding sexual abuse allegation investigation files that occurred during the audit period.

Corrective Action Taken (e): The facility submitted updated policy Chapter #35, Grievance System, and staff training rosters which confirm applicable staff have received training on updated policy Chapter #35, Grievance System, which requires grievances of Allegations of Sexual Abuse, (PREA/SAPPI) be forwarded to the ICE/ERO FOD at the end of the grievance process. The facility submitted a memo to Auditor that states, "During the CAP period we have not had any PREA (SAAPI) grievances. Upon review of the submitted documentation the Auditor now finds the facility in substantial compliance with subsection (e) of the standard.

§115. 53 - Detainee access to outside confidential support services

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

Notes:

(a)(b)(c)(d): CCDC Policy #14 states, "The facility shall provide detainees with access to outside victim advocates for emotional support services related to sexual abuse." An interview with the PSA Compliance Manager confirmed that the facility utilizes the services of SOS to provide support in the areas of crisis intervention, counseling, investigation and prosecution of sexual abuse perpetrators to appropriately address the victim's need. During the on-site audit, the Auditor observed the SOS flyer within the housing units; however, the posted flyer was consistent with services that are provided to child victims, not adult victims. The facility immediately, obtained the adult SOS flyer. The Auditor reviewed the updated SOS flyer and confirmed it provided the detainees with an email address, mailing address, and a phone number that can be accessed from the detainee phone. However, the Auditor could not confirm the facility posted the adult version of the flyer prior to the conclusion of the on-site audit. In addition, information was posted in the housing units, in English and Spanish only, on how to access SOS, anonymously or without the call being recorded or monitored. However, a review of all available postings and the Inmate/Detainee handbook confirmed detainees are not advised of the extent to which reports of abuse will be forward to authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor tested the line utilizing the instructions provided and spoke with an SOS advocate. During the interview, the Auditor confirmed the facility has not established an MOU with SOS. However, SOS does provide services for the detainees housed at the facility. The services include crisis intervention, counseling, investigation, and prosecution of sexual abuse perpetrators to appropriately address the victim's need. In addition, the advocates, if needed, would provide in-person support to the detainees. Interviews with detainees indicated they were aware of SOS and had seen the child version of the flyer posted on the housing unit bulletin boards.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The facility does not maintain or has attempted to enter into a memorandum of understanding or any other agreement with SOS to provide legal advocacy and confidential emotional support services for detainee victims of crime. To become compliant, the facility shall attempt to enter into a memorandum of understanding with SOS and provide the Auditor with documentation of the entered MOU or of an attempt to enter one.

Corrective Action Taken (a): The facility submitted a string of emails which confirm CCDC has attempted to enter into an MOU with SOS as required by subsection (a) of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 54 - Third-party reporting

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

Notes:

CCDC Policy #14 states, "The facility will investigate all reports of abuse that are submitted by third parties." A review of the ICE web page (http://www.ice.gov) indicates the Agency provides a means for the public to report incidents of sexual

abuse/harassment on behalf of a detainee. An interview with the facility PSA Compliance Manager confirmed that reports from a third party can be made directly to the facility or to the CCSO. A review of CCDC's web page (www.chasejail.com/PREA) confirms it does not provide information to the public regarding how to report incidents of sexual abuse on behalf of a detainee.

Does Not Meet: The facility is not in compliance with standard §115.54. A review of CCDC's web page (www.chasejail.com/PREA) confirms it does not provide information to the public about how to report incidents of sexual abuse on behalf of a detainee. To become compliant, the facility must provide documentation to the Auditor that confirms the facility has made available to the public information regarding how to report and incident of sexual abuse on behalf of a detainee.

Corrective Action Taken: The Auditor reviewed CCDC updated facility website (www.chasejail.com/PREA) and confirmed CCDC has made available to the public information regarding how to report an incident of sexual abuse on behalf of a detainee. Upon review of all submitted documentation the Auditor now finds the facility in compliance with the standard.

§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)(d): Agency Policy 11062.2, states, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participation in an investigation about such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." CCDC Policy #14 states, "All staff are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse and sexual harassment immediately. Staff shall not reveal any information related to a sexual abuse report to anyone other than to extent necessary to make treatment, investigation, and other security and management decisions." A review of CCDC Policy #14 confirms it does not include the requirements staff must report any knowledge, suspicion, or information regarding retaliation against detainees or staff who reported or participated in an investigation about such an incident or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation and does not include a method staff can report an incident of sexual abuse outside the chain of command. CCDC PREA training curriculum states, "All staff are required to report any knowledge, suspicion or information regarding an incident of sexual abuse and sexual harassment immediately." Interviews with seven DOs indicated that staff are aware of the requirement to immediately report an any knowledge or suspicion of sexual abuse. During interviews with seven DOs, each could articulate that they must report any knowledge, suspicion, or information regarding an incident of sexual abuse. However, none reported they must report any information regarding retaliation or staff neglect or violations of responsibility that may have contributed to an incident. An interview with the JA indicated that staff could report an incident of sexual abuse to the CCSO; however, the policy has not been officially conveyed to staff. In addition, the JA confirmed he was aware that any reports received from a vulnerable adult would be reported to Adult Protective Services (APS). An interview with the SDDO confirmed that the facility policies have been approved by the Agency.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of CCDC Policy #14 confirms it does not include the requirements of staff to report any knowledge, suspicion, or information regarding retaliation against detainees or staff who reported or participated in an investigation about such an incident or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation; or a method for which staff can report an incident of sexual abuse outside the chain of command. An interview with the JA indicated that staff could report an incident of sexual abuse to the CCSO; however, the policy has not been officially conveyed to staff. To become compliant, the facility must update and revise CCDC Policy #14 to include the requirements staff must report allegations or knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who report or participate in an investigation about such an incident; and any staff neglect or violation of responsibility that may have contributed to an incident of retaliation and staff shall have a method to report an incident of sexual abuse outside the chain of command. Once updated, the facility must refer updated CCDC Policy #14 to the Agency for review and approval and train all staff on the updated requirements.

Corrective Action Taken (a): The facility submitted updated policy Chapter #14, SAAPI, which requires staff report allegations or knowledge, suspicion, or information regarding an incident of sexual abuse which occurs in a facility, retaliation against detainees or staff who report or participate in an investigation about such an incident, and any staff neglect or violation of responsibility that may have contributed to an incident of retaliation. A review of updated policy Chapter #14, SAAPI, further confirms it requires staff have a method to report an incident of sexual abuse outside the chain of command to the Sheriff's Office. The facility submitted Mandatory Reporting training and a training roster which confirm

staff have received training on the standard's requirements staff must report allegations or knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility, retaliation against detainees or staff who report or participate in an investigation about such an incident, any staff neglect or violation of responsibility that may have contributed to an incident of retaliation, and staff can report an incident of sexual abuse outside the chain of command to the Sheriff's Office. The facility submitted an email which confirms updated policy Chapter #14, SAAPI, has been submitted to the Agency for review and approval. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 64 - Responder duties

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

Notes:

(a)(b): CCDC Policy #14 states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report shall; a) separate the alleged victim and abuser; b) preserve and protect any crime scene until appropriate steps can be taken to collect any evidence with proper evidence collections procedures." In addition, CCDC Policy #14 states, "In the event of a report incident of sexual abuse [sic], first responder staff, medical personal, and all command staff shall follow the procedures set forth herein; a) any information received will be forwarded to Jail Administrator; b) the medical staff will ensure all clothing is gathered and placed in a paper evidence bag; c) the evidence will be forwarded to the facility investigator." A review of CCDC Policy #14 confirms it does not include the requirements if the time period allows for collection of physical evidence, request that the alleged victim, and ensure that the alleged abuser, do not take any actions that could destroy physical evidence (e.g., washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, eating); or if the first responder is not a security staff member, the responder shall request the alleged victim to refrain from any actions that could destroy physical evidence and then immediately notify a deputy. The Auditor reviewed CCDC PREA training curriculum states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report shall: separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence with proper evidence collections procedures. DO NOT LET THE VICTIM SHOWER, URINATE OR DEFICATE." Interviews with seven DOs confirmed they were knowledgeable regarding the first responder duties that include separating the victim and the abuser, call for backup, preserve the crime scene, and call for medical staff. However, all DOs reported that they would not allow the victim, or the alleged abuser take any action that could destroy evidence. During an interview with the facility RN, it was confirmed that she could not articulate her responsibilities as a non-security first responder indicating she is never alone in the facility without the custody staff with her.

Does Not Meet (a)(b): The facility is not in compliance with subsection (a) and (b) of this standard. Interviews with seven DOs, confirmed they could articulate their first responder duties that include separating the victim and the abuser, calling for backup, preserving the crime scene and calling for medical staff; however, the DOs reported that they would not allow the victim, or the alleged abuser take any action that could destroy evidence. To become compliant, the facility must train all custody staff on first responder duties, which include the requirement to request the alleged victim not to take any action that could destroy evidence, such as washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, eating and document such training and submit documentation of said training. In addition, the facility shall train non-custody staff, to request the alleged victim not to take any action that could destroy physical evidence and then notify security staff. Documentation of training shall be provided to the Auditor.

Corrective Action Taken (a)(b): The facility submitted updated policy Chapter #14, SAAPI, which requires "officers ensure there is no damage to the physical evidence of the body by urging the victim and ensuring that the perpetrator refrain from: washing, showering, brushing teeth, changing clothing, eating, drinking, defecating, urinating." In addition, the facility submitted training rosters which confirm security and non-security first responders have received training on their responsibilities as first responders. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

§115. 65 - Coordinated response

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

Notes:

(a)(b)(c)(d): During an interview with the JA, it was confirmed that the CCDC Policy #14 serves as the facility's plan for coordinating actions taken by staff first responders, medical and mental health practitioners, investigators, and the facility leadership. CCDC Policy #14 states, "The facility is responsible for investigating allegations of sexual abuse and shall follow a uniform evidence protocol. 1) All clothing and bedding will be collected. These items will be placed in a paper evidence bag and labeled according to procedure. 2) All evidence will be turned over to the investigator; 3) Victim will be scheduled

for an examination and/or treatment as necessary." In addition, CCDC Policy #14 further states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to responds to the report shall; a) separate the alleged victim and abuser; b) preserve and protect any crime scene until appropriate steps can be taken to collect any evidence with proper evidence collection procedures. In the event of a report incident of sexual abuse, first responder staff, medical personal and all command staff shall follow the procedures set forth herein. A) Any information received will be forwarded to Jail Administrator. B) The medical staff will ensure all clothing is gathered and placed in a paper evidence bag; c) evidence will be forwarded to the facility investigator." A review of CCDC Policy #14 confirms it does not include the required verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." In an interview with the facility RN, if was indicated that she would inform the receiving facility of the incident and the victim's potential need for medical or mental health services and would send a packet of information with the detainee to be delivered to medical personnel at the receiving facility regardless of the detainee victim requesting otherwise. There were no allegations of sexual abuse reported at CCDC that included the detainee victim being transferred.

Does Not Meet (c)(d): The facility is not in compliance with subsection (c) and (d) of the standard. The protocol does not address the provision (c) which states, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." And provision (d) "If a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." During an interview with the facility RN, it was indicated that she would inform the receiving facility of the incident and the victim's potential need for medical or mental health services and would send a packet of information with the detainee to be delivered to medical personnel at the receiving facility regardless of the detainee victim requesting otherwise. To become compliant, the facility must update the facility coordinated response plan to include subsections (c) and (d) of the standard. In addition, the facility must document that all applicable staff, including medical staff, have received training regarding the content of the updated coordinated response plan. The facility must provide the Auditor with any investigation, medical, and detainee files regarding any detainee victim of sexual abuse transferred during the CAP period.

Corrective Action Taken (c)(d): The facility submitted updated policy Chapter #14, SAAPI, which requires if a victim of sexual abuse or assault is transferred between facilities covered by DHS PREA, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and if a victim of sexual abuse or assault is transferred from a DHS immigration detention facility to a facility not covered by the DHS PREA Standards, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. The facility submitted a training bulletin and training roster which confirmed medical staff have received training on the standard's requirements if a victim of sexual abuse or assault is transferred between facilities covered by DHS PREA, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and if a victim of sexual abuse or assault is transferred from a DHS immigration detention facility to a facility not covered by the DHS PREA Standards, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise. The facility submitted a memorandum to Auditor which confirms the facility did not have any sexual abuse allegation investigations that occurred during the CAP period which included a detainee victim being transferred due to an incident of sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (c) and (d) of the standard.

§115. 67 - Agency protection against retaliation
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): CCDC Policy #14 states, "The facility shall take necessary measures to protect all detainees and staff that report sexual abuse or sexual harassment or cooperated with sexual abuse or sexual harassment investigations from retaliation by other detainees or staff." A review of CCDC Policy #14 confirms it does not include the requirements that detainees shall be protected against retaliation or participating in sexual active as a result of force, coercions, threats or fear of force; and that the facility shall provide protective measures, including: housing changes, transfers, removal of alleged abusers from contact with victims, administrative reassignment or reassignment of the victim or alleged perpetrator to another housing area, and support services for inmates or staff who fear retaliation. In an interview with the PSA Compliance Manager, it was indicated the facility has not been conducting retaliation monitoring. The Auditor reviewed five sexual abuse allegation

investigation files and further confirmed retaliation monitoring is not being conducted at CCDC.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. During an interview with the PSA Compliance Manager, it was confirmed the facility has not been conducting retaliation monitoring. In addition, the Auditor reviewed five sexual abuse allegation investigation files and further confirmed retaliation monitoring is not being conducted at CCDC. To become compliant, the facility must develop and implement a procedure to monitor staff and/or the detainee victim of sexual abuse beginning at the time of the allegation through at least 90 days to see if there are facts that may suggest possible retaliation by detainees or staff regardless of the final determination. In addition, the facility must consider detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff as required by subsection (c) of the standard and provide 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 facility must train all applicable staff involved in the monitoring of detainee victims of sexual abuse in the new practice and document such training. The facility must also provide the Auditor with copies of any sexual abuse allegation investigation files and corresponding monitoring documentation that occurred during the CAP period.

Corrective Action Taken (a)(b)(c): The facility submitted updated policy Chapter #14, SAAPI, which requires for at least 90 days following a report of sexual abuse, the Agency and facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Updated policy Chapter #14, SAAPI, further requires the Agency monitors any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. In addition, updated policy Chapter #14 SAAPI requires DHS shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need and multiple protection measures shall be employed, 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. However, the facility submitted a "Protection Against Retaliation Form – Inmates" that confirms it allows for the monitoring to cease should the facility determine the allegation to be "unfounded." The facility submitted a training roster which confirms the PSA Compliance Manager received training on the updated policy Chapter #14, SAAPI, however, a review of the submitted "Protection Against Retaliation Form – Inmates" confirms the facility's practice is not compliant. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (c) of the standard.

§115. 68 - Post-allegation protective custody
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d): CCDC Policy #15 states, "An inmate/detainee will be placed in "protective custody" status in Administrative Segregation only when there is documentation that is warranted and that no reasonable alternatives are available." CCDC Policy #14 states, "Detainees at high risk for sexual victimization shall not automatically be place in involuntary segregated housing unless an assessment of all available alternatives had been made. Detainees at high risk for sexual victimization may be placed in involuntary segregated housing if an assessment of all available alternatives indicates there is no available alternatives means of separation from likely abusers." In a review of CCDC Policies #14 and #15, the Auditor could not confirm if: the facility would place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing options possible; victims would not be held longer than 5 days in any type of administrative segregation; or the facility would conduct a proper reassessment prior to being returned to the general population taking into consideration any increased vulnerability of the detainee as a result of sexual abuse. In an interview with the JA, it was indicated detainee victims of sexual abuse or assault would not be generally placed into administrative segregation; however, if the need did arise, the detainee victim would not be held in segregation for more than 72 hours. The JA further indicated the facility would notify ICE FOD immediately if a detainee victim is placed into administrative segregation or protective custody due to an alleged sexual abuse. However, the interview with the JA could not confirm the facility would conduct a proper re-assessment of a detainee victim of sexual abuse taking into consideration any increased vulnerabilities of the detainee as a result of the sexual abuse prior to returning the detainee to general population. The Auditor reviewed five allegation of sexual abuse investigation files and confirmed none of the alleged victims had been placed into administrative segregation or protective custody due to being the victim of sexual abuse. Through observation, the Auditor confirmed there were no detainees housed in administrative segregation or protective custody due being a victim of sexual abuse.

Does Not Meet (c): In an interview with the JA, it could not be confirmed that a reassessment taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse prior to returning the detainee back to general population would be conducted. To become compliant, the facility must implement a practice that requires detainee victims,

who are in protective custody after having been subjected to sexual abuse, not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. Once implemented, the facility must document that the practice has been implemented and that all applicable staff have been trained on the new practice. If applicable, the facility must submit to the Auditor any detainee files in which the detainee was placed into administrative segregation due to an allegation of sexual abuse.

Corrective Action Taken (c): The facility submitted updated policy Chapter #14, SAAPI, which requires "a detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." The facility submitted a training bulletin, and a staff roster, which confirm all security staff have received training on updated policy Chapter #14, SAAPI. In addition, the facility submitted a memo to Auditor which confirms there have been no detainees placed into administrative segregation during the CAP period due to being a victim of sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (c) of the standard.

§115. 71 - Criminal and administrative investigations

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

Notes:

(a)(b)(c): CCDC Policy #14 states, "When the facility conducts its own investigations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third party and anonymous reports." CCDC Policy #14 further states, "The facility shall develop written procedures for administrative investigations, including provisions requiring a) Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; b) Interviewing alleged victims, suspected perpetrators, and witnesses; c) Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; d) Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; e) An effort to determine whether actions or failures to act at the facility contributed to the abuse; f). Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and g) Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation." A review of Policy #14 confirms the facility shall develop written procedures to include all provisions of subsection (c) of the standard; however, the facility has not submitted to the Auditor the facility's developed written procedures. In an interview, the PSA Compliance Manager indicated the CCSO would conduct criminal investigations and the facility would conduct an administrative investigation. In an interview with the facility Investigator, it was indicated that the facility utilizes two trained investigators to conduct sexual abuse allegation investigations. The Auditor reviewed the facility general PREA training documentation and confirmed both investigators had received the training pursuant to §115.31. However, interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each investigator struggled with basic investigative questions, to include the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. The Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training. During the on-site audit, the Auditor reviewed five sexual abuse allegation investigation files and confirmed in each file, the investigative report lacked a description of physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. In addition, the Auditor was unable to confirm all perpetrators or witnesses had been interviewed in all the cases. In review of two of the sexual abuse allegation investigation files confirmed the facts of the allegation would be consistent with the elements of criminal sexual contact; however, the allegations were not reported to law enforcement. There were no indications that facts or an assessment of credibility of either the victim or the perpetrator had been considered to support an unfounded conclusion. In addition, in review of all five sexual abuse allegation investigation files, the Auditor could not determine that a review of prior complaints and reports of sexual abuse and assault involving the suspected perpetrator was conducted. Discussions with a facility Investigator, indicated that video evidence was present in two of the investigations; however, there was no discussion in the reports or information to determine what facts may have been gathered from videos. In addition, the facility Investigator indicated allegations of sexual abuse would only be reported to law enforcement if there was evidence that supported a substantiated allegation, which indicates the administrative investigation is completed prior to a criminal investigation. In an interview with the facility Investigator, it was confirmed that she could not articulate if during the investigative process the facility made an effort to determine

whether actions or failures to act at the facility contributed to the abuse, or if reports of sexual abuse are retained for as long as the alleged abuser is detained or employed by the agency or facility, plus five years.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b) and (c) of this standard. The facility has not established the required written procedures for conducting administrative investigations. The Auditor reviewed five investigations. In each file, the investigative report was severely lacking information. Interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each Investigator struggled with basic investigative questions, to include the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. The Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training. To become compliant, the facility must develop a protocol that includes all elements of subsections (a), (b), (e), and (f) of the standard. In addition, the facility must document that all applicable staff have received training regarding the written procedures content. In addition, the facility must provide the Auditor with copies of all sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action Taken (a)(b)(c): The facility submitted updated policy Chapter #14, SAAPI, which includes all elements required by subsections (a), (b), (c), (e), and (f) of the standard. The facility submitted a training bulletin, and a staff training roster, which confirm all security staff have received training on updated policy Chapter #14, SAAPI. The facility submitted one sexual abuse allegation investigation file which confirms the investigation was conducted in accordance with all subsections of the standard. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

§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:

Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse." CCDC Policy #14 states, "The facility shall impose no standard than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated [sic]." In interviews with two facility Investigators, it was indicated they were unable to articulate the standard of proof that the facility utilizes to determine whether a sexual abuse allegation is substantiated.

Does Not Meet: The facility is not in compliance with this standard. Interviews with both facility Investigators indicated that they were unable to articulate the standard of proof that the facility utilizes to determine whether a sexual abuse allegation is substantiated. To become compliant, the facility shall train all investigators on the standard of proof for administrative investigations. In addition, the facility must submit copies of all sexual abuse allegation investigation files that occurred during the CAP period.

Corrective Action Taken: The facility submitted a training curriculum "Administrative Investigations of Jail/Corrections Officer Misconduct" and a training roster which confirms all facility Investigators have received training on the preponderance of evidence as the standard of proof for administrative investigations of sexual abuse. The facility submitted one sexual abuse allegation file which was investigated by a specially trained investigator who determined the allegation of sexual abuse to be unsubstantiated. Upon review of all submitted documentation the Auditor now finds the facility in compliance with standard 115.72.

§115. 73 - Reporting to detainees
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

CCDC Policy #14 states, "All detainees will receive a write notification of the outcome of the case [sic]." In an interview with the facility PSA Compliance Manager, it was indicated a detainee would receive a written notification of the outcome of an investigation. The Auditor reviewed five investigative files. In all five cases there was no evidence that the Agency or the facility provided the detainee with notification of the outcome or any responsive actions that had been taken. There were no detainees who reported a sexual abuse housed at the facility during the on-site audit, therefore no interview was conducted.

Does Not Meet: The facility is not in compliance standard §115.73. During the on-site audit, the Auditor reviewed five sexual abuse allegation investigation files and confirmed the detainee did not receive notification of the outcome or any responsive actions that had been taken. To become compliant, the Agency and the facility must develop and implement a procedure to ensure that detainees who report an allegation of sexual abuse are notified of the outcome of investigation or any responsive action the facility has taken and submit documentation that all applicable staff have received training on the new procedure. In addition, the facility must submit copies of all sexual abuse allegation investigation files and the corresponding detainee notification that occurred during the CAP period.

Corrective Action Taken: The facility submitted updated policy Chapter #14, SAAPI, and a staff training roster that confirms all security staff have received training on the standard's requirement following an investigation conducted by the facility into a detainee's allegation of sexual abuse and assault. The facility shall notify ICE/ERO of the results of the investigation and any responsive actions taken so that the information can be reported to ICE/ERO headquarters and to the detainee. The facility submitted one sexual abuse allegation investigation file and the corresponding detainee notification that occurred during the CAP period which confirms the detainee victim was notified of the determination; however, as the determination was not substantiated the Auditor could not confirm the detainee was notified of any responsive actions taken by the facility. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with standard 115.73.

§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): CCDC Policy #14 states, "Detainees shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the detainee engaged in detainee-on-detainee sexual abuse or following criminal finding of guilt for detainee-on-detainee sexual abuse. Such discipline shall be administered according to the guidelines set forth." In addition, CCDC Policy #14 states, "Reports 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 the allegation is not substantiated." CCDC Policy #19 "Disciplinary System" states, "Any sanctions imposed will be commensurate with the severity of the committed prohibited act and intended to encourage the inmate/detainee to conform to rules and regulations" and "inmate/detainees will be able to appeal disciplinary decisions through a formal grievance system." CCDC Policy #19 further states, "No inmate/detainee will be harassed, disciplined, punished, or otherwise retaliated against for filing a complaint or grievance" and "disciplinary system cannot be used to discipline a detainee for sexual contact with a staff unless there is a finding that the staff member did not consent." A review of CCDC Policy #19 could not confirm that the disciplinary process considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. Interviews with the JA and PSA Compliance Manager indicated a detainee would not be disciplined for sexual contact with a staff member if the staff willingly participated in the contact, and a detainee would not be disciplined for reports made in good faith. In addition, interviews with the JA and PSA Compliance Manager indicated detainees are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse and that sanctions imposed would be commensurate with the severity of the conducted behavior. In an interview with the JA, the Auditor could not confirm the disciplinary process considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. The Auditor reviewed five sexual abuse allegation investigation files and confirmed none of the cases were substantiated.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The Auditor interviewed the JA and could not confirm that the disciplinary process considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. To become compliant, the facility shall implement a practice that considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. In addition, the facility must document that all applicable staff have been trained on the new practice. If applicable, the facility must submit to the Auditor copies of any detainee files that includes a detainee with a mental disability or mental illness who was sanctioned due to a substantiated act of sexual abuse.

Corrective Action Taken (d): The facility submitted updated policy Chapter #14, SAAPI, and a staff training roster, which confirm all applicable staff have been trained on the standard's requirement when investigating, investigators should take into considers whether a detainee's mental disability or mental illness contributed to his/her behavior, when determining the sanctions to be imposed; however, the corrective action refers to the disciplinary procedures not the investigations. The facility submitted a memorandum to Auditor which confirms there were no detainees with a mental disability or mental illness who were sanctioned due to a substantiated act of sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

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

(a)(b)(c): CCDC Policy #14 states, "If the screening process indicates that a detainee has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall contact the facility medical or mental health practitioner within 14 days of the detainee screening." Informal interviews with intake DOs indicated that if a detainee has previously experienced or perpetrated sexual abuse, a referral will be immediately made to the medical staff. An interview with the facility RN indicated the detainee would receive a health evaluation immediately and that she would refer the detainee to Crosswinds for a mental health follow-up. The Auditor reviewed 12 detainee files, of which 2 of the files indicated that the detainee had disclosed previous sexual abuse. In both cases, the detainees were referred to Crosswinds on the same day the assessment was conducted; however, both detainees had been seen via Zoom by Crosswinds within 10 days of the referral and not within 72 hours as required by subsection (c) of the standard.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed 12 detainee files, of which 2 of the files indicated that the detainee had disclosed previous sexual abuse. In both cases, the detainee was referred to Crosswinds the same day the assessment was conducted; however, both detainees had been seen via Zoom by Crosswinds within 10 days of the referral and not within 72 hours as required by the standard. To become compliant, the facility must develop and implement a practice that requires all detainees referred to mental health be seen within 72 hours as required by subsection (c) of the standard. If applicable, the facility must submit to the Auditor any intake, medical and mental health records of any detainee, who pursuant to §115.41 indicates they have experienced prior sexual victimization or perpetrated sexual abuse during the CAP period.

Corrective Action Taken (c): The facility submitted updated policy Chapter #14, SAAPI, which requires if the screening process indicates a detainee has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall, as appropriate, 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. Updated policy Chapter #14, SAAPI, further requires the detainee receive a medical or mental health evaluation no later than 72 hours after the referral; however, the standard requires 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 the assessment and when a referral for a mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral. In addition, a review of updated policy Chapter #14, SAAPI, confirms updated policy Chapter #14, SAAPI, does not include if the assessment pursuant to 115.41 indicates a detainee has perpetrated sexual abuse. The facility submitted an itemized log which includes five detainees who were referred to mental health for a follow-up and eight detainees who refused a mental health follow-up. The Auditor reviewed the submitted log and confirmed if the detainee refused a mental health follow-up the facility did not submit a referral for a mental health follow-up as required by subsection (a) of the standard. The facility did not provide the Auditor with the intake, medical, and/or mental health records of any detainee, who pursuant to 115.41, has perpetrated sexual abuse. The facility submitted a memorandum indicating there have been no detainees who experienced prior sexual victimization or perpetrated sexual abuse following the implementation of the revised initial risk assessment; however, the deficiency did not lie with a deficient risk assessment in regard to whether or not a detainee experienced prior sexual victimization or perpetrated sexual abuse. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (c) of the standard.

§115. 82 - Access to emergency medical and mental health services
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): CCDC Policy #14 states, "Detainee victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. Such services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperated with any investigation arising out of the incident." During an interview with the facility RN, it was indicated detainee victims of sexual abuse are given timely, unimpeded access to emergency medical treatment at no cost and in accordance with professionally accepted standards of care. The facility RN further indicated facility medical staff would provide the detainee with emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standard of care; however, facility medical staff are not qualified to perform a forensic medical examination. Should the detainee victim require a forensic exam, he/she would be transported to Newman Regional Health where the exam would be performed by a SANE. The Auditor reviewed an MOU between the facility and Newman Regional Health and confirmed emergency medical treatment would be provided free of charge for an alleged victim of sexual abuse. In addition, an interview with SOS staff indicated detainee victims would be provided crisis intervention services in accordance with professionally accepted standards of care.

The Auditor reviewed five sexual abuse allegation investigation files and confirmed each alleged victim had immediately been evaluated by medical staff; however, four files indicated that mental health was offered, and the detainee refused, and one was immediately determined unfounded based on video evidence; and therefore, the detainee had not been referred to mental health. A review of the PREA allegation spreadsheet confirms that none of the sexual abuse allegation investigation files were closed immediately after the allegation was reported.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. In a review of five sexual abuse investigation files, it was confirmed that one detainee victim was not referred to mental health as required by the standard as the facility immediately determined the allegation to be unfounded. A review of the PREA allegation spreadsheet confirms that none of the sexual abuse allegation investigation files were closed immediately after the allegation was reported; and therefore, the detainee victim should have been offered crisis intervention services at the time the allegation was reported. To become compliant, the facility must implement procedure that ensures that all detainee victims of sexual abuse are offered crisis intervention services at the time the allegation is reported. Once implemented, the facility must train all applicable staff on the new procedure. In addition, the facility must submit to the Auditor a copy of all sexual abuse allegation investigation files and the corresponding mental health records that occurred during the CAP period.

Corrective Action Taken (a): The facility submitted a 2023 PREA policy training curriculum and a staff roster which confirm all applicable staff have received training on the standard's requirement all victims of sexual abuse/assault shall be offered crisis intervention services at the time the allegation is reported. The facility submitted one sexual abuse allegation investigation file which confirms the detainee victim was offered crisis intervention services at the time the allegation was reported. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 83 - Ongoing medical and mental health care for sexual abuse victims and abusers
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d)(e)(f): CCDC Policy #14 states, "The facility shall offer medical and mental health evaluations and, as appropriate, treatment to all detainees who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility." In an interview with the facility RN, it was indicated detainees would receive timely emergency access to medical and mental health treatment that would include follow-up services and treatment plans and that care provided within the facility would be free of charge and consistent with level of care received in the community. Crosswinds would conduct a mental health evaluation and would provide the detainee a treatment plan. Female victims would be offered pregnancy tests and, if positive, would receive timely and comprehensive information about lawful pregnancy related medical services. All detainees would be offered tests for sexually transmitted infections, free of charge. In addition, the facility RN indicated, if needed, the medical staff would provide referrals for continued care prior to the detainee being released from custody or if the detainee was being transferred to another facility. The Auditor reviewed five sexual abuse allegation investigation files and confirmed each alleged victim had immediately been evaluated by medical staff; however, four files indicated that mental health was offered, and the detainee refused, and one was immediately determined unfounded based on video evidence; and therefore, the detainee had not been referred to mental health. A review of the PREA allegation spreadsheet confirms that no sexual abuse allegation investigation file was closed immediately after the allegation was reported.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. In a review of five sexual abuse investigation files, it was confirmed that one detainee victim was not referred to mental health as required by the standard as the facility immediately determined the allegation to be unfounded. A review of the PREA allegation spreadsheet confirms that no sexual abuse allegation investigation file was closed immediately after the allegation was reported; and therefore, the detainee victim should have been offered crisis intervention services at the time the allegation was reported. To become compliant, the facility must implement procedure that ensures that all detainee victims of sexual abuse are offered crisis intervention services at the time the allegation is reported. Once implemented, the facility must train all applicable staff on the new procedure. In addition, the facility must submit to the Auditor a copy of all sexual abuse allegation investigation files and the corresponding mental health records that occurred during the CAP period.

Corrective Action Taken (a): The facility submitted a 2023 PREA policy training curriculum and a staff roster which confirm all applicable staff have received training on the standard's requirement all victims of sexual abuse/assault shall be offered crisis intervention services at the time the allegation is reported. The facility submitted one sexual abuse allegation investigation file with corresponding mental health files which confirmed the detainee victim was seen on the day the allegation was made. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 86 - Sexual abuse incident reviews
Outcome: Does not Meet Standard
Notes:

(a)(b)(c): CCDC Policy #14 states, "The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegations have not been substantiated, unless the allegation has been determined to be unfounded." The Auditor reviewed five investigation files and confirmed the sexual abuse incident review had been completed in one file. During discussions with the PSA Compliance Manager, the Auditor confirmed the facility had not been completing an incident review at the completion of an investigation; however, the facility recently implemented a procedure to comply with the standard. In review of the incident review report confirmed that not all elements required in subsection (b) of the standard are considered in the incident review. Additionally, the Auditor was not provided documentation to confirm the facility has conducted an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of this standard. The Auditor reviewed five investigation files and confirmed the sexual abuse incident review had been completed in one file. During discussions with the PSA Compliance Manager, the Auditor confirmed the facility had not been completing an incident review at the completion of an investigation; however, the facility recently implemented a procedure to comply with the standard. In review of the incident review report confirmed that not all elements required in subsection (b) of the standard are considered in the incident review. Additionally, the Auditor was not provided documentation to confirm the facility has conducted an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. To become compliant, the facility must develop and implement a procedure to ensure that a sexual abuse incident review is completed at the conclusion of each investigation by a review team. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, unless the allegation of sexual abuse is determined to be unfounded, the review team shall prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation(s) or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The review team shall implement the recommendations for improvement or shall document its reason for not doing so. The procedure shall include all reports and responses are forwarded to the Agency PREA Coordinator. Once the procedure has been developed the facility shall train all members of the review team on the newly developed procedure. In addition, the facility must provide copies of all sexual abuse allegation investigation files and the corresponding incident reviews with routing that occurred during the CAP period. In addition, the facility shall provide the Auditor with documentation confirming the facility has conducted an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts for the year 2022 and document that the annual review was forwarded to the JA, ERO FOD, and the Agency PSA Coordinator.

Corrective Action (a)(b)(c): The facility submitted updated policy Chapter #14, SAAPI, which requires the facility to prepare a written report within 30 days of the conclusion of a sexual abuse allegation investigation recommending whether the allegation or investigation indicates a change in policy or practice is required to better prevent, detect, or respond to sexual abuse. Updated policy Chapter #14, SAAPI, further requires the facility to implement the recommendations for improvement or document its reasons for not doing so in a written response, and to forward both the report and response to the Agency PSA Coordinator. In addition, updated policy Chapter #14, SAAPI, requires the review team to consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility and to conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. The facility submitted updated Chase County Detention PREA Review form; however, the form did not include all the required elements of subsection (b) of the standard, including the review team consider whether the incident or allegation was motivated by race, ethnicity, gang affiliation or was motivated or otherwise caused by other group dynamics at the facility or the facility has implemented a practice that confirms the incident review and the results were forwarded to the Agency PREA Coordinator. In addition, a review of the incident review form could not confirm the report and results were forwarded to the Agency PREA Coordinator. The facility submitted a memorandum to Auditor which indicates there have been no allegations of sexual abuse since policy Chapter #14, SAAPI, has been updated; however, the facility did not submit documentation confirming all members of the incident review team have received training on the standard's requirement the review team must consider whether the incident or allegation was motivated by race, ethnicity, gang affiliation or was motivated or otherwise caused by other group dynamics at the facility. The facility submitted a copy of the annual review for the year 2022 and an email confirming the annual review for the year 2022 was forwarded to the JA, ERO FOD, and the Agency PSA Coordinator. Upon review of all submitted documentation the Auditor continues to find the facility does not meet subsections (a) and (b) of the standard.

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.

Robin Bruck October 27, 2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) November 13, 2023

Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) November 14, 2023

Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	2/7/2023	**To:**	2/9/2023
AUDITOR INFORMATION			
Name of auditor:	Robin M. Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Chicago Field Office		
Field Office Director:	(A) Shawn Byers		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	101 W Ida B Wells Drive, Chicago, Il 60605		
Mailing address: (if different from above)	Same as above		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Chase County Detention Center		
Physical address:	307 S Walnut Street, Cottonwood Falls, KS 66845		
Mailing address: (if different from above)	PO Box 639, Cottonwood Falls, KS 66845		
Telephone number:	620-273-7054		
Facility type:	IGSA		
PREA Incorporation Date:	February 28, 2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	620-273-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manger
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	620-273-(b) (6), (b) (7)(C)
ICE HQ USE ONLY			
Form Key:	29		
Revision Date:	02/24/2020		
Notes:			

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 Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Chase County Detention Center (CCDC) was conducted February 7-9, 2023, by U.S. Department of Justice (DOJ) and DHS Certified PREA Auditor Robin M. Bruck, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by ICE PREA Contract Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight for the ICE PREA audit process and liaison with the ICE Office of Professional Responsibilities (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility's compliance with the DHS PREA Standards. CCDC is a county facility and operates under contract with the ICE Enforcement and Removal Operations (ERO). The facility processes detainees while their immigration case is moving through the court system. According to the facility Pre-Audit Questionnaire (PAQ), the facility does not house juveniles or family detainees. The facility is in Cottonwood Falls, Kansas. This audit was the first DHS PREA audit for this facility and included a review of the period between February 28, 2020, and February 9, 2023.

The facility houses adult male and female detainees with various custody levels whose immigration cases are moving through the court system. The design capacity for the facility is 150. The facility reports there were 711 detainees (683 males and 28 females) booked into the facility in the last 12 months. The population on the first day of the audit was 60 (56 male and 4 female detainees). The average length of time in custody is 42 days. In addition to housing ICE adult detainees, the facility also houses U.S. Marshals arrestees and County inmates. Detainees are comingled and housed at the facility based on their classification levels. According to the PAQ, the facility is comprised of one building, which includes eight double cell housing units, one open bay/dorm housing unit with surrounding single cells surrounding the dorm, six segregation cells, and four infirmary beds.

Approximately four weeks prior to the audit, ERAU Inspections and Compliance Specialist (ICS) (b) (6), (b) (7)(C) provided the Auditor with the facility's PAQ, Agency policies, and other documents. All documentation was provided to the Auditor through the ICE SharePoint. The PAQ and supporting documentation were organized with the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into folders for ease of auditing. The main policy that governs CCDC PREA program is CCDC Policy #14, "Sexual Abuse and Assault Prevention." All the documentation, policies, and the PAQ were reviewed by the Auditor.

The entry briefing was held in an office at CCDC at 8:15 a.m. on Tuesday, February 7, 2023. The ICE ERAU Team Lead (TL), (b) (6), (b) (7)(C), opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C), Assistant Field Office Director (AFOD), ICE/ERO, via telephone
(b) (6), (b) (7)(C), ICS, ICE/OPR/ERAU, via telephone
(b) (6), (b) (7)(C), Section Chief, ICE/OPR/ERAU, via telephone
(b) (6), (b) (7)(C), ICS TL, ICE/OPR/ERAU
(b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
(b) (6), (b) (7)(C) Jail Administrator (JA), CCDC
(b) (6), (b) (7)(C), Prevention of Sexual Assault (PSA) Compliance Manager, CCDC
Robin Bruck, Certified PREA Auditor, Creative Corrections, LLC

The Auditor introduced herself and provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained that the audit process is designed to not only assess compliance through written policy and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels in the facility. She further explained compliance with the PREA standards will be determined based on a review of the policies and procedures, observations made during the facility on-site tour, documentation review, and conducting interviews with staff and detainees.

An on-site tour was conducted by the Auditor with key staff from CCDC and ICE. All housing units were toured, as well as program areas, control centers, booking/intake, recreation areas, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or provided services, were observed by the Auditor. During the tour, the Auditor made visual observations of the housing units, including bathrooms and shower areas, officer post sight lines, and camera locations. Sight lines were closely examined, as was the potential for blind spots throughout areas where detainees are housed or have access. In addition, the Auditor informally spoke to random staff and detainees regarding PREA education and the facility practices during the on-site tour. A review of the housing unit logbooks was conducted to verify rounds were being conducted by both custody line and supervisory staff. During the on-site audit, the Auditor confirmed the physical plant consists of one building with an administrative area and eight housing units, which include seven double cell housing units and one dorm which is surrounded by single cells. The facility utilizes intelligent video

monitoring management that consists of (b) (6), (b) (7)(C) to assist with the protection of the detainees from sexual abuse. Cameras have the capability to "pan, tilt, and zoom" (PTZ) and the recordings can be stored for up to 30 days. The Auditor observed all camera angles from the (b) (7)(E) and confirmed there were no cross-gender viewing concerns. The Auditor viewed the site lines for direct viewing of (b) (7)(E) and confirmed the height of the cell door window minimizes accidental viewing when passing by the cell. The dorm toilet areas have curtains to be utilized when in use. The toilet area in the single cells is the same as the other housing units. In addition, the Auditor observed that the showers are single showers with curtains that provide privacy when in use. The Auditor observed PREA information which included but was not limited to the DHS-prescribed sexual assault awareness (SAA) notice, the ICE National Detainee Handbook, and the SOS flyer, in each housing unit in both English and Spanish. In addition, the Auditor observed the "Notice of Audit" in all areas of the facility, including the lobby. The Auditor did not receive correspondence from any staff, detainees, or family members.

According to the PAQ, there are 29 security staff with duty hours from 0600–1800 and 1800–0600, consisting of 17 male and 12 female staff who may have reoccurring contact with detainees. In addition, to the security staff, there are four transport officers with recurring contact with the detainees. The remaining staff consists of administration, medical, and kitchen staff. Mental health services are provided to the detainees at the facility through Crosswinds, a community based mental health agency, via video (Zoom). The facility does not enlist the services of contractors and does not have volunteers within the facility. During the on-site audit, the Auditor interviewed 16 staff, which included: the JA, PSA Compliance Manager, facility Investigators (2), Training Officer, Registered Nurse (RN), Human Resource Manager (HRM), Classification Officer, and 7 Detention Officers (DOs). In addition, the Auditor interviewed an ICE SDDO, a SOS staff member, and a DHS Ombudsman. Several of the staff members in the facility, fill multiple roles. During discussions within each standard, they will be identified based on the interview protocol utilized. The Auditor formally interviewed 20 ICE detainees, which included 17 male and 3 female detainees. Seven detainees were limited English proficient (LEP) and required the use of a language interpreter through Language Service Associates, provided by Creative Corrections, LLC.

The facility has two investigators to complete all allegations of sexual abuse. The Auditor interviewed both Investigators during the investigative file reviews. There were five sexual abuse allegations reported during the audit period. A review of the PREA allegation spreadsheet indicated that all five investigations were closed. Of the five cases reported, four included a detainee-on-detainee allegation and one included a staff-on-detainee allegation. All cases were determined to be unfounded. The ICE OPR was notified on all five cases; however, according to a review of the PREA allegation spreadsheet, only four cases were reported to the ICE Joint Intake Center (JIC). There were no cases referred for prosecution.

An exit briefing was conducted on Thursday, February 9, 2023, at 2:30 p.m. in a CCDC office. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) AFOD, ICE/ERO, via telephone
(b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU, via telephone
(b) (6), (b) (7)(C) ICS TL, ICE/OPR/ERAU
(b) (6), (b) (7)(C) SDDO, ICE/ERO
(b) (6), (b) (7)(C) JA, CCDC
(b) (6), (b) (7)(C) PSA Compliance Manager, CCDC
(b) (6), (b) (7)(E) PM/Certified Auditor, Creative Corrections LLC, via telephone
Robin Bruck, Certified PREA Auditor, Creative Corrections, LLC

The Auditor spoke briefly and informed those present that it was too early in the process to formalize an outcome of the audit and that she would need to review all submitted documentation, interview notes, file review notes, and on-site observations. The Auditor thanked all present for their cooperation. The TL explained the audit report process, timeframes for corrective action, and the final report.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

Number of Standards Not Applicable: 1
§115.14 Juvenile and family detainees

Number of Standards Met: 10
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.18 Upgrades to facilities and technologies
§115.32 Other training
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.66 Protection of detainees from contact with alleged abusers
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 30
§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
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and mental health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.64 Responder duties
§115.65 Coordinated response
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

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

Notes:

(c): CCDC follows written Policy #14, mandating zero-tolerance towards all forms of sexual abuse and sexual harassment. The policy includes definitions of sexual abuse and general PREA definitions. In addition, the policy outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment. During the on-site audit, the Auditor observed the DHS-prescribed SAA notice, the ICE National Detainee Handbook, and the SOS flyer posted in the housing units in English and Spanish. Formal and informal interviews with the facility staff confirmed their knowledge of the Agency's and facility's policies regarding zero-tolerance policy of sexual abuse. Interviews with the facility PSA Compliance Manager and SDDO confirmed that CCDC Policy #14 has been approved by the Agency.

(d): CCDC Policy #14 states, "The facility shall appoint an officer to serve as a PREA Coordinator. This officer shall address each allegation and refer such allegation to the appropriate authority for investigation." The facility has appointed a PSA Compliance Manager. An interview with the facility PSA Compliance Manager confirmed she has sufficient time and authority to oversee the facility's efforts with sexual abuse prevention and intervention policies and procedures. In addition, the interview confirmed the PSA Compliance Manager serves as the facility point of contact for the Agency PSA Coordinator.

§115.13 – Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): CCDC Policy #14 states, "The facility shall provide sufficient staff to ensure that detainee supervision is performed in a manner that will deter and prevent sexual abuse. The use of electronic monitoring devices will be in place to assist and document events. Assigned staff are to make security checks of all areas of responsibility on an irregular basis and unannounced security inspections on all shifts." The facility reported 41 staff employed at the facility who may have recurring contact with detainees, which includes 28 security DOs (16 male and 12 female), 4 transport officers, 3 administrative staff, and 3 medical staff, and 3 full-time ICE staff. According to the PAQ, security custody staff work two 12-hour shifts, 0600-1800 and 1800-0600. During an interview with the JA, the Auditor confirmed the facility utilizes a staff-detainee ratio to maintain sufficient supervision of the detainees. He reported that he strives to maintain a 7/1 ratio. In addition, the JA indicated the facility utilizes video monitoring in its efforts to protect detainees against sexual abuse. During the on-site audit, the Auditor observed appropriate staffing levels within the facility. The facility has a total of (b) (7)(E) strategically located throughout the facility. Video cameras are operated 24 hours a day, 7 days a week and have PTZ functionality. The Control Officer post is manned 24 hours a day, 7 days a week and has line of sight into 7 of the housing units. The (b) (7)(E) is visually monitored with the use of the video monitoring system and continual security inspections but cannot be physically seen by the Control Officer. The Auditor observed the control officer site lines and confirmed there are no blind spots within the (b) (7)(E) . The Auditor observed the facility comprehensive detainee supervision guidelines (Post Orders) and confirmed the guidelines were reviewed and updated in April 2022. Interviews with the JA and PSA Compliance Manager confirmed the facility considers generally accepted detention and correctional practices; the physical layout of the facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents; the findings and recommendations of sexual abuse incident reviews; the length of time the detainees spend in the Agency custody; and any judicial findings of inadequacy when determining the adequate levels of detainee supervision and the need for video monitoring. However, the JA further indicated that the facility did not have an actual staffing plan but strives to maintain a 7/1 ratio of staff to detainee.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. In an interview with the JA, it was confirmed that the facility does not have a staffing plan but strives to maintain a 7/1 staff ratio. To become compliant, the facility must provide the Auditor with documentation to confirm when determining adequate staffing levels at CCDC, and the need for video monitoring, that the facility took into consideration: the physical layout of each holding facility; the composition of the detainee population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the findings and recommendations of sexual abuse incident review reports; or any other relevant factors, including but not limited to the length of time detainees spend in Agency Custody.

(d): CCDC Policy #14 states, "Assigned staff are to make security checks of all areas of responsibility on an irregular basis, and unannounced security inspections on all shifts." A review of CCDC Policy #14 confirmed it did not include the requirement that staff are prohibited from alerting others that unannounced security inspections are being conducted. The Auditor reviewed the facility control logs and could not differentiate the PREA unannounced security inspections from normal security inspections conducted at the facility on each shift. During interviews with the JA and the PSA Compliance Manager, it was indicated all security staff are required to perform security inspections during the day and night shifts. However, interviews with the JA and the PSA Compliance Manager could not confirm these inspections are PREA unannounced security inspections conducted specifically to deter detainee sexual abuse. In

addition, interviews with the DOs could not confirm that staff are prohibited from alerting others that these security inspections are occurring.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The Auditor reviewed the facility control logs and could not differentiate the PREA unannounced security inspections from the standard security inspections conducted at the facility on each shift. During interviews with the JA and PSA Compliance Manager, it was indicated that all security staff are required to perform security inspections during the day shift and the night shift. However, interviews with the JA and the PSA Compliance Manager could not confirm these security inspections are PREA unannounced security inspections conducted specifically to deter detainee sexual abuse. In addition, interviews with the DOs could not confirm staff are prohibited from alerting others that these security inspections are occurring. To become compliant, the facility must develop and implement a procedure to conduct frequent unannounced security inspections to identify and deter sexual abuse of detainees. The procedure shall include requiring supervisors to document the unannounced security inspections to confirm PREA unannounced security inspections are being conducted. Once implemented, the facility shall document training of all custody supervisors on the new procedure, including instruction regarding the purpose of the unannounced security inspections. In addition, the facility must implement a procedure that prohibits staff from notifying others that the unannounced security inspections are being conducted. Once implemented the facility must document training of all security line staff and supervisors on the new procedure.

§115.14 – Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The Auditor reviewed a memorandum to the file which states, "Chase County Detention Facility does not house juveniles or families." Interviews with the JA and the PSA Compliance Manager confirmed the facility does not house juveniles or family detainees for ICE. In addition, during the on-site audit, the Auditor did not observe juvenile or family detainees housed in the housing units.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(c)(d): CCDC Policy #13 "Searches" states, "Staff may search an inmate/detainee upon admission to the facility without notice to or approval from the inmate/detainee." A review of CCDC Policy #13 confirms it does not include the requirements: cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances; the facility shall not permit cross-gender pat-down searches of female detainees, absent exigent circumstances; or the facility shall document all strip searches, visible body cavity searches, and cross-gender pat-down searches. According to the facility PAQ cross-gender pat-down searches are not conducted at the facility. During interviews with the JA, PSA Compliance Manager, and facility DOs, the Auditor confirmed cross-gender pat-searches are not conducted at the facility; however, if there was an exigent circumstance that would require a cross-gender pat-down search it would be documented. The Auditor observed an adequate number of male and female staff to prevent the need to conduct a cross-gender pat-down search at the facility. The Auditor interviewed 20 detainees, including 3 female detainees, and all detainees reported they had only received a pat-down search during the booking process and the search was conducted by a DO of the same gender. As no intake processing occurred during the on-site audit, the Auditor observed video footage of a pat-down search and confirmed the search was conducted by a DO the same gender as the detainee.

(e)(f): CCDC Policy #14 states, "Cross-gender strip searches of cross-gender visual body cavity searches shall not be performed except in exigent circumstances or when performed by medical practitioners following authorization by the Jail Administrator." A review of Policy #14 confirms it does not include the requirement of: cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety or when performed by medical practitioner or all cross-gender strip searches or cross-gender visual body cavity searches shall be documented. The Auditor reviewed CCDC PREA training curriculum which states, "Cross-gender strip searches or cross-gender visual body cavity searches shall not be performed except in exigent circumstances or when performed by medical practitioners following authorization by the Jail Administrator." The Auditor reviewed a memorandum to the file, which indicated there has not been a cross-gender strip or cross-gender body cavity search conducted at the facility during the reporting period. Interviews with the JA, PSA Compliance Manager, and facility DOs indicated that cross-gender strip searches or cross-gender visual body cavity searches are not conducted at the facility; however, if an exigent circumstance was to occur at the facility, and a cross-gender strip search or visual body cavity search was necessary, it would be documented. In interviews with 20 detainees, all reported they have not been strip searched at the facility. In addition, the detainees further indicated that during the booking process they were required to change into facility clothing and the DO observing their clothing change was a DO of the same gender and turned his/her head to avoid viewing the detainee in a complete state of undress.

Recommendation (e)(f): The Auditor recommends that the facility update CCDC Policy #14 to include the requirement of: cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety or when performed by medical practitioner or all cross-gender strip searches or cross-gender visual body cavity searches shall be documented.

(g): CCDC Policy #14 states, "The Chase County Detention Center shall ensure that the detainees may shower, perform bodily functions, 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." During the on-site audit, the Auditor observed the male staff announcing, "Male on the floor", when entering a female unit. The Auditor interviewed two female DOs. One reported she announces every time she enters the unit and the other officer stated she knocks on the door prior to entering the unit; however, the Auditor did not observe the female staff announcing themselves as they entered the housing units. The Auditor interviewed 20 detainees, of which 3 female detainees confirmed all male staff announce themselves when they enter the unit; and all male detainees reported female staff do not announce themselves when entering the unit; however, they are aware they are in the unit due to their voices being heard. In addition, all 20 detainees interviewed stated, to their knowledge, no staff has seen them naked in the shower, using the bathroom, or changing their clothes.

Does Not Meet (g): The facility is not in compliance with subsection (g) of the standard. The Auditor interviewed two female DOs. One reported she announces every time she enters the unit and the other officer stated she knocks on the door prior to entering the unit; however, the Auditor did not observe the female staff announcing themselves as they entered the housing units. In addition, all male detainees interviewed reported female staff do not announce themselves when entering the male housing units. To become compliant, the facility must retrain all female staff, to include the administrative female staff, of the requirement to announce their presence prior to entering housing units that include detainees of the opposite gender. The facility shall provide the Auditor with documentation of the training received.

(h): CCDC is not designated as a Family Resident Center; therefore, provision (h) is not applicable.

(i)(j): A review of CCDC Policy #14 confirms it does not include the requirement that the facility not search or physically examine a transgender or intersex detainee solely to determine their genital status; or if the genital status is unknown, it may be determined during private conversations with detainee, by reviewing medical records, or by learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private by a medical practitioner. CCDC Cross-gender, Transgender, and Intersex training curriculum states, "When a cross-gender, transgender or intersex inmate/detainee enters the facility, under no circumstances shall an officer search the detainee/inmate solely for the purpose of determining their genital characteristics or gender" and "if officers are unsure of the inmate's/detainee's gender, the gender may be determined through conversations with the inmate/detainee. If officers are still unsure of the gender of the inmate/detainee, officers are to contact medical to review their medical records for the determination." During interviews with seven DOs, the Auditor confirmed they would not search or physically examine a detainee for the sole purpose of determining the detainee's gender and that the information could be learned from a medical examination, which occurs during the intake process, in a private setting with the facility medical staff. The facility provided the Auditor with documentation that all staff, who have reoccurring contact with detainees, completed the Cross-Gender, Transgender and Intersex training in July of 2022. There were no transgender or intersex detainees housed at the facility during the on-site audit; therefore, no interview was conducted.

Recommendation (i): The Auditor recommends the facility update CCDC Policy #14 to include the requirement that the facility not search or physically examine a transgender or intersex detainee solely to determine their genital status or if the genital status is unknown, it may be determined during private conversations with detainee, by reviewing medical records, or by learning that information as part of a standard medical examination that all detainees must undergo as part of intake, or other processing procedure conducted in private by a medical practitioner.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): CCDC Policy #14 states, "The facility will take appropriate steps to ensure that detainees with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and sexual harassment. This includes but not limited to 1) detainees who are deaf or hard of hearing; 2) those who are blind or have low vision; 3) those who have intellectual, psychiatric problems; 4) those with speech disabilities." During interviews with seven DOs, it was reported that if a detainee was LEP, communication would be established with the use of the language line or with the assistance of Google Translate. However, the facility did not submit documentation to confirm the use of the language line or Google Translate, nor did the Auditor observe their use while on-site. Interviews with seven DOs further indicated that if a detainee is deaf or hard of hearing, staff would have the detainee read the information. In addition, during the interviews with two DO's the Auditor confirmed they have the ability to speak and translate in American Sign Language. However, the Auditor could not confirm the facility utilizes these services or any other services specifically for those detainees who are deaf or hard of hearing. In interviews with the seven DOs, it was further indicated if a detainee had difficulty reading, had an intellectual, psychiatric, or speech disability, they would speak with them on the same levels they would with their grandchildren or children, in a kind and patient manner, ensuring they understand. In an interview with the PSA Compliance Manager, it was indicated that information is given to the detainees through the facility handbook and during orientation, both of which are available in English and Spanish only. In addition, the PSA Compliance Manager indicated that the facility handbook and ICE National Detainee Handbook, are located on the housing unit kiosks in English and Spanish. This was confirmed through observation by the Auditor. The auditor could not confirm that the DHS-prescribed Sexual Assault Awareness Information (SAAI) pamphlet was available in the 15 most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) as the facility had uploaded the 2021 ICE National Detainee Handbook on the kiosk, which does not include nine of the recently published languages. In addition, the Auditor observed the orientation video on the kiosks in English and Spanish only. During the on-site audit, the Auditor further observed PREA information, including the ICE National Detainee Handbook, the DHS-

prescribed SAA notice, the DHS Office of Inspector General (OIG) contact information, and the SOS Flyer. However, the Auditor observed the bulletin boards are secured, on the wall a little higher than an average height person, and information was printed on pages that were approximately 4x5, which an average height detainee with good eyesight would have difficulty reading. During interviews with 20 detainees, 11 English speaking detainees reported they were given information regarding sexual abuse, how to stay safe, and how to report an incident of sexual abuse; and 9 detainees, including 7 LEP detainees, reported they were not given any PREA information during the intake process; however, they were aware there was PREA information located on the housing unit kiosks. In addition, all seven LEP detainees reported that staff have not communicated with them using the language line or Google Translate, and if communication is necessary, another detainee is utilized to interpret for them. The Auditor reviewed 10 detainee files, all contained documentation that the detainee had received the PREA Orientation, the facility handbook, and the ICE National Detainee Handbook. The documentation could not confirm that they received the information in a manner that they would understand.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of this standard. During interviews with seven DOs, it was reported that if a detainee was LEP, communication would be established with the use of the language line or with the assistance of Google Translate. However, the facility did not submit documentation to confirm the use of the language line or Google Translate, nor did the Auditor observe their use while on-site. Interviews with seven DOs further indicated that if a detainee is deaf or hard of hearing, staff would have the detainee read the information. In addition, during the interviews with two DO's the Auditor confirmed they have the ability to speak and translate in American Sign Language. However, the Auditor could not confirm the facility utilizes these services or any other services specifically for those detainees who are deaf or hard of hearing. During interviews with 20 detainees, 11 English speaking detainees reported they were given information regarding sexual abuse, how to stay safe, and how to report an incident of sexual abuse; and 9 detainees, including 7 LEP detainees, reported they were not given any PREA information during the intake process; however, they were aware there was PREA information located on the housing unit kiosks. In addition, all seven LEP detainees reported that staff have not communicated with them using the language line or Google Translate, and if communication is necessary, another detainee is utilized to interpret for them. During the on-site audit, the Auditor further observed PREA information, including the ICE National Detainee Handbook, the DHS-prescribed SAA notice, the DHS Office of Inspector General (OIG) contact information, and the SOS Flyer. However, the Auditor observed the bulletin boards are secured, on the wall a little higher than an average height person, and information was printed on pages that were approximately 4x5, which an average height detainee with good eyesight would have difficulty reading. The auditor could not confirm that the DHS-prescribed Sexual Assault Awareness Information (SAAI) pamphlet was available in the 15 most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) as the facility had uploaded the 2021 ICE National Detainee Handbook on the kiosk, which does not include nine of the recently published languages. To become compliant, CCDC must provide detainees access to the ICE National Detainee Handbook, in all of the 14 most prevalent languages encountered by ICE, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese. In addition, the facility must make available the DHS-prescribed SAAI pamphlet, in the 15 most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) to all detainees. In addition, the facility must implement a practice of providing PREA information to LEP and deaf or hard of hearing detainees in a manner they understand. Once developed, all intake staff must receive documented training on the new procedures and the facility must present the Auditor with 10 detainee files that includes detainees who speak languages, other than English or Spanish to confirm that detainees have access to the information in a language they understand. In addition, if applicable, the facility must provide the Auditor with five detainee files consisting of detainees who are deaf or hard of hearing to confirm they are getting the PREA information in a format they understand.

Recommendation (a)(b): The Auditor recommends that the facility lower the information located on the housing unit bulletin boards to allow access to the information to those detainees who would have difficulty viewing the information.

(c): The Auditor reviewed all policies submitted by the facility and confirmed the facility did not submit a policy that prohibits the use of minors, alleged abusers, detainees who witnessed the alleged abuse or detainees who have a significant relationship with the alleged abuser from providing interpreter services; or that allows the use of another detainee in matters related to sexual abuse should the detainee express a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. In interviews with seven DOs, all DOs indicated that if the victim or witness requested translation by another detainee, they would allow it unless the interpreter is the abuser or someone with a significant relationship with the abuser. None of the DOs interviewed indicated that the use of another detainee would only be utilized after the Agency determines that such interpretation is appropriate and consistent with DHS policy or that detainees who witnessed the alleged abuse may not be used for interpretation.

Does Not Meet (c): The facility is not in compliance with subsection (c) of this standard. In interviews with seven DOs, all DOs indicated that if the victim or witness requested translation by another detainee, they would allow it unless the interpreter is the abuser or someone with a significant relationship with the abuser. None of the DOs interviewed indicated that the use of another detainee would only be utilized after the Agency determines that such interpretation is appropriate and consistent with DHS policy or that detainees who witnessed the alleged abuse may not be used for interpretation. To become compliant, the facility must implement a practice that allows a detainee to use another detainee to provide interpretation for a victim of sexual abuse provided the Agency determines the interpretation is appropriate and consistent with DHS policy and prohibits the use of any detainee who witnessed the

alleged abuse to be used for interpretation. Once implemented, the facility must train all custody supervisors and DOs of the new practice and provide documentation that the training has been received.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government serve undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. CCDC Policy #14 states, "The Facility will not hire or promote anyone who may have contact with detainees and will not enlist the services of any contractor who may have contact with detainees. 1) Who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or 2) who has been convicted of engaging or attempting to engage in sexual activity in the community 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. 3) All new staff will be asked if there has ever been an allegation of PREA made against them. The facility will perform a criminal backgrounds records check before hiring new employees or enlisting the service of contractors who may have contact with detainees." A review of CCDC Policy #14 confirms it does not contain the requirement material omissions regarding misconduct, or the provision of materially false information is grounds for termination or withdrawal of an offer of employment. During interviews with the JA and PSA Compliance Officer, the Auditor confirmed the facility does not enlist the services of contractors. All persons with detainee contact are facility staff or ICE staff. In an interview with the PSA Compliance Manager, who also functions as the HRM, it was indicated that criminal background checks are completed on all prospective employees to determine if the person is suitable for employment. In addition, the PSA Compliance Manager indicated that perspective applicants are asked during the initial interview process if they have ever engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or if they have been convicted of engaging or attempting to engage in sexual activity facilitated by force, or of implied threats of force, or coercions, or if the victim dd not consent or was unable to consent or refuse, or who has been civilly or administratively adjudicated to have engaged in such activity and if there is an affirmative response the applicant would not be hired. However, the questions are asked verbally; and therefore, no documentation is maintained to determine compliance. The PSA Compliance Manager further indicated that all promotional candidates are asked in an interview about any previous misconduct prior to being promoted and all prior institutional employers are contacted and asked if the prospective employee is eligible for re-hire and the reasons for leaving the previous employment; however, prior institutional employers are not asked about substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. During interviews with seven DOs, one DO indicated she believed she had been asked the questions during her interview and the remaining six reported they were not asked or do not remember being asked questions regarding previous sexual misconduct as described in subsection (a) of the standard and were not aware of a continuing duty to disclose sexual misconduct. There have not been any staff promotions during the audit period. The Auditor reviewed 10 randomly selected employee files. All files, except for two food service employees with no contact with detainees confirmed background checks were conducted prior to the employee being hired. The facility is not an immigration only facility, and therefore is not required to complete background investigations, every five years for staff who have contact with detainees. Additionally, the Auditor could not confirm the facility imposes a continually affirmative duty to disclose any such misconduct. The Auditor submitted a Background Investigation for Employees and Contractors form to the OPR PSO Unit to include the three ICE employees assigned to the facility to verify the completion of the background process. OPR PSO confirmed the background investigation status of all Agency employees submitted were completed. An interview with the SDDO confirmed there have not been any promotions of ICE staff at the facility during the audit period. During an interview with the JA, he confirmed the facility does not enlist the services of contractors or volunteers, who may have reoccurring contact with detainees. No documentation was provided to the Auditor to confirm material omissions regarding misconduct, or the provision of materially false information is grounds for termination or withdrawal of an offer of employment. During the on-site audit, the Auditor confirmed there were no contractor or volunteers working in the facility.

Does Not Meet (a)(b)(e): The facility is not in compliance with subsections (a), (b), and (e) of the standard. The PSA Compliance Manager indicated that perspective applicants are asked during the initial interview process: if they have ever engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution; or if they have been convicted of engaging or attempting to engage in sexual activity facilitated by force, or of implied threats of force, or coercions, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity and if there was an affirmative response answer the applicant would not be hired. However, the questions are asked verbally; and therefore, no documentation is maintained to determine compliance. During interviews with seven DOs, one DO indicated she believed she had been asked about previous sexual misconduct during her interview and the remaining six reported they were not asked or do not remember being asked questions regarding previous sexual misconduct as described in subsection (a) of the standard. In addition, the PSA Compliance Manager indicated all prior institutional employers are contacted and asked if the

prospective employee is eligible for re-hire and the reasons for leaving the previous employment; however, past institutional employers are not asked about substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. During interviews with seven DOs, or through review of personnel records, the Auditor could not confirm the facility imposes a continually affirmative duty to disclose any such misconduct or material omissions regarding misconduct, or the provision of materially false information was grounds for termination or withdrawal of an offer of employment. The Auditor reviewed 10 randomly selected employee files. To become compliant, the facility must implement a practice that requires and informs staff they have a continuing affirmative duty to report any misconduct involving sexual abuse. The new procedure must also include the requirement material omissions regarding misconduct, or the provision of materially false information would be grounds for termination or withdrawal of an offer of employment. Once implemented the facility shall train all HR staff on the new procedures. In addition, the procedure must ensure the facility inquires and refrains from hiring, promoting or enlisting the services of any employee, contractor or volunteer who may have contact with detainees, who has: engaged in sexual abuse in a prison, jail, holding facility, confinement facility, juvenile facility, or other institution; been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or been civilly or administratively adjudicated to have engaged in the activity described above. Once implemented, the facility must provide documentation that confirms the procedure ensures the facility inquires and refrains from hiring, promoting or enlisting the services of any employee, contractor or volunteer who may have contact with detainees, who has: engaged in sexual abuse in a prison, jail, holding facility, confinement facility, juvenile facility, or other institution; been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or been civilly or administratively adjudicated to have engaged in the activity described above, staff have a continuing duty to report any pervious misconduct, and that material omissions regarding misconduct, or the provision of materially false information would be grounds for termination or withdrawal of an offer of employment. In addition, the facility must train all HR staff on the new procedures and document that the training was received.

(f): During an interview with the PSA Compliance Manager/HRM, the Auditor confirmed although the facility will not ask previous employers about substantiated allegations or resignation during an investigation as required by (b) of the standard, they will provide information on substantiated allegations of sexual abuse involving a former employee to an institutional employer seeking the information prior to hiring the applicant. In an interview with the HRM, it was confirmed the facility has not received a request from a facility wishing to hire a previous employee about sexual misconduct during the reporting period.

115.18 - Upgrades to facilities and technologies.

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

Notes:

(a)(b): CCDC Policy #14 states, "At such time as the Facility plans any expansions or upgrades to The Facility [sic], such expansions or upgrades shall take into consideration, the need to accommodate inmate safety and prevent sexual abuse." The facility PAQ and an interview with the JA confirmed that during the audit period, there have been no acquisitions, expansions, or modifications to any areas in the facility where detainees are allowed to enter. The facility is in the process of adding (b) (7)(E) to the video monitoring system. An interview with the facility PSA Compliance Manager confirmed the JA and the PSA Compliance Manager had many discussions regarding the placement of the additional cameras to enhance their ability to protect detainees from sexual abuse. However, the facility did not provide documentation to confirm all elements of subsection (c) of standard §115.13 were considered in determining the cameras placement.

Recommendation (b): Prior to implementing the video monitoring system and operating the system to its full capability, the Auditor recommends that the facility 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 an unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in Agency custody as required by subsection (c) of standard §115.13.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): The Agency's Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (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 ICE ERO 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 Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." CCDC Policy #14 states, "The facility is responsible for investigating allegations of sexual abuse and shall follow a uniform evidence protocol. 1) All clothing and bedding will be collected. These items will be placed in paper evidence bag and labeled according to procedure. 2) All evidence will be turned over the Investigator. 3) Victims will be scheduled for an examination and/or treatment as necessary." A review of CCDC Policy #14 confirms it does not include the requirements: the protocol shall be developmentally appropriate for juveniles where applicable and developed in coordination with DHS; how to best utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, information, and referrals; the presence of his

or her outside or internal victim advocate if requested by the detainee including any available victim advocacy services offered by a hospital conducting the forensic exam such as support during a forensic exam and investigatory interviews. In addition, a review of CCDC Policy #14 confirms it does not include the requirements facilities shall offer all detainees who experience sexual abuse access to forensic medical examinations with the victim's consent and without cost to the detainee and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident or examinations shall be performed by a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forensic Examiner (SAFE) or a qualified medical practitioner if a SAFE or SANE is not available. In interviews with the JA and PSA Compliance Manager, it was confirmed all criminal allegations would be investigated by the Chase County Sheriff's Office (CCSO). In an interview with the facility RN, it was indicated that if a detainee is sexually assaulted, the detainee would be transported to Newman Regional Health for a SANE Exam and victim advocate services would be provided by SOS. The Auditor reviewed a Memorandum of Understanding (MOU) between CCDC and Newman Regional Health. The MOU is in effect from November 28, 2022, through December 31, 2023. According to the MOU, CCDC services to be rendered include CCDC will transport the related party(ies) to the Newman Region health for sexual assault examination and assessment of care. Newman Regional Health services include an appropriate SANE who will complete an assessment with evidence collection and completed rape kit. The hospital will coordinate, as needed, with any investigation and provide reports to the facility regarding necessary treatment and findings. SANE exams are at no cost to the victim of a sexual abuse. During the on-site audit, utilizing a detainee phone, the Auditor spoke with an advocate from SOS who indicated in the event a forensic exam was required, advocacy services would be provided to the victim during the forensic exam. The advocate further indicated SOS would provide emotional support, crisis intervention, information and referrals that may be needed; however, the SOS advocate could not articulate how they would be notified of the incident or the steps that would be taken to provide the services to the detainee; and therefore, the Auditor could not determine that procedures have been established to provide a victim advocate, if the victim requests they be made available, if a sexual abuse were to occur. There were five allegations of sexual abuse reported at CCDC during the audit period. One case included staff-on-detainee and four cases involved detainee-on-detainee. The Auditor reviewed five sexual abuse allegation investigation files and determined that uniform evidence procedures, to include ensuring detainees do not destroy usable evidence, were followed during the administrative investigations. The facility does not house juvenile detainees.

Does Not Meet (a)(b)(c)(d): The facility is not in compliance with subsections (a), (b) and (c) of the standard. The facility has not provided the Auditor with the required protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions to determine compliance. As the facility did not provide the required protocol, the Auditor could not confirm the requirements of subsections (b), (c), (d), are included in the protocol. The elements include how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address the victim's needs. The procedures shall include outside victim advocates services following an incident of sexual abuse. The facility shall attempt to make available to the victim a victim advocate from the local rape crisis center to provide the victim advocate services, if not available the agency shall provide these services by making available a qualified staff member from a community-based organization or a qualified staff member. The outside or internal victim advocate shall provide emotional support, crisis intervention, information and referrals. As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by the hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. To become compliant, the facility must develop a protocol, in conjunction with DHS, that includes all elements how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address the victim's needs. The procedures shall include outside victim advocates services following an incident of sexual abuse. The facility shall attempt to make available to the victim a victim advocate from the local rape crisis center to provide the victim advocate services, if not available the agency shall provide these services by making available a qualified staff member from a community-based organization or a qualified staff member. The outside or internal victim advocate shall provide emotional support, crisis intervention, information and referrals. As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by the hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews. The facility shall provide the established protocol to the Auditor to confirm compliance with all elements of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content. If applicable, the facility must provide the Auditor with all sexual abuse investigation files that occurred during the corrective action period (CAP) period.

(e): The facility is responsible to conduct all administrative investigations of sexual abuse. All criminal investigations are conducted by the CCSO. Interviews with the JA and PSA Compliance Manager indicated that the facility has not requested the CCSO to follow all requirements of standard §115.21 (a)-(d).

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. Interviews with the JA and the PSA Compliance Manager indicated that the facility has not requested the CCSO to follow all requirements of standard §115.21 (a)-(d). To become compliant, the facility shall request the CCSO to follow all requirements of standard §115.21 (a)-(d).

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that, "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as

soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." CCDC Policy #14 states, "The facility shall develop written procedures for administrative investigations, including provision requiring a. Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data: b. Interviewing alleged victims, suspected perpetrators, and witnesses. c. Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; d. Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; e. An effort to determine whether actions or failures to act at the facility contributed to the abuse; f. Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and g. Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." In addition, "The Jail Administrator will notify the Chase County Sheriff's Office of the abuse immediately. The Chase County Sheriff's Office will conduct the investigation, maintain all records, and will coordinate all actions with the probable cause of a criminal act being committed, the report will be forwarded to the Chase County Prosecuting Attorney for consideration of formal charges. All allegations or suspicion of sexual abuse will be investigated and reported in a timely manner." CCDC Policy #14 further states, "The Jail Administrator will notify the Chase County Sheriff's Office of the abuse immediately. The Chase County Sheriff's Office will conduct the investigation, maintain all records, and will coordinate all actions with the probable cause of a criminal act being committed, the report will be forwarded to the Chase County Prosecuting Attorney for consideration of formal charges. All allegations or suspicion of sexual abuse will be investigated and reported in a timely manner." An initial review of the PREA allegation spreadsheet indicated that there were five allegations of sexual abuse reported during the audit period. In addition, the PREA allegation spreadsheet indicated all five cases were closed and all five cases were determined to be unfounded by the facility investigator. The review of the PREA allegation spreadsheet further confirmed the ICE OPR was notified of all the allegations; however, one case did not have a date the ICE JIC was notified, noting, "JICMS not notified." Of the five cases included on the PREA allegation spreadsheet, four included a detainee-on-detainee allegation and one included a staff-on-detainee allegation. All cases were determined to be unfounded by the facility investigator. There were no cases referred for prosecution. During the on-site audit, the Auditor reviewed five sexual abuse allegation investigation files and confirmed an administrative investigation had been completed on all five allegations. However, during the review, two of the allegations appeared to include the elements consistent with sexual contact as per DHS PREA standard definitions. The Auditor confirmed that neither allegation had been referred to local law enforcement for a criminal investigation as per the facility policy and subsection (d) of the standard. In an interview with the PSA Compliance Manager/Investigator, it was confirmed the allegations were not referred to local law enforcement, as required by the facility policy and the standards as the facility determined there was no evidence of the allegations occurring.

Does Not Meet (a)(b)(d)(e)(f): The facility is not in compliance with subsections (a), (b), (d), (e) and (f) of the standard. The facility is not in compliance with subsections (a), (b), (d), (e), and (f) of the standard. The facility has not established the required protocol to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority as required in subsection (a) of the standard. As the facility does not have a protocol, the requirements of subsections (b), (d), (e), and (f) that require what is included in the protocol is also non-compliant. An initial review of the PREA allegation spreadsheet indicated that there were five allegations of sexual abuse reported during the audit period. In addition, the PREA allegation spreadsheet indicated all five cases were closed and all five cases were determined to be unfounded by the facility investigator. The review of the PREA allegation spreadsheet further confirmed the ICE OPR was notified of all the allegations; however, one case did not have a date the ICE JIC was notified noting "JICMS not notified." During the on-site audit the Auditor reviewed four sexual abuse allegation investigation files and confirmed two of the allegations included elements consistent with sexual contact as per PREA definitions; however, neither allegation had been referred to local law enforcement for a criminal investigation as per CCDC Policy #14 and subsection (d) of the standard. In an interview with the PSA Compliance Manager/Investigator, it was confirmed that the allegations were not referred to local law enforcement, as the facility determined there was no evidence of the allegations occurring. To become compliant, the facility must develop a protocol that includes all elements of subsections (b), (d), (e), and (f) of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content. If applicable, the facility must submit all closed sexual abuse allegation investigations with confirmation that the facility notified ICE OPR, the ICE JIC, the appropriate ERO FOD, and if clearly not criminal local law enforcement of the reported allegation.

(c): During a review of the Agency and the facility website, it was confirmed that the Agency website (www.ice.gov) does include the required Agency protocol; however, a review of the CCDC website (www.chasejail.com/PREA) confirmed CCDC Policy #14 and a dedicated investigative protocol are not included.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of the CCDC website (www.chasejail.com/PREA) confirmed CCDC Policy #14 and a dedicated investigative protocol are not included. To become compliant, the facility must develop an investigative protocol that contains all elements of standard §115.22 and place it on its website.

§115.31 – Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): CCDC Policy #40 "Staff Training" states, "The agency shall train, or require the training of all employees who may have contact with immigration detainees, and the facility staff, to be able to fulfill their responsibilities under this part, including training on: 1) the agency and the facility's zero-tolerance policies for all forms of sexual abuse; 2) the right of detainees and staff to be free from sexual and from retaliation for reporting sexual abuse; 3) definitions and examples of prohibited and illegal sexual behavior; 4) recognition of situations where sexual abuse may occur; 5) recognition of physical, behavioral, and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; 6) how to avoid inappropriate relationships with detainees; 7) how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; 8) procedures for reporting knowledge or suspicion of sexual abuse; and 9) 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 or investigative purposes." The Auditor reviewed the facility PREA training curriculum and confirmed the training does not include: the agency's zero tolerance of all forms of sexual abuse; definitions of prohibited behaviors; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on examples of prohibited and illegal behaviors; recognition of situations where sexual abuse may occur; recognition of physical, behavioral and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; how to avoid an inappropriate relationship with a detainee; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, 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 or investigative purposes. In addition to the facility on-site PREA training, staff is required to complete PREA training through the Detention and Online Training Academy (DACOTA), which includes Prison Rape Elimination Act (PREA): A Legal Proactive Approach to PREA. The facility did not provide the Auditor with the on-line training curriculum to determine if all elements of the standard are included in the on-line training. An interview with the facility Training Director indicated that all staff have received PREA training. The Training Director maintains and excel spreadsheet to keep track of all those that need to complete training. During interviews with seven DOs, it was confirmed they are required to attend PREA training every year. The facility PAQ indicated there are 32 staff employed at the facility, who may have recurring contact with detainees. The Auditor reviewed a PREA sign-in sheet and confirmed all 32 staff attended PREA training in 2022.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed the facility PREA training curriculum. The training did not include the agency's zero tolerance of all forms of sexual abuse; definitions of prohibited behaviors; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on examples of prohibited and illegal behaviors; recognition of situations where sexual abuse may occur; recognition of physical, behavioral and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; how to avoid an inappropriate relationship with a detainee; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, 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 or investigative purposes. In addition to the facility on-site PREA training, staff is required to complete PREA training through DACOTA, which includes Prison Rape Elimination Act (PREA): A Legal Proactive Approach to PREA. The facility did not provide the Auditor with the on-line training curriculum to determine if all elements of the standard are included in the on-line training. To become compliant, the facility must provide the Auditor with a copy of the training curriculum for DACOTA to confirm it is compliant with the requirements of subsection (a) of the standard. If it is not, the facility must revise the training curriculum to include all elements of subsection (a) of the standard. Once revised, the facility shall provide the Auditor with documentation that all staff have completed 2023 PREA training utilizing the revised curriculum.

§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): CCDC Policy #14 states, "The facility shall ensure that all volunteers and contractors who have contact with detainees have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection and response policies and procedures." The Auditor reviewed the facility PREA Volunteer/Contractor Training Agreement, which states, "CCDF is a PREA (Prison Rape Elimination Act) compliant facility that observes a ZERO-TOLERANCE policy. Any sexual misconduct (harassment or abuse) is prohibited whether it be staff/volunteer/contractor on inmate, inmate on inmate, inmate on staff/volunteer/contractor and must be reported to administration right away for investigation and possible criminal prosecution. Any contractor of volunteer that may witness, be reported to, or suspect sexual harassment or abuse must report the allegation or suspicion to administration immediately for investigation and possible criminal prosecution." The Auditor reviewed the facility PAQ, which stated the facility had zero contract staff and zero volunteers at the facility. Interviews with the JA and PSA Compliance Manager confirmed CCDC has not had contractors or volunteers who may contact detainees at the facility during the audit period.

§115.33 – Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e): CCDC Policy #14 states, "During the intake Transactions detainees shall receive information explaining the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse and sexual harassment. The detainee receives information regarding the "zero tolerance" during the detainee screening process in booking. PREA statement are places in detainees living area, c. All detainees must sign in and acknowledge they understand the policy prior to

their assignment to a cell/pod. The record of their acknowledgement of the policy is then stored in their detainee history in TEAM." CCDC Policy #4 "Admission and Release" states, "Each newly admitted inmate/detainee will be oriented to the facility through written material on the facility policies, rules, prohibited acts, and procedures all included in the facility handbook and on zero-tolerance PREA policy." The Auditor reviewed the facility PREA Orientation document, which states, "We have a zero-tolerance policy. If you have any questions or concerns, please speak with the jail staff. If you have any allegations of sexual assault or sexual abuse, please contact the PREA Coordinator (name inserted) either email with a Grievance, General Request, and/or by asking staff to speak with the PREA Coordinator." However, a review of the PREA Orientation document confirms it does not include the following information: prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting including a staff member other than an immediate point-of-contact line officer, the DHS OIG and the ICE JIC; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to received treatment and counseling. Interviews with the PSA Compliance Manager and seven DOs, trained in the booking process, indicated the PREA Orientation document is given to all detainees during the booking process. If a detainee is LEP, the document is provided in a language that they can understand by using Google Translation. Interviews with seven DOs further indicated if a detainee is deaf or hard of hearing, the document is printed with the use of Google Translation, in a language they can read. If a detainee has limited reading skills or is blind, the document is read to them in a language that they can understand, utilizing Google Translation. If a detainee has intellectual, psychiatric, or speech disabilities, the seven DOs reported they would deliver the material to them as they would their children or grandchildren to ensure they understand the document. Interviews with three Spanish speaking detainees indicated the PREA Orientation document was provided in Spanish, and if they had questions or did not understand, a Spanish speaking detainee assisted with explaining the document. Interviews with 13 English speaking detainees confirmed the PREA Orientation was provided in English, in which they could understand; however, it was not provided in their preferred language. During the on-site audit, the Auditor did not observe the DHS-prescribed SAAI pamphlet, available in 15 of the most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian) available to the detainees in the intake area. However, the Auditor observed the facility Inmate/Detainee Handbook, the ICE National Detainee Handbook, a PREA video, and the PREA Orientation are available to the detainees on the housing unit kiosks in both English and Spanish. The ICE National Detainee Handbook contained the DHS-prescribed SAAI pamphlet in nine languages (Arabic, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi and Spanish). However, the newly published languages (Bengali, Romanian, Russian, Turkish, Ukrainian, Vietnamese) were not available. The Auditor reviewed 10 detainee files and confirmed the PREA Orientation document had been utilized and signed by each of the detainees. However, the Auditor could not confirm the completion of an orientation program for detainees whose preferred language was not English or Spanish.

Does Not Meet (a)(b)(e): The facility is not in compliance with subsections (a), (b), and (e) of this standard. The PREA Orientation document does not include all required elements of this standard. The document does not include prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting including a staff member other than an immediate point-of-contact line officer, the DHS OIG and the ICE JIC; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to received treatment and counseling. The Auditor could not confirm the document is provided in a format that is accessible to all detainees nor does the facility distribute to the detainee during the orientation process a copy of the DHS-prescribed SAAI pamphlet in a manner they could understand. During the on-site audit the Auditor observed the facility handbook, the ICE National Detainee Handbook, and the PREA orientation video on the housing unit kiosks in English and Spanish only. To become compliant, the facility must develop and implement a PREA Orientation that informs the detainees of each element required in subsection (a) of the standard in a language that they understand. Once implemented, the PREA Orientation shall be made available to all detainees in a language they understand. The facility must make available and distribute during the orientation process the DHS-prescribed SAAI pamphlet available in the most prevalent languages encountered by ICE (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian). In addition, the facility shall provide the Auditor with 10 detainee files, which include detainees who do not speak English or Spanish are getting the facility orientation program, which includes: the Orientation document, facility Inmate/Detainee handbook, the DHS-prescribed SAAI pamphlet; and the orientation video in a manner that they can understand, including the use of Google Translation services.

(d)(f): During the on-site audit, the Auditor observed the DHS-prescribed SAA notice, with the name of the PSA Compliance Manager, posted on only a few of the housing unit bulletin boards. In addition, the Auditor observed the SOS brochure that can assist detainees who have been victims of sexual abuse. The flyer appeared to be a flyer that is intended for child victims. After discussions with the PSA Compliance Manager, the facility obtained the adult version of the flyer. However, prior to the exit brief, the Auditor could not confirm it had been posted on all housing unit bulletin boards. The Auditor observed the ICE National Detainee Handbook, which contains information about reporting a sexual abuse, is available to the detainees on the facility kiosk in the housing units. However, the handbook is only available in English and Spanish.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. During the on-site audit, the Auditor observed the DHS-prescribed SAA notice, with the name of the PSA Compliance Manager, posted on only a few of the housing unit bulletin boards. In addition, the Auditor observed the SOS brochure that can assist detainees who have been victims of sexual abuse. The flyer appeared to be a flyer that is intended for child victims. After discussions with the PSA Compliance Manager, the facility

obtained the adult version of the flyer. However, the Auditor could not confirm prior to the exit interview that the flyer had been posted on all housing unit bulletin boards. To become compliant, the facility shall post the DHS-prescribed SAA notice, with the name of the PSA Compliance Manager; and information regarding SOS on all housing unit bulletin boards and submit documentation the signage has been posted.

§115.34 – Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): ICE Directive 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, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on ICE OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. CCDC Policy #14 states, "In addition to the general training provided to all employees pursuant to §115.31, the facility shall ensure that, to the extent the facility itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement setting." The facility PAQ indicated the facility has two investigators who have received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed two training certificates indicating the investigators completed the PREA: Investigating Sexual Abuse in a Confinement Setting through National Institute of Corrections. The Auditor is familiar with this training and has confirmed all elements are included in the training. The Auditor reviewed the facility general PREA training documentation and confirmed both investigators had received the training pursuant to §115.31. However, during interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each investigator struggled with basic investigative questions, to include but not limited to the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. The Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. During interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each investigator struggled with basic investigative questions, to include but not limited to the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. In addition, the Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training. To become compliant, the facility must retrain the two facility investigators to confirm they are knowledgeable in the information provided in the training. In addition, the facility must submit documentation to confirm the training was received. If applicable the facility must provide copies of all sexual abuse allegation investigation files that occurred during the CAP period to confirm the facility Investigators who complete the investigations have received specialized training to do so.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): The facility does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners; therefore, subsection (a) of the standard is not applicable. Auditor observations during the on-site audit confirmed there are no DHS or Agency medical staff employed at the facility.

(b)(c): CCDC Policy #14, states, "The facility shall ensure that all full and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in a) how to detect and assess signs of sexual abuse and sexual harassment; b) how to preserve physical evidence of sexual abuse; c) how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and d) how and to who, to report allegations of suspicions of sexual abuse and sexual harassment." During an interview with the SDDO, the Auditor confirmed the facility policy has been approved by the Agency. In an interview with the facility RN, it was indicated that medical staff are required to attend training every year through the National Coalition of Correctional Health Care. She reported this training covers the specialized training required for this standard. However, the facility did not submit a copy of the training curriculum or certificates of training completion to determine compliance.

Does Not Meet (b)(c): The facility is not in compliance with subsections (b) and (c) of this standard. The facility did not provide the training curriculum for the specialized training received through the National Coalition of Correctional Health Care to determine if all elements required under this standard are contained in the curriculum. In addition, the facility did not provide documentation that confirmed the required training was received by medical staff. To become compliant, the facility must submit a copy of the National Coalition of Correctional Health Care curriculum to determine all elements required are included in the training.. If it does not, the facility must provide a curriculum that includes all elements of subsection (b). In addition, the facility must provide documentation that all medical staff have received the training.

§115.41 – Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(g): CCDC Policy #14 states, "All Detainees shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other detainees or sexually abusive toward other detainees." CCDC Policy #5 "Classification System" states, "All inmate/detainees shall be classified upon arrival and before being admitted into the general population. All facility staff assigned to classification duties shall be adequately trained in the facility's classification process. Any inmate/detainee who cannot be classified because of missing information at the time of processing shall be kept separated from the general population. Once the needed information is obtained, classification shall be expedited, and the inmate/detainee may be housed in the general population if warranted." CCDC Policy #14 further states, "Staff shall use facts and other objective, credible evidence documented in the inmate/detainee's file, criminal history checks during the classification process, Relevant considerations include current offense(s), past offense(s), escapes(s), institutional disciplinary history, documented violent episodes and incidents, medical information, and a history of victimization while in detention." The PSA Compliance Manager confirmed all detainees are classified by the ICE Field Office prior to arrival at the facility by completing the Risk Classification Assessment (RCA) and are screened upon arrival to CCDC utilizing the Intake Assessment at Booking document. The Auditor reviewed the RCA and confirmed it takes into consideration whether the detainee has a mental, physical, or developmental disability; the age of the detainee; whether the detainee has been previously incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has self-identified as LGBTI or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety. In addition, the Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include if the detainee has mental, physical, or developmental disabilities; if the detainee has been previously incarcerated or detained; or whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. The PSA Compliance Manager further confirmed detainees are given a housing assignment within the first few hours of booking; however, they are housed within the booking holding cells, with one other detainee, for several days before they are moved to the assigned housing unit due to ICE covid protocol. During the on-site audit, the Auditor was unable to observe a detainee being processed, as no detainees arrived at the facility while the Auditor was on-site. However, the Auditor was able to review a video recording of a detainee being process into the facility. During the review of the video, the Auditor was able to confirm another detainee was present to interpret and/or explain the Intake Assessment at Booking form to an incoming detainee thus exposing the detainee's responses to the initial risk assessment to be assessable to other detainees to exploit the information to the detainee's detriment by staff or other detainees. The Auditor reviewed 12 detainee files and confirmed each file contained the completed RCA and the signed Intake Assessment at Booking form completed during the booking process. During interviews with 20 detainees, all detainees reported translation services, and/or, help in completing the Intake Assessment at Booking form was provided by another detainee.

Does Not Meet (g): The facility is not in compliance with subsection (g) of the standard. During the on-site audit, the Auditor was able to review a video recording of a detainee being process into the facility. As the Auditor was viewing the video, the Auditor was able to confirm there was another detainee present to interpret and/or explain the Intake Assessment at Booking form to an incoming detainee, thus exposing the detainee's responses to the initial risk assessment to be assessable to other detainees to exploit the information to the detainee's detriment by staff or other detainees. During interviews with 20 detainees, all detainees reported translation services, and/or help in completing the Intake Assessment at Booking form was provided by another detainee. To become compliant, the facility must implement appropriate controls on the dissemination within the facility of responses to questions asked to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees, including but not limited to utilizing another detainee during the booking process to translate, and/or help the incoming detainee complete the Intake Assessment at Booking form. Once implemented, the facility must train all applicable staff on the new procedure and submit documentation that the training was received. In addition, the facility must provide the Auditor with 15 detainee files consisting of detainees whose preferred language is other than English or Spanish to confirm compliance with subsection (g) of the standard.

(e): CCDC Policy #5 states, "Each inmate/detainee's classification will be reviewed at regular intervals, when required by changes in the inmate/detainee's behavior or circumstances, or upon discovery of additional, relevant information." In an interview with the facility PSA Compliance Manager, it was indicated that detainees are reassessed for risk of victimization and abusiveness between 60 to 90 days from the date of the initial assessment and when warranted. The Auditor reviewed the facility Inmate/Detainee Reclassification form. The form inquires if the detainee had been involved in an incident and if the detainee acts out when asked to do something. The form does not address the detainee's risk of victimization or abusiveness. The Auditor reviewed 12 detainee files and confirmed 3 files contained documentation of the reassessment between 60 to 90 days of the initial assessment; 3 files indicated no reassessment was completed in the required timeframe; and 6 files indicated the reassessment had not been completed but was in the 90-day timeframe. In addition, the Auditor reviewed five sexual abuse allegation investigation files and confirmed none of the files included a reassessment of the detainee victim after an incident of sexual abuse.

Does Not Meet (e): The facility is not in compliance with subsection (e) of this standard. The Auditor reviewed the facility Inmate/Detainee Reclassification form. The form inquires if the detainee had been involved in an incident and if the detainee acts out when asked to do something. The form does not address the detainee's risk of victimization or abusiveness. The Auditor reviewed 12 detainee files, and of the 6 files that required a reassessment be conducted, 3 files did not contain documentation that a reassessment had been conducted during the 90-day timeframe. In addition, the Auditor reviewed five sexual abuse allegation investigation files and confirmed none of the files indicated the facility had conducted a reassessment of the detainee victim after an incident of sexual abuse. To become compliant, the facility must implement a practice that ensures all detainees are reassessed for risk of abusiveness

or victimization between 60 to 90 days of the initial assessment, and if warranted based upon receipt of additional relevant information or following an incident of abuse or victimization. In addition, the facility must provide documentation that all classification staff and facility Investigators are trained on the new procedure. If applicable, the facility must provide the Auditor with 10 detainee files that include reassessments of detainee's risk of victimization and abusiveness between 60 to 90 days of the initial assessment. In addition, the facility must provide the Auditor with all sexual abuse allegation investigation files that occurred during the CAP period to confirm the detainee victim was reassessed for risk of sexual victimization after an incident of sexual abuse.

(f): The Auditor confirmed during interviews with the JA, the PSA Compliance Manager, and the DOs that detainees are not disciplined for refusing to answer or for not disclosing complete information in response to the questions asked on the facility Intake Assessment at Booking form.

Recommendation (f): The Auditor recommends that the facility update CCDC Policy #5 to include the requirement that detainees are not disciplined for refusing to answer or for not disclosing complete information in response to the questions asked on the facility Intake Assessment at Booking form.

§115.42 – Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): CCDC Policy #14 states, "The Facility shall use information from the risk screening required by 115.41 to inform housing, bed, education, and program assignments with the goal of keeping separate those detainees at high risk of being sexually victimized from those at high risk of being sexually abusive." During an interview, the PSA Compliance Manager indicated that each detainee is provided the Intake Assessment at Booking document to assess the detainee and that the form is completed by the detainee during the booking process. The Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include if the detainee has mental, physical or developmental disabilities; if the detainee has been previously incarcerated or detained; or whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; and therefore, the initial risk assessment is not compliant with the requirements of §115.41 (c). The PSA Compliance Manager further indicated all detainees are classified by the ICE Field Office prior to arrival at the facility and that detainees are given a housing assignment within the first few hours of booking; however, the PSA Compliance Manager could not articulate the facility's practice regarding the consideration of the information obtained during the initial risk assessment screening in determining housing, recreation, work and voluntary programming.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. During an interview the PSA Compliance Manager indicated that each detainee is provided the Intake Assessment at Booking document to assess the detainees and that the form is completed by the detainee during the booking process. The Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include if the detainee has mental, physical, or developmental disabilities; if the detainee has been previously incarcerated or detained; or whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; and therefore, the initial risk assessment is not compliant with the requirements of §115.41 (c). The PSA Compliance Manager further indicated all detainees are classified by the ICE Field Office prior to arrival at the facility and that detainees are given a housing assignment within the first few hours of booking; however, the PSA Compliance Manager could not articulate the facility's practice regarding the consideration of the information obtained during the initial risk assessment screening in determining housing, recreation, work and voluntary programming. To become compliant, the facility must establish and implement a procedure to ensure that information gained from the risk assessment is compliant with standard §115.41 subsection (c). In addition, the facility must implement a practice that requires the facility to use the information gained during the initial PREA risk screening to determine detainee housing, recreation, and other activities. The facility shall train all applicable staff on the new procedures and submit documentation to the Auditor to confirm the training was received. The facility must submit 10 detainee files to confirm information gained from the updated initial risk assessment was considered in determining the detainee's housing, recreation and other activities, and voluntary work assignment.

(b): During an interview the PSA Compliance Manager indicated that each detainee is provided the Intake Assessment at Booking document to assess the detainees and that the form is completed by the detainee during the booking process. The Auditor reviewed the Intake Assessment at Booking form and confirmed it does not include whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. In interviews with the PSA Compliance Manager and seven DOs, it was confirmed the question is not asked of any detainee. During an interview with the facility RN, it was confirmed medical staff would be consulted regarding housing decisions for a transgender/intersex detainee. In addition, medical staff would consult with Crosswinds, the mental health provider, in determining the most suitable placement, that would ensure his/her safety needs and the security needs of the facility; however, without learning the detainee's gender self-identification, the facility cannot consider the information when making an assessment for housing decisions or able to consider the effects that a housing placement may have on the health and safety of a transgender/intersex detainee. During the on-site audit, the Auditor could not determine through interviews with staff that housing decisions of a transgender/intersex detainee would not be based solely on the identity documents or physical anatomy of the detainee. The facility has not knowingly housed a transgender/intersex detainee; and therefore, has not conducted a reassessment of a transgender or intersex detainee to review any threats to safety experienced by the detainee.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard. The facility does not inquire whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. Without learning the detainee's gender self-identification, the facility cannot consider the information when making an assessment for housing decisions or

able to consider the effects that a housing placement may have on the health and safety of a transgender/intersex detainee. To become compliant, the facility must develop a practice that includes asking the detainee if he/she self-identifies as gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. In addition, the facility must develop a practice that requires the facility consider the effects that a housing placement may have on the health and safety of a transgender/intersex detainee consistent with the safety and security of on the facility. The facility must also implement a practice that requires the facility reassess all transgender and intersex detainees twice each year to review any threats to safety experienced by the detainee.

(c): Through Auditor observations and interviews with seven DOs, the Auditor confirmed the facility does not have group showers. All showers in the facility are single showers which contain a dressing area; and therefore, a self-identified transgender/intersex detainee would be afforded an opportunity to shower separately from other detainees.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e): CCDC Policy #15 "Special Management Unit" (SMU) states, "An inmate/detainee will be place in "protective custody" status in Administrative Segregation only when there is documentation that it is warranted and that no reasonable alternatives are available." Additionally, it states, "Detailed records will be maintained on the circumstances related to an inmate/detainee's confinement in an SMU, through required permanent SMU logs and individual inmate/detainee records. Administrative Segregation-generally, these inmate/detainees shall receive the same privileges as are available to inmate/detainees in the general population, depending on any safety and security considerations for inmate/detainees, facility staff and security." The Auditor reviewed a memorandum to the file which states, "we have had no one in protective custody in the reporting period." During an interview with the SDDO, the Auditor confirmed that CCDC Policy #15 was developed in consultation with ICE ERO. A review of Policy #15 confirmed it does include written procedures that require: a supervisory staff member to conduct a review within 72 hours of a detainee's placement in administrative segregation; an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter; or that placement in protective custody shall not ordinarily exceed a period of 30 days. In an interview with the JA, it was confirmed detainees vulnerable to sexual abuse or assault would only be placed into administrative segregation after all reasonable efforts had been made to provide other appropriate housing. The JA further indicated detainees would have access to the same privileges (i.e., programs, visitation, counsel and other services available to the general population) as those in general population. In addition, the JA indicated that the facility would notify ICE immediately if a detainee is placed into administrative segregation based on vulnerability to sexual abuse. During the on-site audit the Auditor confirmed through observation there were no detainees housed in administrative segregation based on vulnerability to sexual abuse.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. In a review of CCDC Policy #15 the Auditor confirmed the facility does not have written procedures that requires a supervisory staff member to conduct a review within 72 hours of a detainee's placement in administrative segregation and an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter; or that placement in protective custody shall not ordinarily exceed a period of 30 days. To become compliant, the facility must in consultation with the ERO FOD update CCDC Policy #15 to include the requirements of supervisory staff to conduct a review within 72 hours of a detainee's placement in administrative segregation, an identical review of all vulnerable detainees placed in administrative segregation for their protection after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter, and that placement in protective custody shall not ordinarily exceed a period of 30 days. Once developed the facility must provide the Auditor with a copy of CCDC Policy #15 with documentation that the policy was updated in consultation with the ERO FOD. Once implemented the facility must train all security supervisors on the requirements of updated CCDC Policy #15 and provide the Auditor with documentation that confirms the training was received. If applicable, the facility must submit to the Auditor any detainee files that include a detainee being placed in protective custody due to being vulnerable to sexual abuse.

§115.51 – Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): CCDC Policy #14 states, "The facility shall provide multiple internal ways for detainees to privately report sexual abuse and sexual harassment or violations of those responsible for such incidents. 1) detainees may report sexual abuse and sexual harassment by using the form to report to the administrative staff or externally mailing to family member who can contact the Jail Administrator; 2) detainee can report sexual abuse and sexual harassment directly to detention and/or medical staff; 3) detainees have access to phone and any contact a family member to have them report the allegation to the Jail Administrator." [sic] CCDC Policy #14 further states, "Detainees have access to phone and any contact a family member to have them report the allegation to the Jail Administration." [sic] In review of the facility Inmate/Detainee Handbook, the Auditor confirmed detainees are instructed on the following ways to report an alleged sexual abuse: write a letter reporting sexual misconduct to the ICE AFOD, Deputy FOD, or the FOD; file an inmate/detainee grievance form; or write to the DHS OIG. During the on-site audit, the Auditor observed on housing unit bulletin boards information that advised detainees how to contact the DHS OIG, to confidentially and, if desired, anonymously, report an incident of sexual abuse; the ICE Detainee Reporting and Information Line (DRIL) posters; and signage that advised the detainee how to contact their consulate official and SOS. Utilizing the detainee telephone in the units, the Auditor tested each line. The phone calls made to the DHS OIG were not successful. The Auditor was Instructed the call would be answered in the order it was received

and was informed it would be a fifteen-minute wait; however, the call immediately began to ring and then went silent. The Auditor remained on the line for an additional five minutes before hanging up. A test call made to the ICE DRIL was successful. However, the Auditor inquired if the call was of an actual detainee reporting sexual abuse, what steps would be taken. The person on the line did not know and placed the Auditor on hold for approximately five minutes. Once the person returned on the line, she informed the Auditor she would take the information and report it to headquarters. Interviews with the JA and PSA Compliance Manager indicated that detainees are provided multiple ways to report sexual abuse. However, no documentation was submitted that confirms detainees are notified they may report retaliation for reporting an incident of sexual abuse, staff neglect, or violations of staff responsibilities that may have contributed to an incident. In addition, the PSA Compliance Manager indicated detainees can report an allegation of sexual abuse through SOS. SOS is not part of the facility or the Agency. During an interview with a staff member at SOS, the Auditor confirmed SOS would not take a report of sexual abuse, but their services are to provide detainees who have suffered sexual abuse with advocacy services, crisis intervention, and counseling.

Does Not Meet (a)(b): The facility is not in compliance with subsection (a) and (b) of the standard. CCDC Policy #14 does not include the requirement that detainees may report retaliation for reporting an incident of sexual abuse, any staff neglect, or violations of responsibilities that may have contributed to the incident. The Auditor attempted a test call to DHS OIG and was advised the call would be answered in the order it was received and that it would be a fifteen-minute wait. However, the call immediately began to ring and then went silent. In an interview, the PSA Compliance Manager indicated detainees can report an allegation of sexual abuse through SOS. However, during an interview with a staff member at SOS, the Auditor confirmed SOS would not take a report of sexual abuse and that their services are to provide detainees who have suffered sexual abuse with advocacy services, crisis intervention, and counseling. To become compliant, the facility must develop and implement policy and procedure to ensure that in addition to reporting sexual abuse, detainees have multiple ways to privately report retaliation for reporting sexual abuse, staff neglect, or violations of responsibilities that may have contributed to an incident of sexual abuse. Once implemented, the facility must train all staff and provide the Auditor with documentation that confirms the training was completed. In addition, the facility must provide detainees at least one way to report an allegation to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request, including but not limited to, working telephones that enable a detainee to contact the DHS OIG. Once implemented, the facility must provide the Auditor with documentation that confirms the new procedure was implemented. In addition, the facility must provide documentation that facility telephones are in working order to allow detainees access to the DHS OIG to report an allegation of sexual abuse, retaliation for reporting an incident of sexual abuse, staff neglect, or violations of staff responsibilities that may have contributed to an incident to a public or private entity or office that is not part of the Agency and is able to receive and immediately forward reports of sexual abuse to Agency officials, allowing the detainee to remain anonymous upon request.

(c): The Auditor reviewed CCDC Policy #14 and confirmed it does not include the provision for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. Interviews with facility Dos confirmed they are required to accept all reports of sexual abuse verbally, in writing, anonymously or by a third party, and document all such reports.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of CCDC Policy #14 confirms it does not include the provision for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. To become compliant, the facility shall revise CCDC Policy #14 to include the requirement for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. Once revised all staff shall be trained on updated Policy #14 and the facility must submit documentation to confirm that staff have received the training.

§115.52 – Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): CCDC Policy #14 states, "There is no time limit to submit grievance on an allegation of sexual abuse or assault" and "all allegations we be [sic] investigated immediately." CCDC Policy #14 further states, "Emergency Grievances that involve an immediate threat to an inmate/detainee's health, safety or welfare shall be identified and handled in a time-sensitive manner. Staff shall respond to emergency grievances in and [sic] expeditious manner. Once staff who is approached by the inmate/detainee determines that he or she is in fact raising an issue requiring urgent attention, emergency grievance procedures shall apply. The protocol for emergency grievance procedures shall bring the matter to the immediate attention of a Supervisor or the Administrator, even if it is later to be determined that it is not a true emergency, and the grievance is subsequently routed through normal non-emergency channels." Additionally, "All medical grievances will be received by the medical department within 24 hours or the next business day." CCDC Inmate/Detainee handbook states, "An inmate/detainee may file a grievance only for himself but will be given the opportunity to obtain assistance from another inmate/detainee in filing a grievance" and "any inmate/detainee who does not accept the decision of the Jail Supervisor may appeal to the Jail Administrator within 5 days of receiving the decision of the Jail Supervisor. The Jail Administrator will provide the inmate/detainee with a written decision within five days of receiving the appeal." An interview with the PSA Compliance Manager, who acts as the facility grievance officer, indicated detainees can file a grievance at any time through the housing unit kiosk. The detainee is not required to participate in the informal grievance process and can immediately file a formal grievance and any time limits imposed for filing a grievance are removed if the grievance involves a sexual abuse or assault. The grievance officer further indicated, a detainee can file an appeal to the JA, and it will be answered within five days, and if a medical emergency grievance is received, it will be immediately forwarded to the facility RN for an assessment. In

addition, the grievance officer indicated if a grievance is received that involve an immediate threat to the detainee's health or safety, he/she would be immediately removed from the threat and the threat would be investigated. Although the facility handbook states a detainee may request the assistance of another detainee in filing the grievance, the PSA Compliance Manager confirmed the detainee may also request the assistance of facility staff, a family member or his/her attorney. An interview with the facility RN indicated that all sexual abuse grievances would be treated as a medical emergency and would be brought to her attention and if required she would see the detainee immediately. During the interview with the grievance officer, the Auditor could not confirm that all grievances related to sexual abuse and the facility's decision in respect to such grievance would be sent to the appropriate ICE FOD at the end of the grievance process. The facility PAQ indicated that the facility has not received any grievances regarding an allegation of sexual abuse during the audit period. The Auditor reviewed five allegation of sexual abuse investigation files and confirmed none of the allegations were reported through the grievance system.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. During an interview with the grievance officer, the Auditor could not confirm that the facility would send all grievances related to sexual abuse and the facility's decision with respect to such grievances to the appropriate ICE FOD at the end of the grievance process. To become compliant, the facility shall develop and implement a procedure to ensure that all sexual abuse related grievances shall be forwarded to the ICE FOD at the end of the grievance process. In addition, the facility must train all grievance staff on the new procedure and submit documentation that the training was received. If applicable, the facility must submit copies of all grievances that include an allegation of sexual abuse and the corresponding sexual abuse allegation investigation files that occurred during the audit period.

§115.53 – Detainee access to outside confidential support services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): CCDC Policy #14 states, "The facility shall provide detainees with access to outside victim advocates for emotional support services related to sexual abuse." An interview with the PSA Compliance Manager confirmed that the facility utilizes the services of SOS to provide support in the areas of crisis intervention, counseling, investigation and prosecution of sexual abuse perpetrators to appropriately address the victim's need. During the on-site audit, the Auditor observed the SOS flyer within the housing units; however, the posted flyer was consistent with services that are provided to child victims, not adult victims. The facility immediately, obtained the adult SOS flyer. The Auditor reviewed the updated SOS flyer and confirmed it provided the detainees with an email address, mailing address, and a phone number that can be accessed from the detainee phone. However, the Auditor could not confirm the facility posted the adult version of the flyer prior to the conclusion of the on-site audit. In addition, information was posted in the housing units, in English and Spanish only, on how to access SOS, anonymously or without the call being recorded or monitored. However, a review of all available postings and the Inmate/Detainee handbook confirmed detainees are not advised of the extent to which reports of abuse will be forward to authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor tested the line utilizing the instructions provided and spoke with an SOS advocate. During the interview, the Auditor confirmed the facility has not established an MOU with SOS. However, SOS does provide services for the detainees housed at the facility. The services include crisis intervention, counseling, investigation and prosecution of sexual abuse perpetrators to appropriately address the victim's need. In addition, the advocates, if needed, would provide in-person support to the detainees. Interviews with detainees indicated they were aware of SOS and had seen the child version of the flyer posted on the housing unit bulletin boards.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. The facility does not maintain or has attempted to enter into a memorandum of understanding or any other agreement with SOS to provide legal advocacy and confidential emotional support services for detainee victims of crime. To become compliant, the facility shall attempt to enter into a memorandum of understanding with SOS and provide the Auditor with documentation of the entered MOU or of an attempt to enter one.

§115.54 – Third-party reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

CCDC Policy #14 states, "The facility will investigate all reports of abuse that are submitted by third parties." A review of the ICE web page (http://www.ice.gov) indicates the Agency provides a means for the public to report incidents of sexual abuse/harassment on behalf of a detainee. An interview with the facility PSA Compliance Manager confirmed that reports from a third party can be made directly to the facility or to the CCSO. A review of CCDC's web page (www.chasejail.com/PREA) confirms it does not provide information to the public regarding how to report incidents of sexual abuse on behalf of a detainee.

Does Not Meet: The facility is not in compliance with standard §115.54. A review of CCDC's web page (www.chasejail.com/PREA) confirms it does not provide information to the public about how to report incidents of sexual abuse on behalf of a detainee. To become compliant, the facility must provide documentation to the Auditor that confirms the facility has made available to the public information regarding how to report and incident of sexual abuse on behalf of a detainee.

§115.61 – Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): Agency Policy 11062.2, states, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participation in an investigation about such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." CCDC Policy #14 states, "All staff are required to report any

knowledge, suspicion, or information regarding an incident of sexual abuse and sexual harassment immediately. Staff shall not reveal any information related to a sexual abuse report to anyone other than to extent necessary to make treatment, investigation, and other security and management decisions." A review of CCDC Policy #14 confirms it does not include the requirements staff must report any knowledge, suspicion, or information regarding retaliation against detainees or staff who reported or participated in an investigation about such an incident or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation and does not include a method staff can report an incident of sexual abuse outside the chain of command. CCDC PREA training curriculum states, "All staff are required to report any knowledge, suspicion or information regarding an incident of sexual abuse and sexual harassment immediately." Interviews with seven DOs indicated that staff are aware of the requirement to immediately report an any knowledge or suspicion of sexual abuse. During interviews with seven DOs, each could articulate that they must report any knowledge, suspicion or information regarding an incident of sexual abuse. However, none reported they must report any information regarding retaliation or staff neglect or violations of responsibility that may have contributed to an incident. An interview with the JA indicated that staff could report an incident of sexual abuse to the CCSO; however, the policy has not been officially conveyed to staff. In addition, the JA confirmed he was aware that any reports received from a vulnerable adult would be reported to Adult Protective Services (APS). An interview with the SDDO confirmed that the facility policies have been approved by the Agency.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. A review of CCDC Policy #14 confirms it does not include the requirements of staff to report any knowledge, suspicion, or information regarding retaliation against detainees or staff who reported or participated in an investigation about such an incident or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation; or a method for which staff can report an incident of sexual abuse outside the chain of command. An interview with the JA indicated that staff could report an incident of sexual abuse to the CCSO; however, the policy has not been officially conveyed to staff. To become compliant, the facility must update and revise CCDC Policy #14 to include the requirements staff must report allegations or knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who report or participate in an investigation about such an incident; and any staff neglect or violation of responsibility that may have contributed to an incident of retaliation and staff shall have a method to report an incident of sexual abuse outside the chain of command. Once updated, the facility must refer updated CCDC Policy #14 to the Agency for review and approval and train all staff on the updated requirements.

§115.62 – Protection duties.

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

Notes:

CCDC Policy #14 states, "Upon learning that an inmate is subject to a substantial risk of imminent sexual abuse, facility staff shall take immediate action to protect the detainee." In an interview with the JA and the PSA Compliance Manager, it was indicated that staff are required to take immediate action to ensure the safety of all detainees. Interviews with seven DOs confirmed if they had reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, their first response would be to ensure the safety of the detainee by separating the detainee from the threat. The Auditor reviewed five sexual abuse investigation files and confirmed all detainees who reported the allegation of sexual abuse were immediately separated from the alleged abuser.

§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): CCDC Policy #14 states, "Upon receiving an allegation that a detainee was sexually abused while confined at another facility the Jail Administrator shall; a) Notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. B) Such notification shall be provided as soon as possible, but no later than 72hours after receiving the allegation." A review of CCDC Policy #14 confirms it does not include the requirements the Agency or facility shall document that it has provided such notification or the Agency or facility office that receives such notification shall ensure that the allegation is reported to the appropriate ICE FOD. In an interview with the JA, it was indicated that he would notify the Administrator/Warden of the facility where the alleged sexual abuse occurred by phone and follow-up with an email to document the communications. If the facility was to receive notification from another facility, notification would be made to the ICE Field Office and an investigation would be immediately started. There have been no allegations of sexual abuse that included another facility during the audit period.

§115.64 – Responder duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): CCDC Policy #14 states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report shall; a) separate the alleged victim and abuser; b) preserve and protect any crime scene until appropriate steps can be taken to collect any evidence with proper evidence collections procedures." In addition, CCDC Policy #14 states, "In the event of a report incident of sexual abuse [sic], first responder staff, medical personal, and all command staff shall follow the procedures set forth herein; a) any information received will be forwarded to Jail Administrator; b) the medical staff will ensure all clothing is gathered and placed in a paper evidence bag; c) the evidence will be forwarded to the facility investigator." A review of CCDC Policy #14 confirms it does not include the requirements if the time period allows for collection of physical evidence, request that the alleged victim, and ensure that the alleged abuser, do not take any actions that could destroy physical evidence (e.g., washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, eating); or if the first responder is not a security staff member, the responder shall request the alleged victim to refrain from any actions that could destroy physical evidence and then immediately notify a deputy. The Auditor reviewed CCDC PREA training curriculum states, "Upon learning of an allegation that a detainee was sexually

abused, the first security staff member to respond to the report shall: separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence with proper evidence collections procedures. DO NOT LET THE VICTIM SHOWER, URINATE OR DEFICATE." Interviews with seven DOs confirmed they were knowledgeable regarding the first responder duties that include separating the victim and the abuser, call for backup, preserve the crime scene, and call for medical staff. However, all DOs reported that they would not allow the victim or the alleged abuser take any action that could destroy evidence. During an interview with the facility RN, it was confirmed that she could not articulate her responsibilities as a non-security first responder indicating she is never alone in the facility without the custody staff with her.

Does Not Meet (a)(b): The facility is not in compliance with subsection (a) and (b) of this standard. Interviews with seven DOs, confirmed they could articulate their first responder duties that include separating the victim and the abuser, calling for backup, preserving the crime scene and calling for medical staff; however, the DOs reported that they would not allow the victim, or the alleged abuser take any action that could destroy evidence. To become compliant, the facility must train all custody staff on first responder duties, which include the requirement to request the alleged victim not to take any action that could destroy evidence, such as washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, eating and document such training and submit documentation of said training. In addition, the facility shall train non-custody staff, to request the alleged victim not to take any action that could destroy physical evidence and then notify security staff. Documentation of training shall be provided to the Auditor.

Recommendation (a): The Auditor recommends that the facility update CCDC Policy #14 to include the requirements if the time period allows for collection of physical evidence, request that the alleged victim, and ensure that the alleged abuser, do not take any actions that could destroy physical evidence (e.g., washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, eating), and, if the first responder is not a security staff member, the responder shall request the alleged victim to refrain from any actions that could destroy physical evidence and then immediately notify a deputy.

§115.65 – Coordinated response.

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

Notes:

(a)(b)(c)(d): During an interview with the JA, it was confirmed that the CCDC Policy #14 serves as the facility's plan for coordinating actions taken by staff first responders, medical and mental health practitioners, investigators, and the facility leadership. CCDC Policy #14 states, "The facility is responsible for investigating allegations of sexual abuse and shall follow a uniform evidence protocol. 1) All clothing and bedding will be collected. These items will be placed in a paper evidence bag and labeled according to procedure. 2) All evidence will be turned over to the investigator; 3) Victim will be scheduled for an examination and/or treatment as necessary." In addition, CCDC Policy #14 further states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to responds to the report shall; a) separate the alleged victim and abuser; b) preserve and protect any crime scene until appropriate steps can be taken to collect any evidence with proper evidence collection procedures. In the event of a report incident of sexual abuse, first responder staff, medical personal and all command staff shall follow the procedures set forth herein. A) Any information received will be forwarded to Jail Administrator. B) The medical staff will ensure all clothing is gathered and placed in a paper evidence bag; c) evidence will be forwarded to the facility investigator." A review of CCDC Policy #14 confirms it does not include the required verbiage, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" or "if a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." In an interview with the facility RN, if was indicated that she would inform the receiving facility of the incident and the victim's potential need for medical or mental health services and would send a packet of information with the detainee to be delivered to medical personnel at the receiving facility regardless of the detainee victim requesting otherwise. There were no allegations of sexual abuse reported at CCDC that included the detainee victim being transferred.

Does Not Meet (c)(d): The facility is not in compliance with subsection (c) and (d) of the standard. The protocol does not address the provision (c) which states, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of this part, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services." And provision (d) "If a victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." During an interview with the facility RN, it was indicated that she would inform the receiving facility of the incident and the victim's potential need for medical or mental health services and would send a packet of information with the detainee to be delivered to medical personnel at the receiving facility regardless of the detainee victim requesting otherwise. To become compliant, the facility must update the facility coordinated response plan to include subsections (c) and (d) of the standard. In addition, the facility must document that all applicable staff, including medical staff, have received training regarding the content of the updated coordinated response plan. The facility must provide the Auditor with any investigation, medical, and detainee files regarding any detainee victim of sexual abuse transferred during the CAP period.

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

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

Notes:

CCDC Policy #14 states, "The Facility will not enter into any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any detainees pending the outcome of an investigation with a determination as to whether and to what extent discipline is warranted." Although CCDC Policy #14 does not clearly state all staff, contractors, and volunteers suspected of perpetrating sexual abuse, interviews with the JA, PSA Compliance Manager, and 7 DOs confirmed that if an allegation was received alleging a staff member of perpetrating sexual abuse, the staff member would be placed on administrative leave until the conclusion of an investigation. The facility does not have contractors or volunteers employed at the facility. The Auditor reviewed one sexual abuse allegation investigation file that included a staff-on-detainee and confirmed the staff member was removed from detainee contact.

Recommendation: The Auditor recommends that the facility update CCDC Policy #14 to include the verbiage that staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): CCDC Policy #14 states, "The facility shall take necessary measures to protect all detainees and staff that report sexual abuse or sexual harassment or cooperated with sexual abuse or sexual harassment investigations from retaliation by other detainees or staff." A review of CCDC Policy #14 confirms it does not include the requirements that detainees shall be protected against retaliation or participating in sexual active as a result of force, coercions, threats or fear of force; and that the facility shall provide protective measures, including: housing changes, transfers, removal of alleged abusers from contact with victims, administrative reassignment or reassignment of the victim or alleged perpetrator to another housing area, and support services for inmates or staff who fear retaliation. In an interview with the PSA Compliance Manager, it was indicated the facility has not been conducting retaliation monitoring. The Auditor reviewed five sexual abuse allegation investigation files and further confirmed retaliation monitoring is not being conducted at CCDC.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. During an interview with the PSA Compliance Manager, it was confirmed the facility has not been conducting retaliation monitoring. In addition, the Auditor reviewed five sexual abuse allegation investigation files and further confirmed retaliation monitoring is not being conducted at CCDC. To become compliant, the facility must develop and implement a procedure to monitor staff and/or the detainee victim of sexual abuse beginning at the time of the allegation through at least 90 days to see if there are facts that may suggest possible retaliation by detainees or staff regardless of the final determination. In addition, the facility must consider detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff as required by subsection (c) of the standard and provide 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 facility must train all applicable staff involved in the monitoring of detainee victims of sexual abuse in the new practice and document such training. The facility must also provide the Auditor with copies of any sexual abuse allegation investigation files and corresponding monitoring documentation that occurred during the CAP period.

§115.68 – Post-allegation protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): CCDC Policy #15 states, "An inmate/detainee will be placed in "protective custody" status in Administrative Segregation only when there is documentation that is warranted and that no reasonable alternatives are available." CCDC Policy #14 states, "Detainees at high risk for sexual victimization shall not automatically be place in involuntary segregated housing unless an assessment of all available alternatives had been made. Detainees at high risk for sexual victimization may be placed in involuntary segregated housing if an assessment of all available alternatives indicates there is no available alternatives means of separation from likely abusers." In a review of CCDC Policies #14 and #15, the Auditor could not confirm if: the facility would place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing options possible; victims would not be held longer than 5 days in any type of administrative segregation; or the facility would conduct a proper reassessment prior to being returned to the general population taking into consideration any increased vulnerability of the detainee as a result of sexual abuse. In an interview with the JA, it was indicated detainee victims of sexual abuse or assault would not be generally placed into administrative segregation; however, if the need did arise, the detainee victim would not be held in segregation for more than 72 hours. The JA further indicated the facility would notify ICE FOD immediately if a detainee victim is placed into administrative segregation or protective custody due to an alleged sexual abuse. However, the interview with the JA could not confirm the facility would conduct a proper re-assessment of a detainee victim of sexual abuse taking into consideration any increased vulnerabilities of the detainee as a result of the sexual abuse prior to returning the detainee to general population. The Auditor reviewed five allegation of sexual abuse investigation files and confirmed none of the alleged victims had been placed into administrative segregation or protective custody due to being the victim of sexual abuse. Through observation, the Auditor confirmed there were no detainees housed in administrative segregation or protective custody due being a victim of sexual abuse.

Does Not Meet (c): In an interview with the JA, it could not be confirmed that a reassessment taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse prior to returning the detainee back to general population would be conducted. To become compliant, the facility must implement a practice that requires detainee victims, who are in protective

custody after having been subjected to sexual abuse, not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. Once implemented, the facility must document that the practice has been implemented and that all applicable staff have been trained on the new practice. If applicable, the facility must submit to the Auditor any detainee files in which the detainee was placed into administrative segregation due to an allegation of sexual abuse.

Recommendation (a)(b): The Auditor recommends that the facility update CCDC Policy #15, to include the facility would place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing options possible, victims would not be held longer than 5 days in any type of administrative segregation/protective custody, and facilities shall notify the appropriate FOD whenever a detainee victim has been held in administrative segregation for 72 hours.

§115.71 – Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): CCDC Policy #14 states, "When the facility conducts its own investigations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third party and anonymous reports." CCDC Policy #14 further states, "The facility shall develop written procedures for administrative investigations, including provisions requiring a) Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; b) Interviewing alleged victims, suspected perpetrators, and witnesses; c) Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; d) Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; e) An effort to determine whether actions or failures to act at the facility contributed to the abuse; f). Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and g) Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation." A review of Policy #14 confirms the facility shall develop written procedures to include all provisions of subsection (c) of the standard; however, the facility has not submitted to the Auditor the facility's developed written procedures. In an interview, the PSA Compliance Manager indicated the CCSO would conduct criminal investigations and the facility would conduct an administrative investigation. In an interview with the facility Investigator, it was indicated that the facility utilizes two trained investigators to conduct sexual abuse allegation investigations. The Auditor reviewed the facility general PREA training documentation and confirmed both investigators had received the training pursuant to §115.31. However, interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each investigator struggled with basic investigative questions, to include the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. The Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training. During the on-site audit, the Auditor reviewed five sexual abuse allegation investigation files and confirmed in each file, the investigative report lacked a description of physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. In addition, the Auditor was unable to confirm all perpetrators or witnesses had been interviewed in all the cases. In review of two of the sexual abuse allegation investigation files confirmed the facts of the allegation would be consistent with the elements of criminal sexual contact; however, the allegations were not reported to law enforcement. There were no indications that facts or an assessment of credibility of either the victim or the perpetrator had been considered to support an unfounded conclusion. In addition, in review of all five sexual abuse allegation investigation files, the Auditor could not determine that a review of prior complaints and reports of sexual abuse and assault involving the suspected perpetrator was conducted. Discussions with a facility Investigator, indicated that video evidence was present in two of the investigations; however, there was no discussion in the reports or information to determine what facts may have been gathered from videos. In addition, the facility Investigator indicated allegations of sexual abuse would only be reported to law enforcement if there was evidence that supported a substantiated allegation, which indicates the administrative investigation is completed prior to a criminal investigation. In an interview with the facility Investigator, it was confirmed that she could not articulate if during the investigative process the facility made an effort to determine whether actions or failures to act at the facility contributed to the abuse, or if reports of sexual abuse are retained for as long as the alleged abuser is detained or employed by the agency or facility, plus five years.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b) and (c) of this standard. The facility has not established the required written procedures for conducting administrative investigations. The Auditor reviewed five investigations. In each file, the investigative report was severely lacking information. Interviews with the facility PSA Compliance Manager/Investigator and the Training Director/Investigator, confirmed each Investigator struggled with basic investigative questions, to include the meaning of unsubstantiated and unfounded PREA findings, definition of the preponderance of evidence, and the definitions of PREA sexual misconduct that would require a criminal investigation. The Auditor reviewed the PREA allegation spreadsheet and confirmed two of the five investigations reported on the spreadsheet were concluded prior to the assigned investigator receiving the required training. To become compliant, the facility must develop a protocol that includes all elements of subsections (a), (b), (e), and (f) of the standard. In addition, the facility must document that all applicable staff have received training regarding the written procedures content. In addition, the facility must provide the Auditor with copies of all sexual abuse allegation investigation files that occur during the CAP period.

(e)(f): CCDC Policy #14 states, "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. When outside agencies investigate sexual abuse and assault, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." In interviews with two Investigators, it was indicated that an investigation would continue regardless of if the alleged abuser or victim is released from the employment or control of the facility. In addition, the Auditor confirmed they would cooperate with outside Investigators and would attempt to remain informed on the progress of the investigation. The Auditor reviewed five sexual abuse allegation investigation files and confirmed in the two files where the detainee victim or abuser left the facility, the investigation continued until an outcome could be determined.

§115.72 – Evidentiary standard for administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse." CCDC Policy #14 states, "The facility shall impose no standard than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated [sic]." In interviews with two facility Investigators, it was indicated they were unable to articulate the standard of proof that the facility utilizes to determine whether a sexual abuse allegation is substantiated.

Does Not Meet: The facility is not in compliance with this standard. Interviews with both facility Investigators indicated that they were unable to articulate the standard of proof that the facility utilizes to determine whether a sexual abuse allegation is substantiated. To become compliant, the facility shall train all investigators on the standard of proof for administrative investigations. In addition, the facility must submit copies of all sexual abuse allegation investigation files that occurred during the CAP period.

§115.73 – Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

CCDC Policy #14 states, "All detainees will receive a write notification of the outcome of the case [sic]." In an interview with the facility PSA Compliance Manager, it was indicated a detainee would receive a written notification of the outcome of an investigation. The Auditor reviewed five investigative files. In all five cases there was no evidence that the Agency or the facility provided the detainee with notification of the outcome or any responsive actions that had been taken. There were no detainees who reported a sexual abuse housed at the facility during the on-site audit, therefore no interview was conducted.

Does Not Meet: The facility is not in compliance standard §115.73. During the on-site audit, the Auditor reviewed five sexual abuse allegation investigation files and confirmed the detainee did not receive notification of the outcome or any responsive actions that had been taken. To become compliant, the Agency and the facility must develop and implement a procedure to ensure that detainees who report an allegation of sexual abuse are notified of the outcome of investigation or any responsive action the facility has taken and submit documentation that all applicable staff have received training on the new procedure. In addition, the facility must submit copies of all sexual abuse allegation investigation files and the corresponding detainee notification that occurred during the CAP period.

§115.76 – Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d): CCDC Policy #14 states, "Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies to the disciplinary provisions set forth in the county's personnel policies and procedures." A review of CCDC Policy #14 confirms it does not contain the verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" or "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." However, as termination is greater than removal from Federal Service, the Auditor finds CCDC Policy #14 in substantial compliance with the wording required by subsection (b) of the standard. An interview with the SDDO, confirmed the facility has submitted CCDC Policy #14 to the Agency and it has been approved. In interviews with the JA and seven DOs it was indicated the presumptive disciplinary action for staff who have engaged, attempted to engage, or threatened to engage in sexual abuse is termination. The Auditor reviewed one sexual abuse allegation investigation file that included staff-on-detainee and confirmed the allegation was determined to be unfounded.

§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): CCDC Policy #14 states, "Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with detainees and shall be reported to all appropriate authorities." The Auditor reviewed a memorandum to the file which states, "There has been no report of a contractor or volunteer with a PREA allegation reporting period [sic]." Interviews with the JA, PSA Compliance Manager, and review of the facility PAQ indicated the facility does not utilize the services of any contractors or volunteers at the facility.

§115.78 – Disciplinary sanctions for detainees.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c)(d)(e)(f): CCDC Policy #14 states, "Detainees shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the detainee engaged in detainee-on-detainee sexual abuse or following criminal finding of guilt for detainee-on-detainee sexual abuse. Such discipline shall be administered according to the guidelines set forth." In addition, CCDC Policy #14 states, "Reports 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 the allegation is not substantiated." CCDC Policy #19 "Disciplinary System" states, "Any sanctions imposed will be commensurate with the severity of the committed prohibited act and intended to encourage the inmate/detainee to conform to rules and regulations" and "inmate/detainees will be able to appeal disciplinary decisions through a formal grievance system." CCDC Policy #19 further states, "No inmate/detainee will be harassed, disciplined, punished, or otherwise retaliated against for filing a complaint or grievance" and "disciplinary system cannot be used to discipline a detainee for sexual contact with a staff unless there is a finding that the staff member did not consent." A review of CCDC Policy #19 could not confirm that the disciplinary process considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. Interviews with the JA and PSA Compliance Manager indicated a detainee would not be disciplined for sexual contact with a staff member if the staff willingly participated in the contact, and a detainee would not be disciplined for reports made in good faith. In addition, interviews with the JA and PSA Compliance Manager indicated detainees are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse and that sanctions imposed would be commensurate with the severity of the conducted behavior. In an interview with the JA, the Auditor could not confirm the disciplinary process considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. The Auditor reviewed five sexual abuse allegation investigation files and confirmed none of the cases were substantiated.

Does Not Meet (d): The facility is not in compliance with subsection (d) of the standard. The Auditor interviewed the JA and could not confirm that the disciplinary process considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. To become compliant, the facility shall implement a practice that considers whether a detainee's mental disabilities or mental illness contributed to his/her behavior, when determining the sanction to be imposed. In addition, the facility must document that all applicable staff have been trained on the new practice. If applicable, the facility must submit to the Auditor copies of any detainee files that includes a detainee with a mental disability or mental illness who was sanctioned due to a substantiated act of sexual abuse.

§115.81 – Medical and mental health assessments; history of sexual abuse.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c): CCDC Policy #14 states, "If the screening process indicates that a detainee has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall contact the facility medical or mental health practitioner within 14 days of the detainee screening." Informal interviews with intake DOs indicated that if a detainee has previously experienced or perpetrated sexual abuse, a referral will be immediately made to the medical staff. An interview with the facility RN indicated the detainee would receive a health evaluation immediately and that she would refer the detainee to Crosswinds for a mental health follow-up. The Auditor reviewed 12 detainee files, of which 2 of the files indicated that the detainee had disclosed previous sexual abuse. In both cases, the detainees were referred to Crosswinds on the same day the assessment was conducted; however, both detainees had been seen via Zoom by Crosswinds within 10 days of the referral and not within 72 hours as required by subsection (c) of the standard.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed 12 detainee files, of which 2 of the files indicated that the detainee had disclosed previous sexual abuse. In both cases, the detainee was referred to Crosswinds the same day the assessment was conducted; however, both detainees had been seen via Zoom by Crosswinds within 10 days of the referral and not within 72 hours as required by the standard. To become compliant, the facility must develop and implement a practice that requires all detainees referred to mental health be seen within 72 hours as required by subsection (c) of the standard. If applicable, the facility must submit to the Auditor any intake, medical and mental health records of any detainee, who pursuant to §115.41 indicates they have experienced prior sexual victimization or perpetrated sexual abuse during the CAP period.

Recommendation (a)(b): The Auditor recommends that CCDC Policy #14 be updated to state, "staff shall contact the facility medical or mental health immediately if the assessment pursuant to §115.41 indicates the detainee has experienced prior victimization or perpetrated sexual abuse" and "when a referral to medical is made the detainee shall receive a health evaluation no later than two working days from the date of assessment."

§115.82 – Access to emergency medical and mental health services.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b): CCDC Policy #14 states, "Detainee victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. Such services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperated with any investigation arising out of the incident." During an interview with the

facility RN, it was indicated detainee victims of sexual abuse are given timely, unimpeded access to emergency medical treatment at no cost and in accordance with professionally accepted standards of care. The facility RN further indicated facility medical staff would provide the detainee with emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standard of care; however, facility medical staff are not qualified to perform a forensic medical examination. Should the detainee victim require a forensic exam, he/she would be transported to Newman Regional Health where the exam would be performed by a SANE. The Auditor reviewed an MOU between the facility and Newman Regional Health and confirmed emergency medical treatment would be provided free of charge for an alleged victim of sexual abuse. In addition, an interview with SOS staff indicated detainee victims would be provided crisis intervention services in accordance with professionally accepted standards of care. The Auditor reviewed five sexual abuse allegation investigation files and confirmed each alleged victim had immediately been evaluated by medical staff; however, four files indicated that mental health was offered, and the detainee refused, and one was immediately determined unfounded based on video evidence; and therefore, the detainee had not been referred to mental health. A review of the PREA allegation spreadsheet confirms that none of the sexual abuse allegation investigation files were closed immediately after the allegation was reported.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. In a review of five sexual abuse investigation files, it was confirmed that one detainee victim was not referred to mental health as required by the standard as the facility immediately determined the allegation to be unfounded. A review of the PREA allegation spreadsheet confirms that none of the sexual abuse allegation investigation files were closed immediately after the allegation was reported; and therefore, the detainee victim should have been offered crisis intervention services at the time the allegation was reported. To become compliant, the facility must implement procedure that ensures that all detainee victims of sexual abuse are offered crisis intervention services at the time the allegation is reported. Once implemented, the facility must train all applicable staff on the new procedure. In addition, the facility must submit to the Auditor a copy of all sexual abuse allegation investigation files and the corresponding mental health records that occurred during the CAP period.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d)(e)(f): CCDC Policy #14 states, "The facility shall offer medical and mental health evaluations and, as appropriate, treatment to all detainees who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility." In an interview with the facility RN, it was indicated detainees would receive timely emergency access to medical and mental health treatment that would include follow-up services and treatment plans and that care provided within the facility would be free of charge and consistent with level of care received in the community. Crosswinds would conduct a mental health evaluation and would provide the detainee a treatment plan. Female victims would be offered pregnancy tests and, if positive, would receive timely and comprehensive information about lawful pregnancy related medical services. All detainees would be offered tests for sexually transmitted infections, free of charge. In addition, the facility RN indicated, if needed, the medical staff would provide referrals for continued care prior to the detainee being released from custody or if the detainee was being transferred to another facility. The Auditor reviewed five sexual abuse allegation investigation files and confirmed each alleged victim had immediately been evaluated by medical staff; however, four files indicated that mental health was offered, and the detainee refused, and one was immediately determined unfounded based on video evidence; and therefore, the detainee had not been referred to mental health. A review of the PREA allegation spreadsheet confirms that no sexual abuse allegation investigation file was closed immediately after the allegation was reported.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. In a review of five sexual abuse investigation files, it was confirmed that one detainee victim was not referred to mental health as required by the standard as the facility immediately determined the allegation to be unfounded. A review of the PREA allegation spreadsheet confirms that no sexual abuse allegation investigation file was closed immediately after the allegation was reported; and therefore, the detainee victim should have been offered crisis intervention services at the time the allegation was reported. To become compliant, the facility must implement procedure that ensures that all detainee victims of sexual abuse are offered crisis intervention services at the time the allegation is reported. Once implemented, the facility must train all applicable staff on the new procedure. In addition, the facility must submit to the Auditor a copy of all sexual abuse allegation investigation files and the corresponding mental health records that occurred during the CAP period.

(g): The facility does not employ mental health staff at the facility. All detainees are seen by the community-based organization, Crosswinds via Zoom. The facility RN stated the facility would refer a known detainee abuser to Crosswinds for an evaluation and would offer treatment, if appropriate. At the time of on-site audit, there were no detainees housed at the facility determined to be at risk for abusiveness. In addition, the Auditor reviewed five investigations and all were determined to be unfounded.

Recommendation (g): The Auditor recommends that the facility updated CCDC Policy #14 to include the requirement that the facility attempt to conduct a mental health evaluation of all known detain-on-detainee abusers within 60 days of learning such abuse.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): CCDC Policy #14 states, "The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegations have not been substantiated, unless the allegation has been determined to be

unfounded." The Auditor reviewed five investigation files and confirmed the sexual abuse incident review had been completed in one file. During discussions with the PSA Compliance Manager, the Auditor confirmed the facility had not been completing an incident review at the completion of an investigation; however, the facility recently implemented a procedure to comply with the standard. In review of the incident review report confirmed that not all elements required in subsection (b) of the standard are considered in the incident review. Additionally, the Auditor was not provided documentation to confirm the facility has conducted an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts.

Does Not Meet (a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of this standard. The Auditor reviewed five investigation files and confirmed the sexual abuse incident review had been completed in one file. During discussions with the PSA Compliance Manager, the Auditor confirmed the facility had not been completing an incident review at the completion of an investigation; however, the facility recently implemented a procedure to comply with the standard. In review of the incident review report confirmed that not all elements required in subsection (b) of the standard are considered in the incident review. Additionally, the Auditor was not provided documentation to confirm the facility has conducted an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. To become compliant, the facility must develop and implement a procedure to ensure that a sexual abuse incident review is completed at the conclusion of each investigation by a review team. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, unless the allegation of sexual abuse is determined to be unfounded, the review team shall prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation(s) or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The review team shall implement the recommendations for improvement or shall document its reason for not doing so. The procedure shall include all reports and responses are forwarded to the Agency PREA Coordinator. Once the procedure has been developed the facility shall train all members of the review team on the newly developed procedure. In addition, the facility must provide copies of all sexual abuse allegation investigation files and the corresponding incident reviews with routing that occurred during the CAP period. In addition, the facility shall provide the Auditor with documentation confirming the facility has conducted an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts for the year 2022 and document that the annual review was forwarded to the JA, ERO FOD, and the Agency PSA 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: CCDC Policy #14 states, "Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." An interview with the facility PSA Compliance Manager, and through direct observations made by the Auditor, it was confirmed all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release are maintained and secured within the PSA Compliance Managers office, at least five years after the alleged abuser detainment or employment with the facility.

§115.201 - Scope of audits.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(d)(e)(i)(j): During all stages of the audit, including the on-site audit, the Auditor was able to review available policies, memos, and other documentation required to make an assessment on PREA compliance. Interviews with detainees were conducted on-site, in private, and remained confidential. The Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. No detainee, outside entity, or staff correspondence was received prior to the on-site audit.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	0
Number of standards met:	10
Number of standards not met:	30
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Robin Bruck 3/27/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 3/11/2023

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 3/28/2023

Assistant Program Manager's Signature & Date