Office of Professional Responsibility

CAP Final Determination Report and PREA Compliance Audit Report

Cibola County Correctional Center

October 22 - 24, 2024

U.S. Immigration and Customs Enforcement

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

Homeland Security

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FIELD OFFICE INFORMATION			
Name of Field Office:	El Paso		
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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Cibola County Correctional Center		
Physical address:	2000 Cibola Loop Milan, New Mexico 87021		
Telephone number:	505-285-4900		
Facility type:	Intergovernmental Service Agreement		
PREA Incorporation Date:	10/27/2016		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer In Charge (OIC)
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	505-285-(b) (6), (b)
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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 that Cibola County Correctional Center met 21 standards, had 0 standards which exceeded, had 1 standard which was non-applicable, and had 19 non-compliant standards. As a result of the facility being out of compliance with 19 standards, the facility entered a 180-day corrective action period which began on December 16, 2024, and ended on June 14, 2025. 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 Initially Not Met: 19

- §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.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.31 - Staff training.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.43 - Protective custody.
- §115.53 - Detainee access to outside confidential support services.
- §115.62 - Protection duties.
- §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.
- §115.81 - 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.

Number of Standards Exceeded: 0

Number of Standards Met: 19

- §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.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.31 - Staff training.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
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- §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.

Number of Standards Not Met: 0

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; compiles in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "The CoreCivic Facility Support Center (FSC) will develop, in coordination with the facility, comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and shall review those guidelines at least annually. Each facility will ensure sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating staffing levels and determining the need for video monitoring, the following factors shall be taken into consideration: Generally accepted detention and correctional practices; Any judicial findings of inadequacy; All components of the facility's physical plant; The composition of the detainee population; The prevalence of Substantiated and Unsubstantiated incidents of sexual abuse; 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. Whenever necessary, but no less frequently than once each year, for each CoreCivic facility, an annual PREA Staffing Plan Assessment will be completed." A review of CCCC's PAQ indicated the facility employs 135 security staff, (67 males and 68 females), 37 medical staff and 2 mental health staff, who have recurring contact with detainees. In addition, to security staff, the remaining staff consists of administration, maintenance, and religious services. Transportation services are provided through TransCor, there are several medical staff, contracted through Agency, who come into the facility on an as needed basis, and there are seven ICE staff (six DOs and one SDDO) assigned to the facility. Security line staff and supervisors work in two shifts (b) (7)(E) . Food services are provided by Trinity Food Service; however, detainees do not have contact with food service staff. The facility has not utilized the services of volunteers during the audit period. (b) (7)(E) . (b) (7)(E) An interview with the facility Warden indicated the facility currently has adequate staffing to protect the detainees from sexual abuse. An interview with the PSA Compliance Manager indicated the staffing plan is reviewed annually utilizing an "Annual PREA Staffing Plan Assessment." The Auditor reviewed the 2022, 2023, and 2024 Annual PREA Staffing Plan Assessments and confirmed when determining adequate staffing levels and the need for video monitoring the facility takes into consideration all elements required by subsection (c) of the standard, which includes generally accepted detention and correctional practices; judicial findings of inadequacy; the physical layout of the 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; and other relevant factors, including but not limited to the length of time detainees spend in agency custody. During the on-site audit, the Auditor reviewed the facility comprehensive supervision guidelines and confirmed they are reviewed annually. In addition, during the on-site audit, the Auditor observed adequate staffing levels in all areas frequented by detainees within the facility.

(d): CoreCivic policy 14.2-DHS states, "Staff, including supervisors, shall conduct frequent unannounced security inspections rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds shall be documented in the applicable log (e.g., Administrative Duty Officer, post log, shift report, etc.) as "PREA

Rounds". This practice shall be implemented on all shifts (to include night, as well as day) and in all areas where detainees are permitted. Employees shall be prohibited from alerting other employees that supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the facility." An interview with the facility PSA Compliance Manager indicated all facility supervisors on all shifts are required to complete unannounced security inspections in all areas of the facility. An interview with a night Shift Commander indicated unannounced PREA security inspections are conducted on every shift and in all areas of the facility. An interview with a night Shift Commander further indicated he documents his unannounced security inspections in red ink in the housing unit logbook; however, he does not go into all areas of the housing unit, or the different pods, going into only one pod a night and completing the round the following night in another pod; and therefore, unannounced security inspections throughout the facility are not completed in all pods of the housing unit until the end of the week during the night shift. An interview with a day Shift Commander indicated she conducts unannounced security inspections every day in all areas of the facility. In interviews with both the night Shift Commander and the day Shift Commander it was confirmed neither Shift Commander could articulate unannounced security inspections were occurring to identify and deter sexual abuse of detainees. During the on-site audit, the Auditor reviewed facility logbooks and confirmed unannounced PREA inspections were noted in red ink and appeared to be conducted on random days and shifts; however, the Auditor could not confirm unannounced security inspections were being conducted every day and every shift.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. An interview with a night Shift Commander confirmed unannounced security inspections rounds are documented in housing unit logbooks in red ink; however, he completes only a weekly round of the entire facility; and therefore, the Auditor confirmed unannounced security inspections on the night shift were not being conducted in accordance with subsection (d) of the standard. In interviews with both a night Shift Commander and a day Shift Commander it was confirmed neither Shift Commander could articulate unannounced security inspections were occurring to identify and deter sexual abuse of detainees. During the on-site audit, the Auditor reviewed facility logbooks and confirmed unannounced security inspections were noted in red ink and appeared to be conducted on random days and shifts; however, the Auditor could not confirm unannounced security inspections were being conducted every day and every shift. To become compliant, the facility must train all security supervisors on the requirement to conduct unannounced security inspections every day, at irregular times, and on every shift in all areas where detainees are permitted to identify and deter sexual abuse from occurring in the facility. In addition, the facility must submit five days of housing unit logs from each shift which occur during the corrective action plan (CAP) period.

Corrective Action Taken:

(d): The facility submitted staff training sign-in sheets. The Auditor reviewed the submitted sign-in sheets and confirmed applicable staff have received training on the standard's requirement to conduct unannounced security inspections at irregular times on both day and night shifts. The facility submitted print outs of the Shift Supervisor Shift Report (Electronic Log) to match a previously submitted Weekly Department Supervisor Walk Through Log. The Auditor reviewed the Weekly Department Supervisor Walk Through Log and the previously submitted Shift Supervisor Shift Report for the week of February 23, 2025, through February 27, 2025, and confirmed, except for two days on the early shift and two days on the late shift, unannounced security inspections were conducted daily at irregular times and on each shift. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

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

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

Notes:

(b)(c)(d): CoreCivic policy 14-2-DHS states, "Whenever operationally feasible, staff conducting a search must be of the same gender, gender identity, or declared gender as the detainee being searched. Pat searches of male

detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required, or, in exigent circumstances. Pat searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All cross-gender pat searches of detainees will be documented in a logbook including details of exigent circumstances." The Auditor reviewed the CoreCivic Search Procedure Facilitator Guide and confirmed the guide includes, "Cross-gender pat-down searches of male inmates/residents/detainees are permissible under PREA standards;" however, subsection (b) of the standard requires pat-down searches of male detainees by female staff not be conducted unless, after reasonable diligence, staff of the same gender are not available at the time the pat-down search is required, or, in exigent circumstances. An interview with the PSA Compliance Manager, and memo to Auditor, indicated staff at CCCC have not conducted a cross-gender pat-down search during the audit period; however, if there were exigent circumstances requiring a cross-gender pat-down search it would be documented. The Auditor interviewed four random COs (two male and two female) and confirmed two of the COs indicated cross-gender pat-searches of detainees are prohibited; however, one male CO confirmed he had witnessed a female officer conduct a pat-search on a male detainee at CCCC. An interview with a female CO confirmed she had conducted a pat-down search of a male detainee; however, there were male COs present, and she was only "helping out." An interview with a female CO further confirmed she did not document the cross-gender pat-down search. During the on-site audit, the Auditor reviewed the facility cross-gender pat-down search log and confirmed no entries had been made. The Auditor interviewed 20 detainees and confirmed a pat-down search of their person was conducted when they arrived at the facility and is conducted every time they leave the housing unit for recreation. In interviews with 20 detainees, it was further confirmed pat-down searches of 18 of the detainees were completed by a male officer; however, 2 detainees confirmed although most searches were conducted by staff of the same gender, at one point, they were searched by staff of the opposite gender. During the on-site audit, the Auditor reviewed a video of a pat-down search of a detainee during the booking process and confirmed the pat-down search was conducted by staff of the same gender. In addition, the Auditor confirmed there were no female or transgender/intersex detainees housed at the facility during the on-site audit.

(e)(f): CoreCivic policy 14-2-DHS states, “Strip searches of detainees by staff of the opposite gender shall not be conducted except in exigent circumstances, or when performed by medical practitioners. Staff shall not conduct strip searches of juveniles. All such body cavity searches of juveniles shall be referred to a medical practitioner. An officer of the same gender as the detainee shall perform strip searches. In the case of an emergency, a staff member of the same gender as the detainee shall be present to observe a strip search performed by an officer of the opposite gender. When an officer of the opposite gender conducts a strip search which is observed by a staff member of the same gender as the detainee, staff shall document the reasons for the opposite gender search in any logs used to record searches and in the detainee's detention file. Body cavity searches will only be conducted by a medical professional and take place in an area that affords privacy from other detainees and from facility staff who are not involved in the search. Staff of the opposite gender, other than a designated qualified medical professional, shall not observe a body cavity search. All strip searches and visual body cavity searches shall be documented. If a strip search of any detainee does occur, the search shall be documented on the 5-1B Notice to Administration (NTA) (refer to CoreCivic Policy 5-1 Incident Reporting).” Interviews with the PSA Compliance Manager and four random COs indicated the facility does not conduct strip searches, cross-gender strip searches, visual body cavity searches, or cross-gender visual body cavity searches on the detainees; however, if these types of searches were to occur, they would be documented, to include the reason the search was needed. Interviews with 20 detainees confirmed they have not been subjected to a strip search, cross-gender strip search, visual body cavity search, or cross-gender visual body cavity search while housed at the facility. The facility does not house juvenile detainees.

(g): CoreCivic policy 14-2-DHS states, “Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement.” CoreCivic policy 14-2-DHS further states, “Employees of the opposite gender

must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." CoreCivic policy 14-2-DHS further states, "All searches of transgender and intersex detainees shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and policy, including officer safety." During the on-site audit the Auditor observed all detainee housing units and confirmed in the housing units with individual cells the toilets are near the cell door which minimized incidental viewing when passing by. During the on-site audit the Auditor further observed the dormitory housing unit has individual toilets with a wall in between which provides privacy while performing bodily functions and the showers are single showers with privacy curtains and provide a space for the detainee to dress without being viewed by staff of the opposite gender. In addition, the Auditor observed the showers within the single cell dorms and confirmed they are single showers with doors. (b) (7)(E) [redacted]. In addition, during the on-site audit, the Auditor observed female staff consistently announcing their presence when entering the housing units. Interviews with 20 detainees confirmed they are provided adequate privacy and felt comfortable while showering or performing bodily functions. Interviews with 20 detainees further confirmed female staff will announce themselves every time they enter the pod, female staff will not enter the bathroom or shower area, and they are aware when female staff enter the housing unit.

(h): CCCC is not designated as Family Residential Centers; and therefore, subsection (h) is not applicable.

(i)(j): CoreCivic policy 14-2-DHS states, "The facility shall not search or physically examine a transgender or intersex detainee for the sole purpose of determining the detainee's genital status. If the detainee's genital status is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner." CoreCivic policy 14-2-DHS further states, "In addition to the general training provided to all employees, security staff shall receive training in how to conduct cross-gender pat-down searches, and searches of transgender and intersex detainees, in a manner that is professional, respectful, and the least intrusive possible while being consistent with security needs." The Auditor reviewed the CoreCivic Search Procedure Facilitator Guide and confirmed the guide includes, "Cross-gender searches, and searches of transgender and intersex inmates, should be conducted professionally and respectfully, and in the least intrusive manner possible, consistent with security needs." An interview with the Training Manager indicated all custody staff are required to complete the Contraband Control and Cell Search training each year during in-service training which includes training on how to conduct a pat-down search. An interview with the Training Manager further indicated all newly hired staff must attend the Search Procedure class within a week or two of their employment with the facility. In addition, in an interview with the Training Manager it was indicated prior to 2024 training documentation was contained in each individual file; however, beginning 2024 all training is provided on-line, and each employee must acknowledge their understanding of the training prior to the on-line system updating from assigned training to completed training. The Auditor reviewed an In-service training report and confirmed between January 2024 and October 2024, 71 staff have completed the search training and between January 2024 and October 2024, 57 newly hired staff have completed the search training. In addition, a review of eight CO training files confirmed training on conducting pat-down searches had been completed on an annual basis. During the on-site audit, there were no transgender or intersex detainees housed at the facility.

Corrective Action:

The facility is not in compliance with subsections (b) and (d) of the standard. The Auditor reviewed the CoreCivic Search Procedure Facilitator Guide and confirmed the guide includes, "Cross-gender pat-down searches of male inmates/residents/detainees are permissible under PREA standards;" however, subsection (b) of the standard requires pat-down searches of male detainees by female staff 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. In an interview with a female CO, it was confirmed she had conducted a pat search of a

male detainee although there were male COs present, and she did not document the cross-gender pat-down search as required by subsection (d) of the standard. In interviews with two detainees, it was confirmed although most pat-down searches are conducted by male COs at one point they were searched by a staff member of the opposite gender. To become compliant, the facility must update the CoreCivic Search Procedure Facilitator Guide to inform staff pat-down searches of male detainees by female staff are not to 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 and all cross-gender pat-down searches of detainees must be documented. Once updated, the facility must submit documentation to confirm all security staff have received training on the updated lesson plan. In addition, if applicable, the facility must provide the Auditor documentation to confirm any, and all, cross-gender pat-down searches which occur during the CAP period have been documented.

Corrective Action Taken:

(b)(d): The facility submitted a memorandum to the file to advise the Auditor the facility has begun utilizing the ICE Cross-Gender, Transgender and Intersex Searches training curriculum to train all staff in the proper procedures for conducting pat-down searches of detainees, to include the pat-down searches of transgender and Intersex detainees. The Auditor reviewed the training ICE Cross-Gender, Transgender and Intersex Searches training curriculum and confirmed the curriculum includes, "All searches shall be performed in a professional and respectful manner, and in the least intrusive manner as possible, consistent with security needs and agency policy, including consideration of officer safety." A review of the curriculum further confirms the curriculum includes, "Cross-gender pat-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 search is required on in exigent circumstances." The facility submitted 35 training certifications to confirm all applicable staff have received the ICE Cross-Gender, Transgender and Intersex Searches training. As the facility is no longer utilizing the CoreCivic Search Procedure Facilitator Guide the Auditor no longer requires the facility to revise the guide. The facility submitted a memorandum to the file which states, "Please be advised, that during the corrective action period, there have been no cross-gender pat-down searches performed at the facility." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (b) and (d) of the standard.

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

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

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, " The facility shall ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. When necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall attempt to accommodate the detainee by providing: Access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary; Access to written materials related to sexual abuse in formats or through methods that ensure effective communication; and Auxiliary aids such as readers, materials in Braille (if available), audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters, and note-takers." CoreCivic policy 14- 2-DHS further states, "The facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated reasonable accommodations are made to ensure detainees receive notification, orientation, and instruction on the Agency's and facility's sexual abuse prevention and response, to

include but not limited to, the use of a teletypewriters (TTY), Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs further indicated for detainees who have limited reading skills staff would read the information to the detainee or use the language line, or staff, to interpret the information should the detainee also be LEP. In addition, interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated if a detainee is blind, staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. During the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area and confirmed the video was available in English and Spanish and included American Sign Language (ASL); however, the facility did not have a transcript of the video to accommodate those detainees whose preferred language was other than English or Spanish. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. An interview with an Intake Officer indicated the ICE National Detainee Handbook and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlets are available on the facility computer system and could be printed in the most prevalent languages encountered by ICE, and other languages, should the need arise. During the on-site audit, the Auditor confirmed the ICE National Detainee Handbook was uploaded on the computer system in 17 most prevalent languages encountered by ICE to include English, Spanish, Arabic, Bengali, French, Haitian Creole, Hindi, K'iche' (Quiché)/Kxlantzij, Portuguese, Pulaar, Punjabi, Romanian, Russian, Simplified Chinese, Turkish, Vietnamese and Wolof and the DHS-prescribed SAA Information pamphlet was available in 15 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Ukrainian, and Vietnamese. During the on-site audit the Auditor further confirmed the ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet, in the above languages, are continuously available to all detainees on the detainee tablets. During the on-site audit, the Auditor further observed the CCCC Handbook Supplement available in English and Spanish. In an interview with the PSA Compliance Manager, it was indicated the facility can convert the handbook to the preferred language of any detainee; and therefore, the Auditor requested the facility to provide a copy of the CCCC Handbook Supplement in Russian which the facility provided within a short period of time. In addition, during the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet located in the audit binder available in English and Spanish and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abused; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet anywhere during the on-site audit. During the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day and the Auditor reviewed a video of the intake process. A review of the video confirmed copies of the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility Handbook Supplemental were on a rolling table taken to each holding cell and handed out to the incoming detainees; however, the Auditor could not confirm if the information was distributed in a manner each detainee could understand. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability

and neither of the detainees had the provided information read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed 18 detainees were LEP and the reading limitations of the two detainees who disclosed their limited reading skills were not documented. In addition, a review of 30 detainee files could not confirm detainees with disabilities, including, but not limited to, detainees who are LEP, deaf or hard of hearing, are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse.

(c): CoreCivic policy 14-2-DHS states, "Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." Interviews with four random COs confirmed they could utilize another detainee for interpretation if the detainee victim expressed a preference; however, they could not articulate the standard's requirement if such interpretation is appropriate and consistent with the DHS policy.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area and confirmed the video was available in English and Spanish and included American Sign Language (ASL); however, the facility did not have a transcript of the video to accommodate those detainees whose preferred language was other than English or Spanish or those who were deaf or hard of hearing. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. During the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet, available in English and Spanish, located in the audit binder and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abuse; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet anywhere during the on-site audit. In addition, during the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day and the Auditor reviewed a video of the intake process. A review of the intake video confirmed copies of the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility Handbook Supplemental were on a rolling table taken to each holding cell and handed out to the incoming detainees; however, the Auditor could not confirm if the information was distributed in a manner each detainee could understand. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability and neither of the detainees had the information provided read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed 18 detainees were LEP and the reading limitations of the three interviewed detainees were not documented. In addition, a review of 30 detainee files could not confirm detainees with disabilities, including, but not limited to, detainees who are LEP,

deaf or hard of hearing, are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. To become compliant, the facility must develop and implement a process to ensure all detainees with disabilities, to include detainees who are LEP, deaf, or hard of hearing, blind or have low vision, have limited reading skills, or have an intellectual, psychiatric, or speech disability, have an equal opportunity to participate in or benefit from all aspects of the agency's and the facility's efforts to prevent, detect, and respond to sexual abuse. The implemented process must include all elements of subsections (a) and (b) of the standard, and CoreCivic policy 14-2-DHS, which requires all written materials related to sexual abuse are provided in formats or through methods which ensure effective communication with detainees who are LEP, have intellectual disabilities, limited reading skills, or who are blind or have low vision. Once implemented the facility must submit documentation which confirms all applicable staff, to include Intake staff, have received training on the implemented procedure. In addition, the facility must submit 10 detainee files, and corresponding documentation, to confirm effective communication was established, to include, if applicable, detainees whose preferred language is other than English or Spanish or have a disability to include detainees with limited reading skills, who have intellectual, psychiatric, or speech disabilities, who are blind or have low vision, or are deaf or hard of hearing.

The facility is not in compliance with subsection (c) of the standard. Interviews with four random COs confirmed they could utilize another detainee for interpretation if the detainee victim expressed a preference; however, they could not articulate the standard's requirement if such interpretation is appropriate and consistent with the DHS policy. To become compliant, the facility must submit documentation to confirm all applicable staff, including but not limited to facility Investigators, have received training in the requirements of subsection (c) of the standard and CoreCivic policy 14-2-DHS which requires in matters relating to allegations of sexual abuse, the agency and each facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy.

Corrective Action Taken:

(a)(b): The facility submitted a training curriculum memorandum which includes all elements of the standard and Training Sign-In Sheets. A review of the submitted training memo and sign-in sheets confirmed 110 staff, including but not limited to Intake staff, Classification staff, Detention Officers (DO)s, and medical staff, have completed the training. The facility submitted Detainee Education Acknowledgment forms for two Portuguese detainees, two Vietnamese detainees, two Chinese detainees, two Turkish detainees, and two Bengali detainees. The Auditor reviewed the acknowledgements and confirmed the detainees had been provided with the DHS-prescribed SAA Information pamphlet, the ICE National Detainee Handbook, a Transcription of the PREA video, and the facility Handbook in their preferred language. In addition, the facility submitted the DHS-prescribed SAA Information pamphlet, the ICE National Detainee Handbook, a Transcription of the PREA video, and the facility Handbook in each respective language to confirm compliance with the standard. A review of the 6 files submitted confirmed compliance with standard 115.16; and therefore, the Auditor no longer requires the facility to submit 10 detainee files to confirm compliance. The facility submitted a memorandum to Auditor which states, "During the CAP Period, please be advised we have received no detainees who have limited reading skills, who have had intellectual, psychiatric or speech disabilities, who are blind or have low vision, or are deaf or hard of hearing." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (b) of the standard.

(c): The facility submitted a memorandum from the Assistant Warden/PSA Compliance Manager to all staff to remind staff CoreCivic policy 14-2-DHS and the DHS Standard 115.16 (c) requires in matters relating to allegations of sexual abuse, the agency and each facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee,

unless the detainee expresses a preference for another detainee to provide interpretation and the Agency determines such interpretation is appropriate and consistent with DHS policy. In addition, the facility submitted sample training rosters which confirmed 48 staff members have received the required training. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

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

Outcome: Meets Standard (substantial compliance; compiles 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)." CoreCivic policy 14-2-DHS states, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators." CoreCivic policy 14-2-DHS further states, "All allegations of sexual abuse shall be promptly reported to a law enforcement agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior." In addition, the policy states, "When a detainee, of the facility in which an alleged detainee victim is housed, is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director/designee. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director/designee, and to any local government entity or contractor that owns or operates the facility." CoreCivic policy 14-2-DHS further states, "Retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years." Interviews with the PSA Compliance Manager and the facility PREA Investigator indicated all allegations of sexual abuse involving penetration are reported to the MPD and an administrative investigation would be completed with the MPD's approval. During the on-site audit, the Auditor reviewed four sexual abuse allegation investigation files and confirmed notification had been made to the ICE ERO, ICE OPR, and the Joint Intake Center (JIC); however, only one of the allegations had been reported to the MPD despite the other allegations involved touching or contact of the detainee victim's body; and therefore, could be considered criminal in nature. (c): The Auditor reviewed the Agency website (https://www.ice.gov/prea) and the CoreCivic website (https://www.corecivic.com) and confirmed both websites contain the respective protocols as required by subsection (c) of the standard.

(c): The Auditor reviewed the Agency website (https://www.ice.gov/prea) and the CoreCivic website (https://www.corecivic.com), and confirmed both websites contain the respective protocols as required by subsection (c) of the standard.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. During the on-site audit, the Auditor reviewed four sexual abuse allegation investigation files and confirmed only one of the allegations had been reported to the MPD despite all four allegations involving touching or contact of the detainee victim's body; and therefore, could be considered criminal in nature. To become compliant, the facility must implement a practice which ensures allegations which involve potentially criminal behavior are promptly referred for investigation to an appropriate law enforcement agency with legal authority to conduct criminal investigations. Once implemented, the facility must submit documentation which confirms all applicable staff, to include but not limited to the facility Investigator, has received training on the implemented practice. In addition, if applicable, the facility, must provide all sexual abuse allegation investigation files occurring during the CAP period to confirm if the allegation was potentially criminal in nature the allegation was reported to the MPD.

Corrective Action Taken:

(d): The facility submitted a refresher training curriculum titled "Law Enforcement and Criminal Investigations." The Auditor reviewed the curriculum and confirmed the curriculum requires allegations which involve potentially criminal behavior be promptly referred for investigation to an appropriate law enforcement agency with legal authority to conduct criminal investigations. In addition, the facility submitted training Sign-In Sheets confirming the facility Investigator had received the refresher training on March 20, 2025. The facility submitted a memorandum to the Auditor which states, "There has been one (1) allegation involving the DHS population. The allegation was reported on 4/12/2025 and is recorded as incident number 2025-0504-088." The facility submitted allegation incident number 2025-0504-088. The Auditor reviewed the submitted allegation incident number 2025-0504-088 and confirmed as the allegation was not criminal in nature, the facility was not required to report the allegation to the local law enforcement. The facility submitted an ICE Significant Incident Report. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

§115.31 - Staff training.

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

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all new employees and shall also be included in annual refresher/in-service training thereafter. (ACI 4-4084; ACI-4-4084-1; 4-ALDF-7B-08; 4-ALDF-7B-10; 4-ALDF-7B-10-1) Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards, and shall include: the facility's zero-tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal sexual behavior; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee-victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities." Policy 14-2- DHS further states, "Employees shall be required to confirm, by either electronic or manual signature, their understanding of the received training. Signed documentation will be maintained in the employee's training file." The Auditor reviewed the CoreCivic PREA Overview curriculum and confirmed the training covers the required elements which include: the Agency and the facility's zero tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal behavior; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on prohibited and illegal behavior; recognition of situations where sexual abuse may occur; recognition of physical,

behavioral, and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees; procedures for reporting knowledge, suspicion of sexual abuse; 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 for law enforcement or investigative purposes. An interview with the Training Manager indicated all staff are required to complete PREA training on a yearly basis and if a staff member has not completed assigned training, an email is sent to the staff supervisor, to ensure they complete the training. Interviews with four random COs indicated they are required to complete PREA training on a yearly basis, and during In-Service training, and they are knowledgeable regarding PREA. The Auditor reviewed 17 staff files, which included 8 security staff, 2 administrative staff, 2 medical staff, and 5 staff contractor medical staff, and confirmed annual PREA training in 10 of the files; however, 4 staff hired in the year 2024 and 5 staff contractor medical staff had not received general PREA training. In addition, the Auditor reviewed three ICE staff training certificates for the years 2023 and 2024 and confirmed all three ICE staff had received the required PREA training.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. The Auditor reviewed 17 staff files and confirmed annual PREA training in 10 of the files; however, 4 staff hired in 2024 and 5 contracted medical staff had not received general PREA training as required by subsections (a) and (b) of the standard. To become compliant, the facility must submit documentation to confirm all staff, and staff contractors, who may have contact with detainees are trained in accordance with subsections (a) and (b) of the standard and CoreCivic policy 14-2-DHS. In addition, if applicable, the facility must submit documentation to confirm all existing staff, and staff contractors hired during the CAP period have received the required training.

Corrective Action Taken:

(a)(b): The facility submitted a staff training report. The Auditor reviewed the report and confirmed 186 employees have completed the PREA In-Service 2024 training, to include those employees and contractors identified as non-compliant during the on-site file review. In addition, the facility submitted a staff training report which confirmed 19 employees hired between February 5, 2025, and March 20, 2025, have completed the required PREA Training. The Auditor accepts the submitted documentation for compliance; and therefore, no longer requires the facility to submit documentation to confirm all staff and staff/contractors hired during the CAP period have received the required training. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

§115.33 - Detainee education.

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

Notes:

(a)(b)(c)(d)(e)(f): CoreCivic policy 14-2-DHS states, "During the intake process, all detainees shall be notified of the facility zero tolerance policy on sexual abuse and assault. Detainees will be provided with information (orally and in writing) about the facility's SAAPI Program. Such information shall include, at a minimum: The facility's zero tolerance policy for all forms of sexual abuse or assault; Prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; Explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS/Office of Inspector General (OIG) and the ICE/Office of Professional Responsibility (OPR) investigation processes; Information about self-protection and indicators of sexual abuse and assault; Prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The facility shall post on all housing unit bulletin boards the following notices: The DHS-prescribed sexual abuse and assault awareness notice; The name

of the facility PSA Compliance Manager; and Information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available). If no such local organizations exist, the facility shall make available the same information about national organizations." Policy 124-2-DHS further states, "The facility shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet." During the on-site audit, the Auditor observed the RCC of Central New Mexico flyer, in English and Spanish and the 2024 DHS-prescribed sexual assault awareness notice posted in all housing units and common areas of the facility; however, many of the 2024 DHS-prescribed sexual assault awareness notices did not have the name of the PSA Compliance Manager. The Auditor advised the facility and prior to the conclusion of the on-site audit, the facility had inserted the PSA Compliance Manager's name on all notices posted through-out the facility. Therefore, the Auditor determined the facility came into compliance with subsection (d) of the standard during the on-site audit. Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated reasonable accommodations are made to ensure detainees receive notification, orientation, and instruction on the Agency's and facility's sexual abuse prevention and response, to include but not limited to, the use of a teletypewriters (TTY), Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs further indicated for detainees who have limited reading skills staff would read the information to the detainee or use the language line, or staff, to interpret the information should the detainee also be LEP. In addition, interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated if a detainee is blind, staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. An interview with an Intake Officer indicated the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlets are available on the facility computer system and could be printed in the most prevalent languages encountered by ICE, and other languages, should the need arise. During the on-site audit, the Auditor confirmed the ICE National Detainee Handbook was uploaded on the computer system in 17 most prevalent languages encountered by ICE to include English, Spanish, Arabic, Bengali, French, Haitian Creole, Hindi, K'iche' (Quiché)/Kxlantzij, Portuguese, Pulaar, Punjabi, Romanian, Russian, Simplified Chinese, Turkish, Vietnamese and Wolof and the DHS-prescribed SAA Information pamphlet was available in 15 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Ukrainian, and Vietnamese. The Auditor reviewed the ICE National Detainee Handbook and confirmed the handbook includes information about reporting sexual abuse. During the on-site audit, the Auditor further observed the CCCC Handbook Supplement available in English and Spanish. In an interview with the PSA Compliance Manager, it was indicated the facility can convert the handbook to the preferred language of any detainee; and therefore, the Auditor requested the facility to provide a copy of the CCCC Handbook Supplement in Russian which the facility provided within a short period of time. In addition, during the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area and confirmed the video was available in English and Spanish and included ASL; however, the facility did not have a transcript of the video to accommodate those detainees whose preferred language was other than English or Spanish. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. During the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet located in the audit binder available in English and Spanish and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abuse; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet available to detainees during the on-site audit. An interview with the PSA Compliance Manager indicated detainees are asked to sign a SAAPI Education Acknowledgement and an Orientation Acknowledgement. The Auditor reviewed the acknowledgement and confirmed the acknowledgement requires the detainee sign to acknowledge he has received the "CoreCivic Zero Tolerance PREA Pamphlet, the ICE Sexual Assault Awareness

Pamphlet, the ICE Detainee Facility Handbook, ICE National Handbook, and has watched the Video "PREA What you need to know" Zero Tolerance." In addition, a review of the acknowledgment confirms the acknowledgement includes whether the facility utilized the language line and in what language. The Auditor further reviewed the Unit Admission and Orientation Acknowledgement and confirmed the acknowledgement includes "I have been orientated in all areas above and have had an opportunity to discuss with orientation staff." During the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day and the Auditor reviewed a video of the intake process. A review of the video confirmed copies of the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility Handbook Supplemental were on a rolling table taken to each holding cell and handed out to the incoming detainees; however, the Auditor could not confirm if the detainee had signed either acknowledgment or if the information was distributed in a manner each detainee could understand. As per the PSA Compliance Manager, the detainee does not sign for the information until they meet with Classification staff at later date. In an interview with the Intake Officer, it was indicated she does not have the detainee sign the SAAPI Education Acknowledgement as the document is completed later by classification staff; however, she has the detainee sign the Receiving and Discharge checklist which includes a statement confirming the detainee received a handbook. The Auditor reviewed the Receiving and Discharge checklist and could not confirm if the handbook received was the ICE National Detainee Handbook or the facility Supplement to the Handbook nor could the Auditor confirm in what language the detainee received the handbook. A review of the Receiving and Discharge checklist further confirmed the checklist does not document the detainee participated in orientation during the intake process. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS- prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability and neither of the detainees had the provided information read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed each file contained the SAAPI Education Acknowledgement and the Unit Admission and Orientation Acknowledgement; however, all the acknowledgements had been signed and dated by the detainee, between three weeks and a month after the detainee arrived at the facility.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (c) of the standard. During the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area and confirmed the video was available in English and Spanish and included ASL; however, the facility did not have a transcript of the video to accommodate those detainees whose preferred language was other than English or Spanish or those who were deaf or hard of hearing. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. During the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet located in the audit binder available in English and Spanish and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abused; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet available to detainees during the on-site audit. In an interview with the Intake Officer, it was indicated she does not have the detainee sign the SAAPI Education Acknowledgement as the document is completed later by classification staff;

however, she has the detainee sign the Receiving and Discharge checklist which includes a statement confirming the detainee received a handbook. The Auditor reviewed the Receiving and Discharge checklist and could not confirm if the handbook received was the ICE National Detainee Handbook or the facility Supplement to the Handbook nor could the Auditor confirm in what language the detainee received the handbook. A review of the Receiving and Discharge checklist further confirmed the checklist does not document the detainee participated in orientation during the intake process. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability and neither of the detainees had the information provided read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed each file contained the SAAPI Education Acknowledgement and the Unit Admission and Orientation Acknowledgement; however, all the acknowledgements had been signed and dated by the detainee, between three weeks and a month after the detainee arrived at the facility. To become compliant, the facility must develop and implement a process to ensure during the intake process, all detainees receive an orientation which notifies and informs detainees of all elements required by subsections (a) of the standard and CoreCivic policy 14-2-DHS. The process shall include the steps to be taken to provide all detainees notification, orientation, and instruction in formats accessible to all detainees, including those who are LEP, are deaf, or hard of hearing, blind or have low vision, have limited reading skills, or have an intellectual, psychiatric, or speech disability and the standards requirement to document the completion of orientation during the intake process. Once implemented the facility must submit documentation which confirms all applicable staff, to include staff assigned to intake and classification, have received training on the implemented procedure. The facility must submit 20 detainee files, which occur during the CAP period to include the intake date, documentation of the detainee participation in the intake process orientation, and documentation the orientation was delivered in a manner the detainee could understand. In addition, if applicable, the facility shall provide the Auditor five detainee files to include detainees whose preferred language is other than English or Spanish and, if applicable, five detainee files which include detainees who are deaf, or hard of hearing, blind or have low vision, have limited reading skills, or have an intellectual, psychiatric, or speech disability.

Corrective Action Taken:

(a)(b)(c): The facility submitted a training curriculum memorandum. The Auditor reviewed the training memorandum and confirmed the training curriculum includes the implemented process to ensure during the intake process, all detainees receive an orientation which notifies and informs detainees of all elements required by subsections (a) of the standard and CoreCivic policy 14-2-DHS. In addition, the facility submitted Training Sign-In Sheets. The Auditor reviewed the Training Sign-In Sheets and confirmed 110 staff, including but not limited to Intake staff, Classification staff, DOs, and medical staff, have completed the required training. The facility submitted Detainee Education Acknowledgment forms for two Portuguese detainees, two Vietnamese detainees, two Chinese detainees, two Turkish detainees, and two Bengali detainees. The Auditor reviewed the acknowledgements and confirmed the detainees had been provided with the DHS-prescribed SAA Information pamphlet, the ICE National Detainee Handbook, a Transcription of the PREA video, and the facility Handbook in their preferred language. In addition, the facility submitted the DHS-prescribed SAA Information pamphlet, the ICE National Detainee Handbook, a Transcription of the PREA video, and the facility Handbook in the respective language to confirm compliance with the standard. A review of the 6 files submitted confirmed compliance with standard 115.33; and therefore, the Auditor no longer requires the facility to submit 15 detainee files to confirm

compliance. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (b), and (c) of the standard.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d)(f)(g): CoreCivic policy 14-2-DHS states, "All detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within twelve (12) hours of admission to the facility." CoreCivic policy 14-2-DHS further states, "The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety" and "the initial screening shall consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive." In addition, CoreCivic policy 14-2-DHS states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to items listed above in section" and "appropriate controls shall be implemented within the facility regarding the dissemination of responses to questions asked pursuant to screening for risk of victimization and abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees to the detainee's detriment." An interview with the PSA Compliance Manager indicated detainees are assessed to identify those likely to be sexual aggressors or sexual abuse victims utilizing the Assessment Questionnaire-Initial Screening Tool and the information gained from the assessment is contained in the detainee's electronic file in the facility Offender Management System (OMS); however, a review of the facility OMS during the on-site audit, confirmed the electronic system carries over alerts identified at previous CoreCivic facilities; and therefore, the Auditor could not confirm if during CCCC's initial detainee risk assessment, the information would update and/or change the posted alerts based on entry of CCCC's initial assessment. An interview with an Intake Officer indicated when detainees arrive at the facility, they are placed into holding cells and are provided a Cibola County Assessment Questionnaire Information form. An interview with an Intake officer further indicated the detainee will be taken out of the holding cell, one by one, to an office where the assessment will be conducted in private utilizing the paper version of the assessment handed to the detainee which will be added into the OMS system. In addition, an interview with an Intake Officer indicated if a detainee is LEP, Intake staff will utilize the facility language line or a staff interpreter to interpret the risk assessment questions and detainees are not disciplined for refusing to answer or for not giving complete answers to the questions. The Auditor reviewed the Sexual Abuse Screening Tool and confirmed the tool includes all required elements of subsections (c) and (d) of the standard. The Auditor reviewed the Cibola County Assessment Questionnaire Information and confirmed the paper version of the assessment contains the same questions as the Assessment Questionnaire-Initial Screening Tool; however, the Cibola County Assessment Questionnaire Information requires the reader circle a yes or no answer to the question, does not have a date or signature line, and each question on the assessment is in English and Spanish. During the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day; and therefore, the Auditor was able to review a video of the intake process. A review of the video confirmed a detainee had been taken into an office to conduct the initial risk assessment. During the on-site audit the Auditor requested the Intake Officer describe how information gained from the initial risk assessment is utilized to determine a

detainee's initial housing and confirmed Intake staff are aware of the detainee's initial housing assignment prior to their arrival at the facility; and therefore, information gained from the initial risk assessment is not utilized to determine initial housing. An interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility is not utilizing all known information to inform housing so necessary steps can be taken to mitigate any such danger. An interview with the PSA Compliance Manager indicated the OMS system would flag the detainee file with an alert if they scored as a victim or a predator and will not allow the housing of the two detainees together; however, a review of the detainee files confirmed the alert occurs after the detainee had received his initial housing. The Auditor interviewed 20 detainees and confirmed 2 of the detainees interviewed were taken to the office where the initial risk assessment was conducted utilizing the language line; however, 18 of the detainees interviewed, to include 1 detainee who arrived the previous day, had been given the form with a pen, and advised to complete the initial risk assessment without staff assistance. During an interview with one detainee, it was further confirmed during his intake, other detainees did not understand the initial risk assessment questions; and therefore, he needed to explain the initial risk assessment to them so they could answer appropriately. In an interview with one detainee, it was confirmed he had not been asked whether he experienced prior sexual abuse by intake staff; however, he had been asked the questions during his medical assessment. The Auditor reviewed 30 detainee files, to include the file of the detainee who was not asked about previous sexual abuse, and confirmed each file contained the Cibola County Assessment Questionnaire Information and the Assessment Questionnaire-Initial Screening Tool and the initial assessment had been completed during the intake process and within twelve hours of intake; however, a review of the detainee's file who indicated he had not been asked about previous sexual abuse by Intake staff confirmed the detainee's initial risk assessment indicated he had responded "no", when asked if he had experienced previous sexual abuse; and therefore, the Auditor cannot confirm medical had shared the information with staff responsible to utilize the information gained from the initial risk assessment to determine to house detainees to prevent sexual abuse taking necessary steps to mitigate such danger. The Auditor reviewed 30 detainee files and confirmed contained in each file was the Cibola County Assessment Questionnaire Information and the Assessment Questionnaire-Initial Screening Tool and the initial assessment had been completed during the intake process and within twelve hours of intake.

(e): CoreCivic policy 14-2-DHS states, "The facility shall reassess each detainee's risk of victimization or abusiveness between sixty (60) and ninety (90) days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." An interview with the PSA Compliance Manager indicated all detainees risk of victimization and abusiveness is reassessed between 60 and 90 days after the initial assessment. The Auditor reviewed 30 detainee files and confirmed the 15 files where a reassessment was required, 2 detainees were reassessed, 10 detainee files did not have documentation of a re-assessment, and 3 files indicated a re-assessment had been completed after 90 days. In addition, the Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed none of the detainees had been reassessed following an incident of sexual abuse.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. During the on-site audit the Auditor requested the Intake Officer describe how information gained from the initial risk assessment is utilized to determine a detainee's initial housing and confirmed Intake staff are aware of the detainee's initial housing assignment prior to their arrival at the facility; and therefore, information gained from the initial risk assessment is not utilized to determine initial housing. An interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility does not utilize all known information to inform housing so necessary steps can be taken to mitigate any such danger. An interview with the PSA Compliance Manager indicated the OMS system would flag the detainee file with an alert if they scored as a victim or a predator and will not allow the housing of the two detainees together; however, a review of detainee files confirmed the alert occurs after the detainee had received his initial housing. The Auditor interviewed 20 detainees and confirmed 2 of the detainees interviewed

were taken to the office where the initial risk assessment was conducted utilizing the language line; however, 18 of the detainees interviewed, to include 1 detainee who arrived the previous day, had been given the form with a pen, and advised to complete the initial risk assessment without staff assistance. During an interview with one detainee, it was further confirmed during his intake, other detainees did not understand the initial risk assessment questions; and therefore, he needed to explain the initial risk assessment to them so they could answer appropriately. In an interview with one detainee, it was confirmed he had not been asked whether he experienced prior sexual abuse by intake staff; however, he had been asked the questions during his medical assessment. The Auditor reviewed 30 detainee files, to include the file of the detainee who was not asked about previous sexual abuse, and confirmed the detainee's initial risk assessment indicated he had responded "no", when asked if he had experienced previous sexual abuse; and therefore, the Auditor cannot confirm medical had shared the information with staff responsible to utilize the information gained from the initial risk assessment to determine to house detainees to prevent sexual abuse taking necessary steps to mitigate such danger. To become compliant, the facility must implement a procedure to ensure the facility is utilizing the information gained from the initial risk assessment to inform housing, so necessary steps can be taken to mitigate any such danger, to include intake staff participating in conducting the initial risk assessment, in the detainee's preferred language, and in a private setting. In addition, the facility must implement a procedure to require upon learning a detainee has experienced previous sexual abuse, or perpetrated sexual abuse, medical and mental health staff will inform staff responsible for detainee housing to ensure detainees are housed to prevent sexual abuse and to take necessary steps to mitigate any such danger. Once implemented, the facility must submit documentation which confirms all Intake, Classification, medical, and mental health staff have received training on the implemented procedure. In addition, the facility shall provide the Auditor 20 detainee files, to include detainees who do not speak English or Spanish, and 5 detainee files identified as likely to be a victim of sexual abuse, or perpetrated sexual abuse, and the corresponding medical files.

The facility is not in compliance with subsection (e) of the standard. The Auditor reviewed 30 detainee files and confirmed of the 15 files where a reassessment was required, 2 detainees were reassessed, 10 detainee files did not have documentation of a re-assessment, and 3 files indicated a re-assessment had been completed after 90 days. In addition, the Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed none of the detainees had been re-assessed following an incident of sexual abuse. In addition, the Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed none of the detainees had been re-assessed following an incident of sexual abuse. To become compliant, the facility must submit documentation to confirm all applicable staff, to include classification and the facility Investigator, have received training on subsection (e) of the standard and CoreCivic policy 14-2-DHS which require each detainee to be re-assessed between 60 and 90 days of the detainee's initial assessment or at any other time when warranted based upon the receipt of new information or following an incident of abuse or victimization. The facility must submit the files of 20 detainees who require a reassessment between 60 and 90 days, which occur during the CAP period, to confirm a re-assessment had been completed between 60 and 90 days. If applicable, the facility must submit all closed sexual abuse allegation investigation files to confirm a re-assessment had been completed following an incident of sexual abuse or victimization. In addition, if applicable, the facility must submit the files of any detainees who were reassessed following the receipt of additional information which occurred during the CAP period.

Corrective Action Taken:

(a): The facility submitted a training curriculum memorandum. The Auditor reviewed the training curriculum and confirmed the curriculum includes the facility implemented procedure to ensure the facility is utilizing the information gained from the initial risk assessment to inform housing, so necessary steps can be taken to mitigate any such danger to include upon learning a detainee has experienced previous sexual abuse, or perpetrated sexual abuse, medical and mental health staff will inform staff responsible for detainee housing to ensure detainees are housed to prevent sexual abuse and to take necessary steps to mitigate any such danger. In addition, the Auditor reviewed the submitted training rosters and confirmed 110 staff, including but not limited to the Intake staff,

Classification staff, DOs, and medical staff, have completed the training. The facility submitted risk assessments, snapshots of the detainee OMS files, to indicate the Alert, and the Detainee housing reports for 10 detainees who entered the facility between March 2025 and May 2025. The Auditor reviewed the risk assessments, snapshots of the detainee OMS file, to indicate the Alert, and the Detainee housing reports OMS Alert Report and confirmed an alert had been entered into the OMS system utilizing information gained from the initial risk assessment of each detainee. A review of the 10 files submitted confirmed compliance with standard 115.41; however, did not include corresponding medical files; and therefore, the Auditor could not confirm medical and mental health staff will inform staff responsible for detainee housing to ensure detainees are housed to prevent sexual abuse and to take necessary steps to mitigate any such danger; and therefore, substantial compliance is based on submitted training documentation. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

(e): The facility submitted a training memorandum to all staff which includes the requirement each detainee shall be re-assessed between 60 and 90 days of the detainee's initial assessment or any other time when warranted based upon the receipt of new information or following an incident of abuse or victimization. The facility submitted a roster of 20 detainees which included the detainee's intake date, initial assessment, the date of the 60–90-day assessment, and the corresponding reassessments. The Auditor reviewed the roster of 20 detainees which included the detainee's intake date, initial assessment, the date of the 60–90-day assessment, and the corresponding reassessments and confirmed the detainees had been reassessed between 60-90 days of the initial screening in a manner they could understand. The facility submitted one sexual abuse allegation investigation file, and the corresponding reassessment. The Auditor reviewed the submitted sexual abuse allegation investigation file, and the corresponding reassessment and confirmed a reassessment had been conducted on both the victim and the alleged perpetrators between 60-90 days of the initial screening in a manner they could understand. 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: Meets Standard (substantial compliance; compiles in all material ways with the standard for the relevant review period)

Notes:

(a): CoreCivic policy 14-2-DHS states, "The facility shall use the information from the 14-2 DHS Sexual Abuse Screening Tool conducted at initial screening in the consideration of housing recreation, work program and other activities." An interview with the PSA Compliance Manager indicated detainees are assessed to identify those likely to be sexual aggressors or sexual abuse victims utilizing the Assessment Questionnaire-Initial Screening Tool located on the facility OMS system. An interview with the PSA Compliance Manager further indicated the OMS system would flag the detainee file with an alert if they scored as a victim or a predator; and therefore, will not allow the housing of detainees who identify as being at risk for sexual victimization with detainees who identified as being likely to be sexual abuse aggressors. The Auditor reviewed the Assessment Questionnaire-Initial Screening Tool Sexual Abuse Screening Tool and confirmed the tool includes all requirements of subsections (c) and (d) of standard 115.41; however, a review of the facility OMS during the on-site audit, confirmed the electronic system carries over alerts identified at previous CoreCivic facilities; and therefore, the Auditor could not confirm if during CCCC's initial detainee risk assessment, the information would update and/or change the posted alerts based on entry of CCCC's initial assessment. In an interview with an Intake Office, it was confirmed she could not articulate if, or how, the information gained from the initial risk assessment could, or would, change the detainee's predetermined housing assignment, recreation or other activities, or voluntary work assignments. In addition, an interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility is not utilizing all known information to determine housing, recreation and other activities, and voluntary work assignments.

(b)(c): CoreCivic policy 14-2-DHS states, "In deciding whether to house a transgender/intersex detainee in a male or female unit, pod, cell, or dormitory within the facility subsequent to arrival, or when making other housing and programming assignments for such detainees, the facility shall consider the transgender or intersex detainee's gender self-identification and self-assessment of safety needs. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. Placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review whether any threats to safety were experienced by the detainee." An interview with the PSA Compliance Manager indicated the facility would consider the detainee's own views of his/her safety at the facility and a transgender or intersex detainee's self-identification is considered when making housing decisions and not based solely on the detainee's genitalia. An interview with the PSA Compliance Manager further indicated medical and mental health would be consulted to determine the effects the assignment would have on the detainee's health and safety. An interview with the HSA indicated medical and mental health participates on a transgender committee and would provide input on a detainee's housing assignment. An interview with the PSA Compliance Manager indicated the facility has not housed a transgender or intersex detainee during the audit period; however, an assessment would be completed every six months if a transgender or intersex detainee were to be housed at the facility for longer than six months. An interview with the PSA Compliance Manager further indicated a transgender or intersex detainee would be given an opportunity to shower separately during count time. During the on-site audit, Auditor observations and formal and informal interviews with staff confirmed the were no transgender or intersex detainees housed at the facility.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated detainees are assessed to identify those likely to be sexual aggressors or sexual abuse victims utilizing the Assessment Questionnaire-Initial Screening Tool located on the facility OMS system. An interview with the PSA Compliance Manager further indicated the OMS would flag the detainee file with an alert if they scored as a victim or a predator; and therefore, will not allow the housing of detainees who identify as being at risk for sexual victimization with detainees who identified as being likely to be sexual abuse aggressors. The Auditor reviewed the Assessment Questionnaire-Initial Screening Tool Sexual Abuse Screening Tool and confirmed the tool includes all requirements of subsections (c) and (d) of standard 115.41; however, a review of the facility OMS during the on-site audit, confirmed the electronic system carries over alerts identified at previous CoreCivic facilities; and therefore, the Auditor could not confirm if during CCCC's initial detainee risk assessment, the information would update and/or change the posted alerts based on entry of CCCC's initial assessment. In an interview with an Intake Officer, it was confirmed she could not articulate if, or how, the information gained from the initial risk assessment could, or would, change the detainee's predetermined housing assignment, recreation or other activities, or voluntary work assignments. In addition, an interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility is not utilizing all known information to determine housing, recreation and other activities, and voluntary work assignments. To become compliant the facility must implement a procedure to ensure information gained from the initial risk assessment under §115.41, is utilized to determine housing, recreation or other activities, and voluntary work assignments to ensure individualized determinations are made to ensure the detainee's safety. Once implemented, the facility must submit documentation which confirms, all applicable staff, to include but not limited to intake, classification, medical, and mental health staff. The facility, if applicable, must submit 15 files of detainees identified during the initial risk assessment as likely to be a victim of sexual abuse or a sexual abuse aggressor, and the corresponding OMS report, who arrive during the CAP period to confirm information gained from the initial risk assessment is utilized to determine housing, recreation and other activities, and voluntary work assignments.

Corrective Action Taken:

(a): The facility submitted a training roster and curriculum. The Auditor reviewed the curriculum and confirmed the curriculum included the facility implemented procedure to ensure information gained from the initial risk

assessment under §115.41, is utilized to determine housing, recreation or other activities, and voluntary work assignments to ensure individualized determinations are made to ensure the detainee's safety. In addition, the Auditor reviewed the submitted training rosters and confirmed 110 staff, including but not limited to Intake staff, Classification staff, DOs, and Medical Staff, have received the required training. The facility submitted a memorandum advising the Auditor detainees go to recreation with their assigned housing unit, the library and law library separately, and work on their assigned units. The Auditor reviewed the memorandum and accepted the memorandum for compliance with the standard's requirement to utilize the information gained from the initial risk assessment to determine recreation and other activities and voluntary programming. The facility submitted risk assessments, snapshots of detainee OMS files, to indicate the Alert, and Detainee housing reports for 10 detainees who entered the facility between March 2025 and May 2025. The Auditor reviewed the risk assessments, snapshots of the detainee OMS file, to indicate the Alert, and the Detainee housing reports OMS Alert Report and confirmed an alert had been entered into the OMS system utilizing information gained from the initial risk assessment of each detainee. A review of the 10 files submitted confirmed compliance with standard 115.42; and therefore, the Auditor no longer requires the facility to submit 15 detainee files to confirm compliance. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "Use of Administrative Segregation to protect detainees at high risk for sexual abuse and assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. Detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director to determine if ICE can provide additional assistance. Such detainees may be assigned to Administrative Segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of thirty (30) days." A review of CoreCivic policy 14-2-DHS confirmed the policy does not include the facility must document detailed reasons for the placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not placed a detainee in protective custody/administrative segregation during the audit period. Cibola County Correctional Center has not had to notify the Field Office of the same, however if it did, the Warden or designee would email the AFOD and the SDDO of the placement." Interviews with the facility Warden and PSA Compliance Manager indicated administrative segregation and/or protective custody is restricted to those instances where reasonable efforts have been made and as a last resort for housing of a detainee who is vulnerable to sexual abuse. Interviews with the facility Warden and PSA Compliance Manager further indicated if a detainee is assigned to administrative segregation and/or protective custody due to being vulnerable to sexual abuse the assignment would be documented to include detailed reasons for the placement and would not exceed 30 days. During the on-site audit, the Auditor observed the facility administrative segregation unit and confirmed there were no detainees vulnerable to sexual abuse assigned to administrative segregation and/or protective custody. The Auditor reviewed a 2023 Policy Document Review/Revision Request and an email string from the facility to ICE ERO confirming CoreCivic policy 14-2-DHS was developed in consultation with the ICE ERO FOD having jurisdiction over the facility.

(d)(e): CoreCivic policy 14-2-DHS states, "A supervisory staff member shall conduct a review within seventy-two (72) hours of the detainee's placement in segregation to determine whether segregation is still warranted; and a supervisory staff member shall conduct, at a minimum, and identical review after the detainee has spent seven

(7) days in Administrative Segregation, and every week thereafter for the first thirty (30) days and every ten (10) days thereafter. Facilities shall notify the appropriate ICE Field Office Director no later than seventy-two (72) hours after the initial placement into segregation, whenever a detainee has been placed in segregation on the basis of a vulnerability to sexual abuse or assault. Detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible." Interviews with the facility Warden and the PSA Compliance Manager, indicated any placement of a detainee vulnerable to sexual abuse into administrative segregation and/or protective custody would require immediate notification to the ICE FOD, regular reviews would be conducted as required by CoreCivic policy 14-2-DHS, and detainees would be provided access to programming, visitation, counsel, and all other services available to other detainees. During the on-site audit, the Auditor confirmed through direct observation there were no detainees vulnerable to sexual abuse housed in administrative segregation or protective custody.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. A review of CoreCivic policy 14-2-DHS confirmed the policy does not include the facility must document detailed reasons for the placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. To become compliant, the facility must revise CoreCivic policy 14-2-DHS in conjunction with the ICE ERO FOD having jurisdiction over the facility to include the facility must document detailed reasons for the placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Once updated the facility must submit documentation to confirm all applicable staff have been trained on the revised policy. In addition, if applicable, the facility must submit the files of any detainees placed into administrative segregation due to being vulnerable to sexual abuse which occur during the CAP period.

Corrective Action Taken:

(a): The facility submitted a training memorandum. The Auditor reviewed the training memo and confirmed the memo advises "should an individual be placed in administrative segregation the facility must document the detailed reasons for the placement of an individual in administrative segregation on the basis of vulnerability to sexual abuse or assault;" and therefore, the Auditor accepts the training memo as the facility written procedures and no longer requires the facility revise CoreCivic policy 14-2-DHS in conjunction with the ICE ERO FOD having jurisdiction over the facility to include the facility must document detailed reasons for the placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. In addition, the facility submitted staff sign-in sheets. The Auditor reviewed the sign-in sheets and confirmed 19 staff have received training on the requirements of standard 115.43. The facility submitted a memorandum which states, "There have been no detainees placed Administrative Segregation on the basis of being vulnerable to sexual abuse or assault during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d): CoreCivic policy 14-2-DHS states, "CoreCivic shall maintain, or attempt to enter into, Memorandums of Understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support for immigrant victims of crimes. Before developing or attempting to enter into an MOU, the facility shall contact the CoreCivic FSC Legal Department. CoreCivic shall maintain copies of agreements or documentation showing attempts to enter into such agreements. Each facility shall establish, in writing, procedures to include outside agencies in the facility sexual abuse prevention and intervention protocols, if such resources are available. Detainees shall be provided access to outside victim advocates for emotional support services related to sexual abuse. Detainees will be provided with mailing addresses and telephone numbers, including toll-free hotline

numbers where available, of local, state, or national victim advocacy or rape crisis organizations. Such information shall be included in the facility's Detainee Handbook. The facility shall enable reasonable communication between detainees and these organizations and agencies, in as confidential a manner as possible." The Auditor reviewed an MOU between CoreCivic and the RCC, dated August 1, 2019, which is open ended, with the clause either party can terminate the agreement with a 30-day written notice, and confirmed the MOU indicates RCC will provide access to victim advocates for confidential emotional support services through a 24-hour sexual abuse/assault crisis hotline number and a mailing address which may be posted throughout the facility. The Auditor reviewed the facility Handbook Supplement which states, "You can also contact the Rape Crisis Center or [sic] Central New Mexico, in writing or by telephone as follows: 24-hour hotline: 505-266-7711, address: Rape Crisis Center of Central New Mexico, 9741 Candeleria NE, Albuquerque, New Mexico 87112;" however, a review of the flyer and the facility supplemental handbook confirmed neither the flyer or the supplemental handbook includes the extent to which communications to the RCC will be monitored or the extent reports of abuse will be forwarded to authorities according to New Mexico mandatory reporting laws. During the on-site audit, utilizing the detainee telephones, the Auditor spoke with a victim advocate from RCC who confirmed RCC provides detainees with access to victim advocates for crisis intervention and counseling utilizing a sexual assault crisis line and RCC advocates have access to a language line to assist with any calls received from detainees who are LEP.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. The Auditor reviewed the facility Handbook Supplement and the RCC flyer and confirmed neither the flyer or the supplemental handbook includes the extent to which communications to the RCC will be monitored or the extent reports of abuse will be forwarded to authorities according to New Mexico mandatory reporting laws. To become compliant, the facility must submit documentation confirming prior to giving detainees access to outside resources, the facility informs detainees the extent to which communications to the RCC will be monitored and the extent reports of abuse will be forwarded to authorities according to New Mexico mandatory reporting laws in a manner all detainees can understand.

Corrective Action Taken:

(d): The facility submitted the revised Cibola County Correctional Center Handbook Supplement in English, Arabic, Chinese, French, and Vietnamese. English. The Auditor reviewed the handbook and confirmed it includes when you call RCCNM, you will be advised that anything that you disclose that may indicate self-harm, harm to another, or abuse of a child will be reported as required by mandatory reporting laws. All calls are confidential, and information is not reported to law enforcement unless it meets these criteria. The Auditor accepts the documentation provided to confirm the revised Cibola County Correctional Center Handbook Supplement includes the required information and is available to detainees in a manner all detainees can understand. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (d) of the standard.

§115.62 - Protection duties.

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

Notes:

CoreCivic policy 14-2-DHS states, "When it is learned that a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee." Interviews with the PSA Compliance Manager and four random COs indicated if they became aware a detainee is at substantial risk of sexual abuse, they would immediately separate the detainee from the threat and notify a supervisor. An interview with the facility Warden indicated all staff are required to take immediate action to protect detainee victims of sexual abuse. A review of four sexual abuse allegation investigation files indicated in two of the files the detainee victim was removed and immediately taken to medical for an emergency medical assessment; however, in a review of

the two remaining investigative files, the Auditor could not confirm staff took immediate measures to protect the detainee.

Corrective Action:

The facility is not in compliance with this standard. A review of four sexual abuse allegation investigation files indicated, in two of the files, the detainee victim was removed and immediately taken to medical for an emergency medical assessment; however, in a review of the two remaining investigative files, the Auditor could not confirm staff took immediate measures to protect the detainee. To become compliant, the facility must submit documentation which confirms all applicable staff have received training on standard 115.62 which requires when staff learns a detainee is the subject to substantial risk of imminent sexual abuse, immediate action is taken to protect the detainee. In addition, if applicable, the facility must submit all closed sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action Taken:

The facility submitted Training Sign-In Sheets and a training curriculum. The Auditor reviewed the staff sign-in sheets and curriculum and confirmed staff have received refresher training on Standard 115.62 which states, "When staff learn a detainee is at substantial risk of imminent sexual abuse, immediate action must be taken to protect the detainee." The facility submitted an Incident Report for an allegation reported on 4/12/2025. The Auditor reviewed the report and confirmed the facility relocated the alleged abuser to ensure separation of the detainees. In addition, the facility submitted the housing history of the abuser which confirms he had been relocated to another housing unit after the allegation had been reported. The facility submitted a memorandum which states, "Please be advised that with the exception of the previously submitted allegation of sexual abuse, there have been no other allegations of sexual abuse reported at the facility during the CAP period." Upon review of all submitted documentation the Auditor finds the facility in compliance with standard 115.62.

§115.67 - Agency protection against retaliation.

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

Notes:

(a)(b)(c): Agency policy 11062.2 states, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." CoreCivic policy 14-2-DHS states, "Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least ninety (90) days following a report of sexual abuse, the 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. Items the facility should monitor include detainee disciplinary reports, housing or program changes, or negative performance reviews, or reassignments of staff. The facility shall continue such monitoring beyond ninety (90) days if the initial monitoring indicates continuing need. The PSA Compliance Manager shall ensure that thirty/sixty/ninety (30/60/90) day retaliation monitoring is conducted by the designated staff, following a report of sexual abuse, to protect against potential retaliation against detainees or employees. This shall include periodic status checks of detainees and review of relevant documentation. Monitoring is documented on the 14-2D DHS PREA Retaliation Monitoring Report (30/60/90) form." The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not had an instance where monitoring for retaliation occurred for at least 90 days during the audit period. This is due to detainees' release." The Auditor reviewed the PREA Retaliation Monitoring Report (30/60/90) and confirmed staff monitoring retaliation are required to monitor detainee disciplinary reports, housing, and program changes and for staff monitoring will include the review of any reassignments or negative performance reviews. In an interview with the PSA Compliance Manager, it was indicated the facility has designated a retaliation monitor for detainee and a retaliation monitor for staff and monitoring would be

completed at 30, 60, and 90 days and longer if needed. In an interview with the PSA Compliance Manager, it was further indicated the monitoring would consist of meeting with the detainee, reviewing disciplinary reports, detainee housing, and any programming changes which may have occurred and for staff reviewing any negative reviews or reassignments which may have occurred because of reporting an allegation of sexual abuse or cooperating in a sexual abuse allegation investigation. During an interview with a Retaliation Monitor the interview was not completed due to unforeseen circumstances; and therefore, compliance could not be determined based on an interview. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed each investigation file included the PREA Retaliation Monitoring Report (30/60/90); indicating the detainee victims had been monitored for retaliation up to their release from the facility custody; however, the review indicated the Retaliation Monitor did not begin monitoring the detainees until 30 days following the allegation of sexual abuse.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed each investigation file included the PREA Retaliation Monitoring Report (30/60/90); indicating the detainee victims had been monitored for retaliation up to their release from facility custody; however, the review confirmed the Retaliation Monitor did not begin monitoring the detainees until 30 days following the allegation of sexual abuse. To become compliant, the facility must implement a practice which ensures retaliation monitoring begins immediately following an allegation of sexual abuse. Once implemented the facility must submit documentation which confirms all applicable staff, to include staff responsible for monitoring both detainees and staff, have received training on the implemented practice. In addition, the facility must submit all sexual abuse allegations, and the corresponding monitoring documentation, which occur during the CAP period to confirm monitoring of both detainees and/or staff begins immediately upon receipt of the allegation.

Corrective Action Taken:

(c): The facility submitted a training curriculum and Training Sign-In Sheets, dated January 29, 2025, and March 25, 2025. The Auditor reviewed the curriculum and sign-in sheets and confirmed all applicable staff responsible for retaliation monitoring have received training on monitoring begins as soon as a report of sexual abuse is made or when cooperation with an investigation begins. The facility submitted an Incident Report for an allegation reported on 4/12/2025 and the corresponding Retaliation Monitoring Report. The Auditor reviewed the Incident Report and the corresponding Retaliation Monitoring Report and confirmed the facility's retaliation monitor met with the detainee victim immediately after reporting the allegation. The facility submitted a memorandum which states, "Please be advised that with the exception of the previously submitted incident, there have been no other allegations of sexual abuse reported at the facility during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d): CoreCivic policy 14-2-DHS states, "The facility shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. Detainee victims shall not be held for longer than five (5) days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee. 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 re-assessment taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." Policy 14-2 DHS further states, "Facilities shall notify the appropriate ICE Field Office Director no later than seventy-two (72) hours after the initial placement into segregation, whenever a detainee has been placed in segregation on the basis of a vulnerability to sexual abuse or assault." The Auditor reviewed a memorandum to the file which states,

"Cibola County Correctional Center had not had an instance where segregated housing was used to protect a detainee victim of sexual abuse. If a detainee victim was held in segregation housing for 72 hours, the appropriate Filed Officer Director would be notified." An interview with the PSA Compliance Manager indicated detainee victims of sexual abuse would only be placed in administrative segregation if there were no other options available. An interview with the PSA Compliance Manager further indicated the facility had recently placed a detainee victim of sexual abuse into administrative segregation for less than 24 hours. The Auditor reviewed the detainee victim's Confinement Record and Administrative Segregation Order and confirmed the detainee victim had been placed in Administrative Segregation Involuntary PREA Placement as there were no other options except to place the detainee into administrative segregation as other units were under a quarantine order. The Auditor's review of the detainee victim's Confinement Record and Administrative Segregation Order further confirmed the detainee was to be given access to all programming. In addition, a review of the detainee victim's Confinement Record and Administrative Segregation Order confirmed within 24 hours the quarantine order had been lifted, and the detainee was released from segregation on October 10, 2024. During the on-site audit, the Auditor requested to review a copy of the detainee's re-assessment prior to returning the detainee to population and confirmed the re-assessment was completed after being requested by the Auditor and not prior to releasing the detainee to general population.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. During the on-site audit, the facility placed a detainee in protective custody due to being a victim of sexual abuse for a period of 24 hours. The Auditor requested to review a copy of the detainee's re-assessment prior to returning the detainee to general population and confirmed the re-assessment was completed after being requested by the Auditor and not prior to releasing the detainee to general population. To become compliant, the facility shall submit documentation which confirms all applicable staff have received training on the standard's requirement to re-assess a detainee who is placed in protective custody due to being a victim of sexual abuse prior to being release to general population. If applicable, the facility must submit the files of all detainees placed in protective custody during the CAP period due to being a victim of sexual abuse to confirm compliance with subsection (c) of the standard.

Corrective Action Taken:

(c): The facility submitted a memorandum to all staff and staff training rosters. The Auditor reviewed the memo and staff training rosters and confirmed all applicable staff have received training on the standard's requirement to reassess a detainee who is placed in protective custody due to being a victim of sexual abuse prior to being released to the general population. The facility submitted a memorandum which states, "Please be advised that with the exception of the previously submitted incident, there have been no detainees placed in protective custody due to being a victim of sexual abuse during the CAP period." 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; compiles in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(e)(f): CoreCivic policy 14-2-DHS states, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators." CoreCivic policy 14-2-DHS further states, "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate." CoreCivic policy 14-2-DHS further states, "Administrative investigations will include:

Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment and investigation facts and findings; and Retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years." CoreCivic policy 14-2-DHS further states, "Discussions with ICE and local law enforcement should articulate a delineation of roles of the facility investigator and the law enforcement investigator to coordinate and sequence administrative and criminal investigations, to ensure that the criminal investigation is not compromised by an internal administrative investigation." An interview with the PSA Compliance Manager and the facility Investigator indicated all allegations of sexual abuse are immediately reported to the Joint Intake Center, the ICE Office of Professional Responsibility, the ICE Field Office Director/designee, and if the allegation involved criminal behavior the facility would notify the MPD. If the MPD investigates an allegation in the facility, the PSA Compliance Manager and the Investigator would keep in contact with the MPD to remain informed and would begin an administrative investigation, as soon as MPD, and ICE, notify the facility, they can proceed. In an interview with the facility Investigator, it was indicated the administrative investigation would be prompt, thorough, and objective and would be completed even if the detainee victim or the perpetrator is no longer housed or employed at the facility. Interviews with the facility PSA Compliance Manager and the facility Investigator indicated investigators are required to receive specialized training prior to conducting administration investigations into allegations of sexual abuse. The Auditor reviewed four sexual abuse allegation investigation files and confirmed all four investigations had been completed by a facility Investigator no longer assigned to the role. The Auditor reviewed the training certificate of the prior facility Investigator and confirmed the prior facility Investigator received specialized training through the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting. The Auditor reviewed the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting training curriculum and confirmed the curriculum contains all elements required by subsection (a) the standard. In addition, the Auditor reviewed the training certificate of the current facility Investigator and confirmed the current facility Investigator has received specialized training through the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews.

Corrective Action:

The facility is not in compliance with subsections (a), (c), and (e) of the standard. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee

victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews. To become compliant, the facility must submit documentation to confirm the current facility Investigator has been trained on standard 115.71 and CoreCivic policy 14-2-DHS which require all investigations into allegations of sexual abuse be prompt, thorough and objective. In addition, the facility must submit documentation which confirms the current facility Investigator has been trained on the provisions of standard 115.71 and CoreCivic policy 14-2-DHS which includes the preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment and investigation facts and findings; and retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years. In addition, the facility must submit all sexual abuse allegation investigation files closed by the Agency during the CAP period.

Corrective Action Taken:

(a)(c)(e): The facility submitted the CoreCivic New Investigator Training curriculum. The Auditor reviewed the curriculum and confirmed the curriculum includes all investigations into allegations of sexual abuse be prompt, thorough and objective. A review of the curriculum further confirms the curriculum includes the preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment and investigation facts and findings; and retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years. The facility submitted a Training Sign-In Sheet, dated March 20, 2025, confirming the facility Investigator has received the required training. The facility submitted a memorandum which states, “Please be advised that there have been no sexual abuse allegation investigations files closed by the Agency during the CAP period.” Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (c), and (e) of the standard.

§115.72 - Evidentiary standard for administrative investigations.

Outcome: Meets Standard (substantial compliance; compiles 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." Policy 14-2 DHS states, "When an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse and assault are Substantiated." An interview with the facility PREA Investigator indicated the facility will not impose a standard higher than a preponderance of evidence when determining whether allegations of sexual abuse are substantiated. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was

determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews.

Corrective Action:

The facility does not meet standard 115.72. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews. To become compliant the facility must submit documentation which confirms the current facility Investigator has received training on standard 115.72 and CoreCivic policy 14-2-DHS which require when an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse and assault are substantiated.

Corrective Action Taken:

The facility submitted the CoreCivic New Investigator Training curriculum. The Auditor reviewed the curriculum and confirmed it includes "The Agency shall impose no standard higher than a preponderance of evidence in determining whether allegations of sexual abuse are substantiated." The facility submitted a Training Sign-In Sheet, dated March 20, 2025, confirming the facility Investigator has completed the required training. Upon review of all submitted documentation the Auditor now finds the facility in compliance with standard 115.72.

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

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

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "If screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, 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. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than seventy-two (72) hours after the referral." An interview with an Intake Officer indicated each detainee is assessed for risk of victimization and abusiveness; however, she could not articulate the circumstances which would require an immediate referral to a qualified medical or mental health indicating referrals to medical and mental health are completed by medical during the medical assessment. Interviews with the PSA Compliance Manager and the MHC indicated if a detainee identifies as having previously experienced sexual abuse or previously perpetrated sexual abuse against a child or an adult, a referral is immediately made to mental health by Intake staff. Interviews with the PSA

Compliance Manager and the MHC further indicated intake staff will complete the SAAPI Medical and Mental Health Referral form and the referral, and initial risk assessment, are emailed to medical and mental health staff. During the on-site audit, the Auditor requested the MHC provide the Auditor with a sample of the email, SAAPI Medical and Mental Health Referral form, and the assessment, which he receives, and the Auditor was provided a sample received earlier in the day. The Auditor reviewed the sample email and confirmed the email was from the Intake Officer previously interviewed by the Auditor. An interview with the PSA Compliance Manager indicated the electronic system would flag the detainee file with an alert if they scored as a victim or a predator on the initial risk assessment. The alerts will indicate a P if the detainee is identified as a perpetrator, an PV if the detainee is identified as a potential victim, and a V if the detainee is identified as victim. An interview with the PSA Compliance Manager further indicated PREA Alert Rosters are exported and sent daily to medical and mental health staff. An interview with the MHC indicated he reviews the rosters and if the review determines there are detainees who need to be referred to medical or mental health for assessments, either medical or mental health staff will create an order (referral) within Allscripts, which is the medical and mental health electronic management system. Based on the order, medical staff will conduct a medical assessment of the detainee within two days and mental health staff will conduct a mental health evaluation within 14 days. Utilizing the PREA Alert Rosters the Auditor attempted to review medical and mental health files of those detainees who had been identified as a victim or an abuser. The Auditor reviewed four detainees' medical and mental health files who were identified on the roster as previous victims of sexual abuse, and confirmed in two of the files the medical and mental health assessment notes were completed by the facility where the detainee had been previously housed and no evaluations were completed based on the initial risk assessment conducted during the detainee's intake into CCCC; and two medical and mental health files confirmed both detainees had received a medical assessment within 2 days of the initial risk assessment, however, neither of the mental health assessments had been completed within 72 hours of the initial risk assessment. The Auditor reviewed three additional medical and mental health files which included detainees who were identified on the rosters as sexual abuse aggressors and confirmed all three files indicated medical and mental health assessments had been completed by the facility where the detainees were previously housed and not based on the initial assessment from CCCC; and in one file the medical assessment had been completed within two days of the initial assessment, however, the mental health assessment had not been completed within 72 hours of the initial assessment. In an interview with a detainee who arrived at the facility during the on-site audit, it was indicated he had reported previous sexual abuse during his initial risk assessment; however, the facility had not offered him a mental health evaluation although he did want to talk with mental health. The Auditor requested the facility provide the Auditor with the detainee's initial risk assessment, and the medical and mental health referral completed during the detainee's intake into the facility and confirmed the initial risk assessment indicated it had been completed on October 23, 2024; however, the SAAPI Medical and Mental Health Referral had been completed on October 24, 2024, following the Auditor's request for the documents.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (c) of the standard. An interview with the MHC indicated he reviews the rosters and if the review determines there are detainees who need to be referred to medical or mental health for assessments, either medical or mental health staff will create an order (referral) within Allscripts, which is the medical and mental health electronic management system. Based on the order, medical staff will conduct a medical assessment of the detainee within two days and mental health staff will conduct a mental health evaluation within 14 days. Utilizing the PREA Alert Rosters the Auditor attempted to review medical and mental health files of those detainees who had been identified as a victim or an abuser. The Auditor reviewed four detainees' medical and mental health files who were identified on the roster as previous victims of sexual abuse, and confirmed in two of the files the medical and mental health assessment notes were completed by the facility where the detainee had been previously housed and no evaluations were completed based on the initial risk assessment conducted during the detainee's intake into CCCC; and two medical and mental health files confirmed both detainees had received a medical assessment within 2 days of the initial risk assessment, however, neither of the mental health assessments had been completed within 72 hours of the initial

risk assessment. The Auditor reviewed the medical and mental health files of three detainees who were identified on the rosters as sexual abuse aggressors and confirmed the files indicated medical and mental health assessments had been completed by the facility where the detainees were previously housed and not based on the initial assessment from CCCC; and in one file the medical assessment had been completed within two days of the initial assessment, however, the mental health assessment had not been completed within 72 hours of the initial assessment. In an interview with a detainee who arrived at the facility during the on-site audit, it was indicated he had reported previous sexual abuse during his initial risk assessment; however, the facility had not offered him a mental health evaluation although he did want to talk with mental health. The Auditor requested the facility provide the Auditor with the detainee's initial risk assessment, and the medical and mental health referral completed during the detainee's intake into the facility and confirmed the initial risk assessment indicated it had been completed on October 23, 2024; however, the SAAPI Medical and Mental Health Referral had been completed on October 24, 2024, following the Auditor's request for the documents. To become compliant, the facility must submit documentation which confirms all applicable staff, to include Intake, medical, and mental health have received training on subsections (a), (b) and (c) of standard 115.81 which requires an immediate referral to medical and mental health staff if the detainee risk assessment pursuant to §115.41 indicates the detainee has experienced sexual victimization or has previously perpetrated sexual abuse. In addition, the facility, if applicable, must submit the files of 15 detainees, and corresponding medical and mental health records, who during the CCCC initial risk assessment were identified as likely to be a victim of sexual abuse or perpetrated sexual abuse to confirm compliance with standard 115.81.

Corrective Action Taken:

(a)(b)(c): The facility submitted a training curriculum memorandum. The Auditor reviewed the training memorandum and confirmed the curriculum included training on subsections (a), (b) and (c) of standard 115.81 which requires an immediate referral to medical and mental health staff if the detainee risk assessment pursuant to §115.41 indicates the detainee has experienced sexual victimization or has previously perpetrated sexual abuse." In addition, the Auditor reviewed the submitted Training Sign-In Sheets and confirmed 110 staff, including but not limited to the Intake staff, Classification staff, DOs, and medical staff, have completed the required training. The facility submitted the files of 10 detainees who identified as likely to be victims of sexual abuse or to have perpetrated sexual abuse with the corresponding risk assessment and mental health records. The Auditor reviewed the submitted files and confirmed, except for one file, each detainee had been immediately referred to medical/mental health based on the initial risk assessment and was seen by mental health within 72 hours of the referral. Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), and (c) of the standard.

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

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

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, "Detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." An interview with the HSA indicated if a detainee victim needed emergency medical treatment, they would be transported to the Cibola General Hospital and then transported to the Albuquerque Family Advocacy Center for a SANE Exam. An interview with the HSA further indicated the detainee victim would have unimpeded access to emergency medical treatment and crisis intervention services, free of charge, to include emergency contraceptives and sexually transmitted infections prophylaxis, according to professionally accepted standards of care and the detainee victim is not required to name the abuser or cooperate with an investigation to receive the required care. An interview with the Executive Director of the Albuquerque SANE Collaborative, confirmed all detainee victims of sexual abuse would be offered tests for sexually transmitted infections and provided infections prophylaxis and emergency contraceptives, at no cost to the detainee regardless

of the detainee naming his abuser or cooperating with an investigation. The Auditor reviewed four sexual abuse allegation investigation files and the corresponding medical file for each detainee and confirmed three of the detainee victims who reported an allegation of sexual abuse were immediately taken to medical and seen by medical and mental health staff at the time the allegation was reported; however, neither of the three required a SANE exam. A review of one sexual abuse allegation investigation file confirmed following an incident of sexual abuse the facility neglected to take the alleged victim to medical; and therefore, the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required by subsection (a) of the standard. During the on-site audit, the Auditor's observations, and informal interviews with staff, confirmed the facility does not house female detainees.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. A review of one sexual abuse allegation investigation file confirmed following an incident of sexual abuse the facility neglected to take the alleged victim to medical; and therefore, the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required by subsection (a) of the standard. To become compliant the facility must submit documentation to confirm all applicable staff to include, but not limited to, security supervisors and the facility Investigator have received training on the standard's requirement to offer timely, unimpeded access to emergency medical treatment and crisis intervention services. In addition, the facility must submit all sexual abuse allegation investigation files closed during the CAP period.

Corrective Action Taken:

(a): The facility submitted Shift Supervisor, Medical/Mental Health, and Supervisor meeting notes which occurred in January 2025. The Auditor reviewed the notes and confirmed the training included medical evaluations will be completed on sexual abuse victims after an allegation of sexual abuse to determine, if necessary, follow-up treatment and follow-up is needed. The facility submitted Training Sign-In Sheets, dated January 29, 2025. The Auditor reviewed the sign-in sheets and confirmed all supervisors, the facility Investigator, Medical, and Mental Health staff have received training on the standard requirements. The facility submitted a memorandum which states, “Please be advised that there have been no sexual abuse allegation investigations files closed by the Agency during the CAP period.” Upon review of all submitted documentation the Auditor now finds the facility in substantial 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; compiles in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c)(d)(e)(f): Policy 14-2 DHS states, "The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. The facility shall provide victims with medical and mental health services consistent with the community level of care. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate." CoreCivic policy 14-2-DHS further states, "All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall provide such victims with medical and mental health services consistent with the community level of care." An interview with the HSA indicated a detainee victim of sexual abuse would receive timely emergency access to medical and mental health treatment, at no cost to the detainee, and regardless of the

detainee victim naming his abuser. Interviews with the HSA and the Mental Health Coordinator indicated that all treatment received at the facility is consistent, if not better, than the community level of care. A detainee victim would be offered a medical and mental health evaluation and if needed, the evaluation and treatment would include follow-up services, treatment plans, and referrals for continued care. If a sexual assault were to occur at the facility, the detainee victim would be transported to the Cibola General Hospital, for emergency medical treatment, and once stable would be transferred to the Albuquerque Family Advocacy Center, for a SANE exam. An interview with the Executive Director or the Albuquerque SANE Collaborative, confirmed all detainee victims of sexual abuse are offered tests for sexually transmitted infections, at no cost to the detainee. During the on-site audit, Auditor observations and informal interviews with staff, confirmed that the facility does not house female detainees, and the Auditor did not observe a transgender male detainee housed at the facility; therefore, subsection (d) of this standard is not applicable. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files, and the corresponding medical files, and confirmed three of the detainee victims who reported an allegation of sexual abuse were immediately taken to medical and seen by medical and mental health staff at the time the allegation was reported; however, a review of one sexual abuse allegation investigation file confirmed the facility neglected to take the alleged victim to medical following an incident of sexual abuse; and therefore, the detainee was not offered a medical and/or mental health evaluation to determine any necessary treatment as deemed appropriate by medical and/or mental health staff.

(g): Policy 14-2 DHS states, "The facility shall attempt to conduct a mental health evaluation of all known Detainee-on-Detainee abusers within sixty (60) days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." An interview with the MHC indicated detainee perpetrators of sexual abuse would receive an evaluation immediately upon learning about the detainee's sexual abuse history and a treatment plan would be established if the abuser is willing to participate. The Auditor reviewed one substantiated detainee-on-detainee sexual abuse allegation investigation files however, the detainee perpetrator was released the day after the allegation had been made; and therefore, mental health did not conduct an evaluation.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the facility neglected to take the alleged victim to medical following an incident of sexual abuse; and therefore, the detainee was not offered a medical and/or mental health evaluation to determine any necessary treatment deemed appropriate by medical and/or mental health staff. The Auditor reviewed the single investigative file and determined that the detainee was not taken to medical for evaluation as required by subsection (a). To become compliant the facility must train all applicable to staff, including but not limited to all supervisory staff and the facility Investigator in the standard's requirement to offer a medical and/or mental health evaluation to all victims of sexual abuse to determine any necessary treatment as deemed appropriate by medical and/or mental health staff. In addition, the facility must submit all sexual abuse allegation investigation files closed during the CAP period.

Corrective Action Taken:

(a): The facility submitted Shift Supervisor, Medical/Mental Health and Supervisor meeting notes which occurred in January 2025. The Auditor reviewed the notes and confirmed the training included medical evaluations will be completed on sexual abuse victims after an allegation of sexual abuse to determine, if necessary, follow-up treatment and follow-up is needed. The facility submitted Training Sign-In Sheets, dated January 29, 2025. The Auditor reviewed the sign-in sheets and confirmed all supervisors, the facility Investigator, Medical, and Mental Health staff have received training on the standard requirements. The facility submitted a memorandum which states, "Please be advised that there have been no sexual abuse allegation investigations files closed by the Agency during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "The Facility Administrator will ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be Unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation. In addition to the Facility Administrator, the incident review team shall include upper-level facility management and the facility SART, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; and Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. All findings and recommendations for improvement will be documented on the 14-2F-DHS Sexual Abuse Incident Review Report. Completed 14-2F-DHS forms will be forwarded to the Facility Administrator, the facility PSA Compliance Manager, and the FSC PSA Coordinator. The facility shall implement the recommendations for improvement or shall document reasons for not doing so. The 14-2F-DHS Sexual Abuse Incident Review Report shall be forwarded to the FSC PSA Coordinator and the ICE Prevention of Sexual Assault (PSA) Coordinator through the local ICE Field Office. Each facility shall conduct an annual review of all sexual [sic] abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the Facility Administrator, FSC PSA Coordinator, and the ICE PSA Coordinator through the local ICE Field Office." Interviews with the PSA Compliance Manager and facility Investigator, both of which are members of the incident review team, indicated the facility has established a review team consisting of upper-level management and allows for input from custody staff, the facility Investigator, and medical and mental health practitioners. An interview with the facility Investigator indicated the facility review team would conduct a sexual abuse incident review 30 days after the conclusion of every administrative investigation, regardless of the outcome the investigation, utilizing the ICE Sexual Abuse or Assault Incident Review Form. The Auditor reviewed the ICE Sexual Abuse or Assault Incident Review Form and confirmed the form requires the facility consider if the incident was motivated by race, ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or motivated or otherwise caused by other group dynamics at the facility. The Auditor reviewed four sexual abuse allegation investigation files and confirmed three files did not include an incident review and one file had a review which was completed; however, not within 30 days of the conclusion of the investigation as required by the standard. In addition, a review of the one completed incident review could not confirm the report and the facility's response had been forwarded to the Agency PSA Coordinator. During the on-site audit, the Auditor reviewed the facility's 2024 Annual Audit Report Memo from the facility Warden and confirmed the report had been forwarded to the Field Office Director (FOD) and the Agency PSA Coordinator.

Corrective Action:

The Facility is not in compliance with subsection (a) of the standard. The Auditor reviewed four sexual abuse allegation investigation files and confirmed three files did not include an incident review and one file had a review which was completed; however, not within 30 days of the conclusion of the investigation as required by the standard. In addition, a review of the one completed incident review could not confirm the report and the facility's response had been forwarded to the Agency PSA Coordinator. To become compliant, the facility must submit documentation which confirms all applicable staff, to include the PSA Compliance Manager, have received training on subsection (a) of the standard which requires a sexual abuse incident review be conducted at the conclusion of every sexual abuse investigation, where the allegation was not determined to be unfounded,

prepare a written report within thirty (30) days of the conclusion of the investigation, and both the report and responses to be forwarded to the Agency PSA Coordinator. If applicable, the facility must submit all closed sexual abuse allegation investigation files, and the corresponding incident review, which occurred during the CAP period. In addition, the facility must submit documentation to confirm the four incident reviews, and responses, not submitted to the Agency PSA Coordinator noted during the on-site audit were ultimately submitted.

Corrective Action Taken:

(a): The facility submitted a training memorandum to all staff which reminds staff of the CoreCivic 14-2-DHS policy and DHS Standard 115.86 which requires a sexual abuse incident review be conducted at the conclusion of every sexual abuse investigation and where the allegation was not determined to be unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation, and both the report and responses to be forwarded to the Agency PSA Coordinator." The facility submitted training sign-in sheets. The Auditor reviewed the sign-in sheets and confirmed review team members, including the facility Investigator, have completed the required training. The facility submitted two Sexual Abuse or Assault Incident Review Reports. The Auditor reviewed the reports and confirmed the facility conducted an incident review within 30 days of the completion of the investigations. The facility submitted an email to confirm the Sexual Abuse or Assault Incident Review Reports had been sent to the Agency PSA Coordinator; however, the Auditor notes the allegation remains open with the Agency; and therefore, the facility must conduct a second incident review upon the Agency determining the outcome of the investigation. The facility submitted a memorandum which states, "Please be advised that there have been no sexual abuse allegation investigations files closed by the Agency during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) 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 6/30/2025

Auditor's Signature & Date

(b) (6), (b) (7)(C) 7/2/2025

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 7/2/2025

Assistant Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	10/22/2024	**To:**	10/24/2024
AUDITOR INFORMATION			
Name of auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(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 #:**	(409) 866-(b) (6), (b
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	El Paso		
Field Office Director:	Mary De Anda-Ybarra		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	11541 Montana Ave., Suite E El Paso, TX 79936		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Cibola County Correctional Center		
Physical address:	2000 Cibola Loop Milan, New Mexico 87021		
Telephone number:	505-285-4900		
Facility type:	Intergovernmental Service Agreement		
PREA Incorporation Date:	10/27/2016		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer In Charge (OIC)
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	505-285-(b) (6), (b
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	505-285-(b) (6), (b

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

Directions: Discuss the audit process to include the date of the audit, names of all individuals in attendance, audit methodology, description of the sampling of staff and detainees interviewed, description of the areas of the facility toured, and a summary of facility characteristics.

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Cibola County Correctional Center (CCCC) was conducted October 22, 2024 – October 24, 2024, by U.S. Department of Justice (DOJ) and Department of Homeland Security (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 the U.S. Immigration and Custom Enforcement (ICE) PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C); both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR) External Reviews and Analysis Unit (ERAU), during the audit report review process. The purpose of the audit was to determine the facility compliance with the DHS PREA standards. CoreCivic operates the facility under contract with DHS ICE Office of Enforcement and Removal Operations (ERO). CCCC is in Milan, New Mexico. This is the third DHS PREA audit for CCCC, and it includes a review period between November 18, 2021 - October 24, 2024.

Approximately 30 days prior to the on-site audit, the ERAU Inspections and Compliance Specialist (ICS) Team Lead (TL), (b) (6), (b) (7)(C), provided the Auditor with the Agency policies, facility's policies, and other pertinent documents through the ICE Audit Management and Reporting System (AMRS). The Pre-Audit Questionnaire (PAQ), policies, and supporting documentation had been organized utilizing the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into exhibit folders within AMRS for ease of auditing. Prior to the on-site audit, the Auditor reviewed all documentation provided, the Agency website, and the CoreCivic/CCCC website. The main policy that governs CCCC's sexual abuse prevention, intervention, and response efforts is 14-2-DHS Sexual Abuse Prevention and Response in Immigration Detention Facilities.

An entrance briefing was held in the CCCC's conference room on Tuesday, October 22, 2024, at approximately 8:15 a.m. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) TL, ICS/ICE/OPR/ERAU
Robin Bruck, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC
(b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
(b) (6), (b) (7)(C), PSA Compliance Manager, CoreCivic/CCCC
(b) (6), (b) (7)(C), Warden, CoreCivic/CCCC

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

Immediately after the entrance briefing, the on-site audit was conducted by the Auditor, accompanied by key staff from CCCC, and staff from ICE ERAU. All areas of the facility where detainees are afforded the opportunity to go or provided services, were observed by the Auditor, which included the ICE detainee housing unit including all pods, booking/intake, library, recreation areas, and medical. In addition, the Auditor

observed the sally port and control centers. During the on-site audit, the Auditor made visual observations of bathrooms and shower areas, camera locations, and the number of staff assigned in all areas of the facility. The Auditor observed PREA information, predominately in English and Spanish, in all common areas of the facility and near the detainee telephones which included the DHS-prescribed sexual assault awareness notice, the Detention and Reporting Information Line (DRIL) poster, DHS Office of Inspector General (OIG) poster, the Rape Crisis Center of New Mexico (RCC) flyer, and information for contacting consular officials. In addition, the Auditor made visual observations of officer post sight lines, facility camera locations, and the potential for blind spots throughout the facility where detainees are housed or have access. There were no notable blind spots observed.

(b) (7)(E) [redacted]. During the on-site audit, the Auditor spoke informally to staff and detainees regarding PREA education and facility practices and confirmed both staff and detainees appeared to be knowledgeable of the Agency and the facility's zero tolerance policies and PREA in general. During the on-site audit, the Auditor further observed opposite gender announcements being made as opposite gender staff entered the housing areas. In addition, the Auditor observed the DHS-prescribed sexual assault awareness notice, methods for reporting sexual misconduct, and victim advocacy contact information, in English and Spanish, and the DHS PREA audit notification in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese posted in all common areas and housing units within the facility. During the on-site audit, the Auditor tested all detainee telephone numbers and confirmed successful calls were made to the DHS OIG, the DRIL, and the RCC of Central New Mexico.

CCCC's design capacity is 1129, with a current population of 735. The facility houses male detainees and male and female offenders for the U.S. Marshals Service and Cibola County. On the first day of the on-site audit, the facility housed 170 male detainees for ICE who are housed separately and do not interact with non-ICE detainees. During the on-site audit, there were no detainees housed in medical or in segregated housing. The facility PAQ indicates the top three nationalities processed through the facility are from Ecuador, Columbia, and the Dominic Republic. The average length of time in custody for ICE detainees is 38 days. The facility does not house juveniles or family units.

The Auditor interviewed 20 (17 Spanish, 1 French speaking, 2 English) detainees. Interviews with limited English proficient (LEP) detainees were conducted utilizing the services of Language Services Associates (LSA) provided by Creative Corrections, LLC. All detainees were interviewed utilizing the random detainee protocol. The facility reported there were no detainees with disabilities housed at the facility; however, during interviews, three of the detainees reported they were unable to read or write in any language; and therefore, these detainees were interviewed utilizing both the random detainee protocol and the disabled detainee protocol. In addition, two of the detainees reported prior sexual abuse during the initial risk assessment; and therefore, these detainees were interviewed with the random detainee protocol and the protocol for detainees who disclose sexual victimization during the initial risk assessment. All interviews were conducted in a private setting allowing confidentiality for those participating in the interview process.

A review of CCCC's PAQ indicated the facility employs 135 security staff, (67 males and 68 females), 37 medical staff and 2 mental health staff, who have recurring contact with detainees. In addition, to security staff, the remaining staff consists of administration, maintenance, and religious services. Transportation

services are provided through TransCor and there are several medical staff, contracted through Agency, who come into the facility on an as needed basis. There are seven ICE staff (6 Deportation Officers (DO)s and one SDDO) assigned to the facility. Security line staff and supervisors work in two shifts 0600-1800 and 1800-0600. Food services are provided by Trinity Food Service; however, detainees do not have contact with food service staff. The facility has not utilized the services of volunteers during the audit period. The Auditor conducted interviews of 18 staff members, utilizing interview protocols, which included the Warden, PSA Compliance Manager, Grievance Officer (GO), Investigator, Human Resource Manager (HRM), and Incident Review Team Member, the Mental Health Coordinator (MHC), the Health Services Administrator (HSA), an Intake Officer, the Training Manager, Retaliation Monitor, two Supervisors who conduct unannounced security inspections, a staff member who supervises detainees in segregation and 4 random Correctional Officers (COs).

The facility PAQ indicated the facility has one investigator who has received specialized training on sexual abuse and cross-agency coordination. The facility PREA Allegation Spreadsheet indicated four PREA allegations were closed during the audit review period. The Auditor reviewed all four investigations and confirmed all four investigations were detainee-on-detainee allegations, (three unsubstantiated and one substantiated) and none of the four investigative files were completed by the current facility Investigator.

An exit briefing was conducted on Thursday, October 24, 2024, at approximately 2:00 p.m. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C) TL, ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), Assistant Field Officer Director (AFOD), ICE/ERO, via telephone
(b) (6), (b) (7)(C), SDDO, ICE/ ERO
(b) (6), (b) (7)(C), PSA Compliance Manager, CoreCivic/CCCC
(b) (6), (b) (7)(C), Warden, CoreCivic/CCCC
(b) (6), (b) (7)(C) Mental Health Clinician, CoreCivic/CCCC
(b) (6), (b) (7)(C), Director PREA Compliance, CoreCivic Central Office
(b) (6), (b) (7)(C), Pro-re-nata (PRN), Contractor
(b) (6), (b) (7)(C), Quality Assurance Manager, CoreCivic/CCCC
Robin Bruck, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC

The Auditor spoke briefly and informed those present it was too early in the process to formalize a determination of compliance on each standard. The Auditor further advised she would review all documentation, interview notes, file review notes, and on-site observations to determine compliance. The Auditor thanked all facility staff for their cooperation in the audit process. The ICE ERAU TL explained the audit report process, timeframes for any corrective action imposed, and the timelines for 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 Met: 21

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator.
- §115.17 - Hiring and promotion decisions.
- §115.18 - Upgrades to facilities and technologies.
- §115.21 - Evidence protocols and forensic medical examinations.
- §115.32 - Other training.
- §115.34 - Specialized training: Investigations.
- §115.35 - Specialized training: Medical and mental health care.
- §115.51 - Detainee reporting.
- §115.52 - Grievances.
- §115.54 - Third-party reporting.
- §115.61 - Staff reporting duties.
- §115.63 - Reporting to other confinement facilities.
- §115.64 - Responder duties.
- §115.65 - Coordinated response.
- §115.66 - Protection of detainees from contact with alleged abusers.
- §115.73 - Reporting to detainees.
- §115.76 - Disciplinary sanctions for staff.
- §115.77 - Corrective action for contractors and volunteers.
- §115.78 - Disciplinary sanctions for detainees.
- §115.87 - Data collection.
- §115.201 - Scope of audits.

Number of Standards Not Met: 19

- §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.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.31 - Staff training.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.43 - Protective custody.
- §115.53 - Detainee access to outside confidential support services.
- §115.62 - Protection duties.
- §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.
- §115.81 - 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.

Number of Standards Not Applicable: 1

- §115.14 - Juvenile and family detainees.

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

Notes:

(c): CoreCivic policy 14-2-DHS states, "CoreCivic maintains a zero-tolerance policy for all forms of sexual abuse or assault." The policy includes definitions of sexual abuse and general PREA definitions. In addition, the policy outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment through; but not limited to, hiring practices, training, unannounced rounds, mandatory reporting, investigations, and support from victim advocates. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice posted in all common areas and on all detainee housing units. Informal and formal interviews with facility staff and detainees confirmed they were knowledgeable regarding Agency and facility zero tolerance policies. The Auditor reviewed emails from the facility to ICE ERO confirming CoreCivic policy 14-2-DHS has been submitted and approved by the Agency.

(d): CoreCivic Policy 14-2-DHS states, "Each CoreCivic facility shall designate a Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager) who shall serve as the facility point-of-contact for the local Immigration and Customs Enforcement (ICE) Field Office and the ICE PSA Coordinator. The PSA Compliance Manager must have sufficient time and authority to oversee facility efforts to comply with facility sexual abuse and assault prevention and intervention policies and procedures." An interview with the PSA Compliance Manager confirmed she has the knowledge, sufficient time, and authority to oversee the facility's efforts to comply with the sexual abuse prevention and intervention policies and procedures. An interview with the PSA Compliance Manager further confirmed she is the facility point of contact for both the Agency PSA Coordinator and the CoreCivic Corporate PREA Coordinator. The Auditor reviewed CCCC's organizational chart and confirmed the PSA Compliance Manager is in a position of authority to oversee the facility's efforts to comply with the facility sexual abuse prevention and intervention policies and procedures.

Corrective Action:

No corrective action needed.

§115.13 - Detainee supervision and monitoring.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "The CoreCivic Facility Support Center (FSC) will develop, in coordination with the facility, comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and shall review those guidelines at least annually. Each facility will ensure sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating staffing levels and determining the need for video monitoring, the following factors shall be taken into consideration: Generally accepted detention and correctional practices; Any judicial findings of inadequacy; All components of the facility's physical plant; The composition of the detainee population; The prevalence of Substantiated and Unsubstantiated incidents of sexual abuse; 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. Whenever necessary, but no less frequently than once each year, for each CoreCivic facility, an annual PREA Staffing Plan Assessment will be completed." A review of CCCC's PAQ indicated the facility employs 135 security staff, (67 males and 68 females), 37 medical staff and 2 mental health staff, who have recurring contact with detainees. In addition, to security staff, the remaining staff consists of administration, maintenance, and religious services. Transportation services are provided through TransCor, there are several medical staff, contracted through Agency, who come into the facility on an as needed basis, and there are seven ICE staff (six DOs and one SDDO) assigned to the facility. Security line staff and supervisors work in two shifts (b) (7)(E). Food services are provided by Trinity Food Service; however, detainees do not have contact with food service staff. The facility has not utilized the services of volunteers during the audit period. (b) (7)(E) (b) (7)(E) An interview with the facility Warden indicated the facility currently has adequate staffing to protect the detainees from sexual abuse. An interview with the PSA Compliance Manager indicated the staffing plan is reviewed annually utilizing an "Annual PREA Staffing Plan Assessment." The Auditor reviewed the 2022, 2023, and 2024 Annual PREA Staffing Plan Assessments and confirmed when determining adequate staffing levels and the need for video monitoring the facility takes into consideration all elements required by subsection (c) of the standard, which includes generally accepted detention and correctional practices; judicial findings of inadequacy; the physical layout of the 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; and other relevant factors, including but not limited to the length of time detainees spend in agency custody. During the on-site audit, the Auditor reviewed the facility comprehensive supervision guidelines and confirmed they are reviewed annually. In addition, during the on-site audit, the Auditor observed adequate staffing levels in all areas frequented by detainees within the facility.

(d): CoreCivic policy 14.2-DHS states, "Staff, including supervisors, shall conduct frequent unannounced security inspections rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds shall be documented in the applicable log (e.g., Administrative Duty Officer, post log, shift report, etc.) as "PREA Rounds". This practice shall be implemented on all shifts (to include night, as well as day) and in all areas where detainees are permitted. Employees shall be prohibited from alerting other employees that supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the facility." An interview with the facility PSA Compliance Manager indicated all facility supervisors on all shifts are required to complete unannounced security inspections in all areas of the facility. An interview with a night Shift Commander indicated unannounced PREA security inspections are conducted on every shift and in all areas of the facility. An interview with a night Shift Commander further indicated he documents his unannounced security inspections in red ink in the housing unit logbook; however, he does not go into all areas of the housing unit, or the different pods, going into only one pod a night and completing the round the following night in another pod; and therefore, unannounced security inspections throughout the facility are not completed in all pods of the housing unit until the end of the week during the night shift. An interview with a day Shift Commander indicated she conducts unannounced security inspections every day in all areas of the facility. In interviews with both the night Shift Commander and the day Shift Commander it was confirmed neither Shift Commander could articulate unannounced security inspections were occurring to identify and deter sexual abuse of detainees. During the on-site audit, the Auditor reviewed facility logbooks and confirmed unannounced PREA inspections were noted in red ink and appeared to be conducted on random days and shifts; however, the Auditor could not confirm unannounced security inspections were being conducted every day and every shift.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. An interview with a night Shift Commander confirmed unannounced security inspections rounds are documented in housing unit logbooks in red ink;

however, he completes only a weekly round of the entire facility; and therefore, the Auditor confirmed unannounced security inspections on the night shift were not being conducted in accordance with subsection (d) of the standard. In interviews with both a night Shift Commander and a day Shift Commander it was confirmed neither Shift Commander could articulate unannounced security inspections were occurring to identify and deter sexual abuse of detainees. During the on-site audit, the Auditor reviewed facility logbooks and confirmed unannounced security inspections were noted in red ink and appeared to be conducted on random days and shifts; however, the Auditor could not confirm unannounced security inspections were being conducted every day and every shift. To become compliant, the facility must train all security supervisors on the requirement to conduct unannounced security inspections every day, at irregular times, and on every shift in all areas where detainees are permitted to identify and deter sexual abuse from occurring in the facility. In addition, the facility must submit five days of housing unit logs from each shift which occur during the corrective action plan (CAP) period.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable

Notes:

(a)(b)(c)(d): CCCC does not house juveniles or family detainees. The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not held Juveniles or Families during the audit period. Contractually, we only house adult male detainees." Interviews with the Warden, PSA Compliance Manager, four random COs, and Auditor observations confirmed the facility does not house juvenile detainees or family detainees; and therefore, standard 115.14 is not applicable.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(b)(c)(d): CoreCivic policy 14-2-DHS states, "Whenever operationally feasible, staff conducting a search must be of the same gender, gender identity, or declared gender as the detainee being searched. Pat searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required, or, in exigent circumstances. Pat searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All cross-gender pat searches of detainees will be documented in a logbook including details of exigent circumstances." The Auditor reviewed the CoreCivic Search Procedure Facilitator Guide and confirmed the guide includes, "Cross-gender pat-down searches of male inmates/residents/detainees are permissible under PREA standards;" however, subsection (b) of the standard requires pat-down searches of male detainees by female staff not be conducted unless, after reasonable diligence, staff of the same gender are not available at the time the pat-down search is required, or, in exigent circumstances. An interview with the PSA Compliance Manager, and memo to Auditor, indicated staff at CCCC have not conducted a cross-gender pat-down search during the audit period; however, if there were exigent circumstances requiring a cross-gender pat-down search it would be documented. The Auditor interviewed four random COs (two male and two female) and confirmed two of the COs indicated cross-gender pat-searches of detainees are prohibited; however, one male CO confirmed he had witnessed a female officer conduct a pat-search on a male detainee at CCCC. An interview with a female CO confirmed she had conducted a pat-down search of a male detainee; however, there were male COs present, and she was only "helping out." An interview with a female CO further confirmed she did not document the cross-gender pat-down search. During the on-site audit, the Auditor reviewed the facility cross-gender pat-down search log and confirmed no entries had been made. The Auditor interviewed 20 detainees and confirmed a pat-down search of their person was conducted when they arrived at the facility and is conducted every time they leave the housing unit for recreation. In interviews with 20 detainees, it was further confirmed pat-down searches of 18 of the detainees were completed by a male officer; however, 2 detainees confirmed although most searches were conducted by staff of the same

gender, at one point, they were searched by staff of the opposite gender. During the on-site audit, the Auditor reviewed a video of a pat-down search of a detainee during the booking process and confirmed the pat-down search was conducted by staff of the same gender. In addition, the Auditor confirmed there were no female or transgender/intersex detainees housed at the facility during the on-site audit.

(e)(f): CoreCivic policy 14-2-DHS states, "Strip searches of detainees by staff of the opposite gender shall not be conducted except in exigent circumstances, or when performed by medical practitioners. Staff shall not conduct strip searches of juveniles. All such body cavity searches of juveniles shall be referred to a medical practitioner. An officer of the same gender as the detainee shall perform strip searches. In the case of an emergency, a staff member of the same gender as the detainee shall be present to observe a strip search performed by an officer of the opposite gender. When an officer of the opposite gender conducts a strip search which is observed by a staff member of the same gender as the detainee, staff shall document the reasons for the opposite gender search in any logs used to record searches and in the detainee's detention file. Body cavity searches will only be conducted by a medical professional and take place in an area that affords privacy from other detainees and from facility staff who are not involved in the search. Staff of the opposite gender, other than a designated qualified medical professional, shall not observe a body cavity search. All strip searches and visual body cavity searches shall be documented. If a strip search of any detainee does occur, the search shall be documented on the 5-1B Notice to Administration (NTA) (refer to CoreCivic Policy 5-1 Incident Reporting)." Interviews with the PSA Compliance Manager and four random COs indicated the facility does not conduct strip searches, cross-gender strip searches, visual body cavity searches, or cross-gender visual body cavity searches on the detainees; however, if these types of searches were to occur, they would be documented, to include the reason the search was needed. Interviews with 20 detainees confirmed they have not been subjected to a strip search, cross-gender strip search, visual body cavity search, or cross-gender visual body cavity search while housed at the facility. The facility does not house juvenile detainees.

(g): CoreCivic policy 14-2-DHS states, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement." CoreCivic policy 14-2-DHS further states, "Employees of the opposite gender must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing." CoreCivic policy 14-2-DHS further states, "All searches of transgender and intersex detainees shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and policy, including officer safety." During the on-site audit the Auditor observed all detainee housing units and confirmed in the housing units with individual cells the toilets are near the cell door which minimized incidental viewing when passing by. During the on-site audit the Auditor further observed the dormitory housing unit has individual toilets with a wall in between which provides privacy while performing bodily functions and the showers are single showers with privacy curtains and provide a space for the detainee to dress without being viewed by staff of the opposite gender. In addition, the Auditor observed the showers within the single cell dorms and confirmed they are single showers with doors. (b) (7)(E) [redacted]. In addition, during the on-site audit, the Auditor observed female staff consistently announcing their presence when entering the housing units. Interviews with 20 detainees confirmed they are provided adequate privacy and felt comfortable while showering or performing bodily functions. Interviews with 20 detainees further confirmed female staff will announce themselves every time they enter the pod, female staff will not enter the bathroom or shower area, and they are aware when female staff enter the housing unit.

(h): CCCC is not designated as Family Residential Centers; and therefore, subsection (h) is not applicable.

(i)(j): CoreCivic policy 14-2-DHS states, "The facility shall not search or physically examine a transgender or

intersex detainee for the sole purpose of determining the detainee's genital status. If the detainee's genital status is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner." CoreCivic policy 14-2-DHS further states, "In addition to the general training provided to all employees, security staff shall receive training in how to conduct cross-gender pat-down searches, and searches of transgender and intersex detainees, in a manner that is professional, respectful, and the least intrusive possible while being consistent with security needs." The Auditor reviewed the CoreCivic Search Procedure Facilitator Guide and confirmed the guide includes, "Cross-gender searches, and searches of transgender and intersex inmates, should be conducted professionally and respectfully, and in the least intrusive manner possible, consistent with security needs." An interview with the Training Manager indicated all custody staff are required to complete the Contraband Control and Cell Search training each year during in-service training which includes training on how to conduct a pat-down search. An interview with the Training Manager further indicated all newly hired staff must attend the Search Procedure class within a week or two of their employment with the facility. In addition, in an interview with the Training Manager it was indicated prior to 2024 training documentation was contained in each individual file; however, beginning 2024 all training is provided on-line, and each employee must acknowledge their understanding of the training prior to the on-line system updating from assigned training to completed training. The Auditor reviewed an In-service training report and confirmed between January 2024 and October 2024, 71 staff have completed the search training and between January 2024 and October 2024, 57 newly hired staff have completed the search training. In addition, a review of eight CO training files confirmed training on conducting pat-down searches had been completed on an annual basis. During the on-site audit, there were no transgender or intersex detainees housed at the facility.

Corrective Action:

The facility is not in compliance with subsections (b) and (d) of the standard. The Auditor reviewed the CoreCivic Search Procedure Facilitator Guide and confirmed the guide includes, "Cross-gender pat-down searches of male inmates/residents/detainees are permissible under PREA standards;" however, subsection (b) of the standard requires pat-down searches of male detainees by female staff 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. In an interview with a female CO, it was confirmed she had conducted a pat search of a male detainee although there were male COs present, and she did not document the cross-gender pat-down search as required by subsection (d) of the standard. In interviews with two detainees, it was confirmed although most pat-down searches are conducted by male COs at one point they were searched by a staff member of the opposite gender. To become compliant, the facility must update the CoreCivic Search Procedure Facilitator Guide to inform staff pat-down searches of male detainees by female staff are not to 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 and all cross-gender pat-down searches of detainees must be documented. Once updated, the facility must submit documentation to confirm all security staff have received training on the updated lesson plan. In addition, if applicable, the facility must provide the Auditor documentation to confirm any, and all, cross-gender pat-down searches which occur during the CAP period have been documented.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, " The facility shall ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. When necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, the facility shall attempt to accommodate the detainee by providing: Access to in-person, telephonic, or video interpretive services

that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary; Access to written materials related to sexual abuse in formats or through methods that ensure effective communication; and Auxiliary aids such as readers, materials in Braille (if available), audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters, and note-takers." CoreCivic policy 14-2-DHS further states, "The facility will provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated reasonable accommodations are made to ensure detainees receive notification, orientation, and instruction on the Agency's and facility's sexual abuse prevention and response, to include but not limited to, the use of a teletypewriters (TTY), Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs further indicated for detainees who have limited reading skills staff would read the information to the detainee or use the language line, or staff, to interpret the information should the detainee also be LEP. In addition, interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated if a detainee is blind, staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. During the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area and confirmed the video was available in English and Spanish and included American Sign Language (ASL); however, the facility did not have a transcript of the video to accommodate those detainees whose preferred language was other than English or Spanish. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. An interview with an Intake Officer indicated the ICE National Detainee Handbook and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlets are available on the facility computer system and could be printed in the most prevalent languages encountered by ICE, and other languages, should the need arise. During the on-site audit, the Auditor confirmed the ICE National Detainee Handbook was uploaded on the computer system in 17 most prevalent languages encountered by ICE to include English, Spanish, Arabic, Bengali, French, Haitian Creole, Hindi, K'iche' (Quiché)/Kxlantzij, Portuguese, Pulaar, Punjabi, Romanian, Russian, Simplified Chinese, Turkish, Vietnamese and Wolof and the DHS-prescribed SAA Information pamphlet was available in 15 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Ukrainian, and Vietnamese. During the on-site audit the Auditor further confirmed the ICE National Detainee Handbook, and the DHS-prescribed SAA Information pamphlet, in the above languages, are continuously available to all detainees on the detainee tablets. During the on-site audit, the Auditor further observed the CCCC Handbook Supplement available in English and Spanish. In an interview with the PSA Compliance Manager, it was indicated the facility can convert the handbook to the preferred language of any detainee; and therefore, the Auditor requested the facility to provide a copy of the CCCC Handbook Supplement in Russian which the facility provided within a short period of time. In addition, during the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet located in the audit binder available in English and Spanish and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abused; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet anywhere during the on-site audit. During the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day and the Auditor reviewed a video of the intake process. A review of the video confirmed copies of the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility Handbook Supplemental were on a rolling table taken to each holding cell and handed out to the incoming

detainees; however, the Auditor could not confirm if the information was distributed in a manner each detainee could understand. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability and neither of the detainees had the provided information read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed 18 detainees were LEP and the reading limitations of the two detainees who disclosed their limited reading skills were not documented. In addition, a review of 30 detainee files could not confirm detainees with disabilities, including, but not limited to, detainees who are LEP, deaf or hard of hearing, are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse.

(c): CoreCivic policy 14-2-DHS states, "Interpretation services shall be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." Interviews with four random COs confirmed they could utilize another detainee for interpretation if the detainee victim expressed a preference; however, they could not articulate the standard's requirement if such interpretation is appropriate and consistent with the DHS policy.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area and confirmed the video was available in English and Spanish and included American Sign Language (ASL); however, the facility did not have a transcript of the video to accommodate those detainees whose preferred language was other than English or Spanish or those who were deaf or hard of hearing. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. During the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet, available in English and Spanish, located in the audit binder and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abuse; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet anywhere during the on-site audit. In addition, during the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day and the Auditor reviewed a video of the intake process. A review of the intake video confirmed copies of the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility Handbook Supplemental were on a rolling table taken to each holding cell and handed out to the incoming detainees; however, the Auditor could not confirm if the information was distributed in a manner each detainee could understand. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was

confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability and neither of the detainees had the provided information read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed 18 detainees were LEP and the reading limitations of the three interviewed detainees were not documented. In addition, a review of 30 detainee files could not confirm detainees with disabilities, including, but not limited to, detainees who are LEP, deaf or hard of hearing, are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. To become compliant, the facility must develop and implement a process to ensure all detainees with disabilities, to include detainees who are LEP, deaf, or hard of hearing, blind or have low vision, have limited reading skills, or have an intellectual, psychiatric, or speech disability, have an equal opportunity to participate in or benefit from all aspects of the agency's and the facility's efforts to prevent, detect, and respond to sexual abuse. The implemented process must include all elements of subsections (a) and (b) of the standard, and CoreCivic policy 14-2-DHS, which requires all written materials related to sexual abuse are provided in formats or through methods which ensure effective communication with detainees who are LEP, have intellectual disabilities, limited reading skills, or who are blind or have low vision. Once implemented the facility must submit documentation which confirms all applicable staff, to include Intake staff, have received training on the implemented procedure. In addition, the facility must submit 10 detainee files, and corresponding documentation, to confirm effective communication was established, to include, if applicable, detainees whose preferred language is other than English or Spanish or have a disability to include detainees with limited reading skills, who have intellectual, psychiatric, or speech disabilities, who are blind or have low vision, or are deaf or hard of hearing.

The facility is not in compliance with subsection (c) of the standard. Interviews with four random COs confirmed they could utilize another detainee for interpretation if the detainee victim expressed a preference; however, they could not articulate the standard's requirement if such interpretation is appropriate and consistent with the DHS policy. To become compliant, the facility must submit documentation to confirm all applicable staff, including but not limited to facility Investigators, have received training in the requirements of subsection (c) of the standard and CoreCivic policy 14-2-DHS which requires in matters relating to allegations of sexual abuse, the agency and each facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy.

§115.17 - Hiring and promotion decisions.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): 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 service 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 6-7.0 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 September

2024, 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. CoreCivic policy 14-2-DHS states, "To the extent permitted by law, CoreCivic will decline to hire or promote any individual, and decline to enlist the services of any contractor or volunteer, who may have contact with detainees, who: has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity as outlined above. To the extent permitted by law, CoreCivic may decline to hire or promote and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information. All applicants, employees, and contractors who may have direct contact with detainees shall be asked about previous misconduct, as outlined above., in written applications or interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees." CoreCivic policy 14-2-DHS states, "Consistent with federal, state, and local law each CoreCivic facility shall make its best effort to contact all prior institutional employers for information on Substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse as defined by this policy. The 3-20-2B PREA Questionnaire for Prior Institutional Employers form shall be used to obtain such prior employment information." CoreCivic policy 14-2-DHS further states, "Unless prohibited by law, CoreCivic shall provide information on Substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." An interview with the HRM indicated the facility would not hire or promote any individual, and decline to enlist the services of any contractor or volunteer, who may have contact with detainees, who: has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in sexual misconduct, or hire or promote, and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information. An interview with the HRM further indicated all potential employees are required to complete an on-line application, interview, and an initial background check conducted by First Advantage and if a potential employee has indicated they have previous institutional employment, the facility will send the previous employer a Prison Rape Elimination Act (PREA) Questionnaire for Prior Institutional Employees form which inquiries about substantiated allegations involving the former employee. In addition, an interview with the HRM indicated if such a request is made of CCCC, the identical information would be provided and all employee contractors and staff seeking a promotion and employees transferring to CCCC, are required to complete a Self-Declaration of Sexual Abuse/Sexual Harassment form. An interview with the HRM further indicated current employees are required to complete a Self-Declaration of Sexual Abuse/Sexual Harassment form every year during In-Service training. The Auditor reviewed the Prison Rape Elimination Act (PREA) Questionnaire for Prior Institutional Employees form and confirmed the applicant, employee, or employee contractor is asked the following questions: have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; have you ever 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 when the victim did not consent or was unable to consent or refuse; have you ever been civilly or administratively adjudicated to have engaged in the activity described in paragraph (2) above; has a substantiated allegation of sexual harassment ever been made against you? The form contains a statement that includes, "You certify your understanding that if you provide false or fraudulent information you could be disqualified from further consideration for employment or, if falsity is discovered after you have become employed, terminated from employment." A review of the form further confirms the form includes "By my

signature below, I understand my continuing affirmative duty to disclose any facts that would change my answers above. I further understand that any material omissions regarding such misconduct, or the provision of materially false information, is grounds for termination or refusal to hire." The Auditor reviewed 17 staff files, which included 8 security staff, 2 administrative staff, 2 medical staff, and 5 contracted medical staff and confirmed each file contained the completed Self-Declaration of Sexual Abuse/Sexual Harassment form. A review of 17 staff files further confirmed three of the staff had been promoted during the audit period and a criminal history check and the Self-Declaration of Sexual Abuse/Sexual Harassment form had been completed prior to each promotion. In addition, utilizing the PSU Background Investigation for Employees and Contractors, the Auditor submitted 20 names, which included 8 security staff, 2 administrative staff, 2 medical staff, 5 contracted medical staff, and 3 ICE staff. The Auditor received confirmation of completed background checks, including those who required a five-year background; however, 12 names were noting "no record found" as staff were in the process of receiving ICE approval. In an interview with the PSA Compliance Manager, it was indicated each person was temporarily granted approval, through a completed background check with First Advantage, while completing the process. There was no ICE staff promoted during the Audit period. In an interview with the PSA Compliance Manager, it was confirmed the facility has not used the services of volunteers during the audit period.

Recommendation: The Auditor recommends the facility update Core Civic policy 14-2-DHS to include the facility's practice to not hire or promote any individual, and decline to enlist the services of any contractor or volunteer, who may have contact with detainees, who: has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in sexual misconduct, or hire or promote, and may terminate employment based on material omissions regarding such misconduct, or the provision of materially false information.

Corrective Action:

No corrective action needed.

§115.18 - Upgrades to facilities and technologies.

Outcome: Meets Standard

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, CoreCivic will consider the effect of the design, acquisition, expansion, or modification on the company's ability to protect detainees from sexual abuse. Such considerations shall be documented on 7-1B PREA Physical Plant Considerations form. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, CoreCivic will consider how such technology may enhance the ability to protect detainees from sexual abuse. Such considerations shall be documented on the 7-1B PREA Physical Plant Considerations form." The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not had any upgrades or modifications to the new or existing facilities during the audit period." Interviews with the Warden, the PSA Compliance Manager, and Auditor observations confirmed the facility has not designed, modified, acquired, or expanded upon new or existing space, or installed or updated electronic monitoring systems since the last PREA audit.

Corrective Action:

No corrective action needed.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Meets Standard

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." CoreCivic policy 14-2-DHS states, "The investigating entity shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developmentally appropriate for youth where applicable, and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic protocols developed after 2011. The investigating entity shall attempt to make available to the victim a victim advocate from a rape crisis center. The investigating entity may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a non-governmental entity that provides similar victim services. The investigating entity shall offer all victims of sexual abuse and assault access to forensic medical examinations, whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate and only with the detainee's consent. Such examinations shall be performed by a SAFE or SANE where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The investigating entity shall document its efforts to provide SAFEs or SANEs. If the agency listed above in section is not available to provide victim advocate services, the investigating entity may make available a qualified staff member from a community-based organization, or a qualified investigating entity staff member, to provide these services." CoreCivic policy 14-2-DHS further states, "As requested by the victim, either the victim advocate, a qualified investigating entity staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals." Interviews with the PSA Compliance Manager and the facility Investigator indicated criminal allegations would be investigated by the Milan Police Department (MPD) and administrative allegations would be investigated by the facility Investigator. The facility Investigator further indicated the facility utilizes a uniform evidence protocol which maximizes the potential for obtaining usable physical evidence. The Auditor reviewed a Memorandum of Understanding (MOU) between CoreCivic and the MPD, dated September 8, 2020, which confirmed the facility will report all criminal activity to the MPD who will conduct a criminal investigation of the allegations. The Auditor reviewed an MOU between CoreCivic and the Albuquerque SANE Collaborative, dated February 26, 2021, and confirmed the facility has established a method for a detainee to undergo a forensic medical examination by a qualified health care provider. In addition, the Auditor reviewed an MOU between CoreCivic and the Rape Crisis Center of Central New Mexico (RCC), dated August 1, 2019, and confirmed RCC agrees to provide a victim advocate, upon dispatch from Albuquerque SANE Collaborative, to accompany the victim to the forensic exam at the Albuquerque Family Advocacy Center and provide emotional support, throughout the forensic sexual assault medical examination process and investigatory interview. All three MOUs shall remain in effect until a thirty (30) day written cancellation notice from either party is received. The Auditor reviewed four detainee-on-detainee sexual abuse investigative files and confirmed none of the allegations required a SANE exam.

(e): An interview with the PSA Compliance Manager indicated the facility has an MOU with the MPD. The Auditor reviewed the MOU between CoreCivic and the MPD, dated September 8, 2020 and confirmed the MOU

does not include a request for the MPD to follow all requirement of PREA Standard §115.21 (a)–(d); however, during the on-site audit, the facility Warden requested the MPD to follow all requirements of PREA standard 115.21 (a) –(d) when investigating an allegation of sexual abuse which occurs within the facility; and therefore, the facility became compliant with subsection (d) of the standard during the on-site audit.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

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)." CoreCivic policy 14-2-DHS states, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators." CoreCivic policy 14-2-DHS further states, "All allegations of sexual abuse shall be promptly reported to a law enforcement agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior." In addition, the policy states, "When a detainee, of the facility in which an alleged detainee victim is housed, is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director/designee. When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director/designee, and to any local government entity or contractor that owns or operates the facility." CoreCivic policy 14-2-DHS further states, "Retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years." Interviews with the PSA Compliance Manager and the facility PREA Investigator indicated all allegations of sexual abuse involving penetration are reported to the MPD and an administrative investigation would be completed with the MPD's approval. During the on-site audit, the Auditor reviewed four sexual abuse allegation investigation files and confirmed notification had been made to the ICE ERO, ICE OPR, and the Joint Intake Center (JIC); however, only one of the allegations had been reported to the MPD despite the other allegations involved touching or contact of the detainee victim's body; and therefore, could be considered criminal in nature.

(c): The Auditor reviewed the Agency website (https://www.ice.gov/prea) and the CoreCivic website (https://www.corecivic.com), and confirmed both websites contain the respective protocols as required by subsection (c) of the standard.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. During the on-site audit, the Auditor reviewed four sexual abuse allegation investigation files and confirmed only one of the allegations had been reported to the MPD despite all four allegations having involved touching or contact of the detainee victim's body; and therefore, could be considered criminal in nature. To become compliant, the facility must implement a practice which ensures all allegations which involve potentially criminal behavior are promptly referred for investigation to an appropriate law enforcement agency with legal authority to conduct criminal investigations. Once implemented, the facility must submit documentation which confirms all applicable staff, to include but not limited to the facility Investigator, has received training on the implemented practice. In addition, if applicable, the facility, must provide all sexual abuse allegation investigation files occurring during the CAP period to confirm if the allegation was potentially criminal in nature the allegation was reported to the MPD.

§115.31 - Staff training.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all new employees and shall also be included in annual refresher/in-service training thereafter. (ACI 4-4084; ACI-4-4084-1; 4-ALDF-7B-08; 4-ALDF-7B-10; 4-ALDF-7B-10-1) Employee training shall ensure facility staff are able to fulfill their responsibilities under DHS standards, and shall include: the facility's zero-tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal sexual behavior; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee-victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities." Policy 14-2- DHS further states, "Employees shall be required to confirm, by either electronic or manual signature, their understanding of the received training. Signed documentation will be maintained in the employee's training file." The Auditor reviewed the CoreCivic PREA Overview curriculum and confirmed the training covers the required elements which include: the Agency and the facility's zero tolerance policies for all forms of sexual abuse; definitions and examples of prohibited and illegal behavior; the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting on prohibited and illegal behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees; procedures for reporting knowledge, suspicion of sexual abuse; 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 for law enforcement or investigative purposes. An interview with the Training Manager indicated all staff are required to complete PREA training on a yearly basis and if a staff member has not completed assigned training, an email is sent to the staff supervisor, to ensure they complete the training. Interviews with four random COs indicated they are required to complete PREA training on a yearly basis, and during In-Service training, and they are knowledgeable regarding PREA. The Auditor reviewed 17 staff files, which included 8 security staff, 2 administrative staff, 2 medical staff, and 5 staff contractor medical staff, and confirmed annual PREA training in 10 of the files; however, 4 staff hired in the year 2024 and 5 staff contractor medical staff had not received general PREA training. In addition, the Auditor reviewed three ICE staff training certificates for the years 2023 and 2024 and confirmed all three ICE staff had received the required PREA training.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. The Auditor reviewed 17 staff files and confirmed annual PREA training in 10 of the files; however, 4 staff hired in 2024 and 5 contracted medical staff had not received general PREA training as required by subsections (a) and (b) of the standard. To become compliant, the facility must submit documentation to confirm all staff, and staff contractors, who may have contact with detainees are trained in accordance with subsections (a) and (b) of the standard and CoreCivic policy 14-2-DHS. In addition, if applicable, the facility must submit documentation to confirm all existing staff, and staff contractors hired during the CAP period have received the required training.

§115.32 - Other training.

Outcome: Meets Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "The facility shall ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees shall be notified of the facility's zero-tolerance policy and informed how to report such incidents." CoreCivic policy 14-2-DHS further states, "Civilians/contractors/ volunteers shall be required to confirm, by either electronic or manual signature, their understanding of the received training. Signed documentation will be maintained in the civilian or contractor's file." The Auditor reviewed the facility PREA Overview: Training for Contractors and Volunteers curriculum and confirmed the training covers the required elements which include their responsibilities under the Agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures; the Agency's and facility's zero-tolerance policies regarding sexual abuse; and inform the how to report an incident of sexual abuse. The Auditor reviewed two "other" contractor files and confirmed neither contractor had received PREA training prior to entering the facility. An interview with the PSA Compliance Manager indicated all "other" contractors are escorted by security staff when they are in the facility; and therefore, do not have contact with detainees. During the on-site audit, the facility implemented a practice which requires a notation in the facility visiting log which confirms "other contractors" received a copy of "PRISON RAPE ELIMINATION ACT (PREA) Zero Tolerance Acknowledgment and signed the acknowledgement form confirming "on this date, I received and understand that Cibola County Correctional Center, maintains a zero tolerance policy in regards to sexual abuse and sexual harassment of individuals in an ICE Facility or Program and I have an obligation to report any form of sexual abuse and/or sexual harassment that I may witness or reported to me while conducting my professional duties inside the facility. I understand that I can report any sexual abuse and/or harassment allegations to any Cibola County Correctional Center staff member at this facility." In addition, the PSA Compliance Manager sent an email to all CCCC staff informing them of the additional verbiage on the sign-in sheet which states, "It is important that all staff, especially those interacting with contractors, are aware of this section and ensure that contractors understand it significance. Please advise contractors that if they "see something say something" and encourage them to read the statement at the bottom of the sign-in log." The facility provided the Auditor three compliant samples of completed daily sign-in logs; and therefore, the Auditor determined the facility came into compliance with standard 115.32 during the on-site audit. In interviews with the PSA Compliance Manager, HRM, and four random COs it was confirmed the facility has not utilized the services of volunteers during the audit period.

Corrective Action:

No corrective action needed.

§115.33 - Detainee education.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): CoreCivic policy 14-2-DHS states, "During the intake process, all detainees shall be notified of the facility zero tolerance policy on sexual abuse and assault. Detainees will be provided with information (orally and in writing) about the facility's SAAPI Program. Such information shall include, at a minimum: The facility's zero tolerance policy for all forms of sexual abuse or assault; Prevention and intervention strategies; Definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; Explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS/Office of Inspector General (OIG) and the ICE/Office of Professional Responsibility (OPR) investigation processes; Information about self-protection and indicators of sexual abuse and assault; Prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The facility shall post on all housing unit bulletin boards the following notices: The DHS-prescribed sexual abuse and assault awareness notice; The name of the facility PSA Compliance Manager; and Information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (toll-free hotline numbers where available). If no such local organizations exist, the facility shall make available the same information about national organizations." Policy 124-2-DHS further states, "The facility shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet." During the on-site audit, the Auditor observed the RCC of Central New Mexico flyer, in English and Spanish and the 2024 DHS-prescribed sexual assault awareness notice posted in all housing units and common areas of the facility; however, many of the 2024 DHS-prescribed sexual assault awareness notices did not have the name of the PSA Compliance Manager. The Auditor advised the facility and prior to the conclusion of the on-site audit, the facility had inserted the PSA Compliance Manager's name on all notices posted through-out the facility. Therefore, the Auditor determined the facility came into compliance with subsection (d) of the standard during the on-site audit. Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated reasonable accommodations are made to ensure detainees receive notification, orientation, and instruction on the Agency's and facility's sexual abuse prevention and response, to include but not limited to, the use of a teletypewriters (TTY), Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for detainees who are deaf or hard of hearing. Interviews with the PSA Compliance Manager, an Intake Officer, and four random COs further indicated for detainees who have limited reading skills staff would read the information to the detainee or use the language line, or staff, to interpret the information should the detainee also be LEP. In addition, interviews with the PSA Compliance Manager, an Intake Officer, and four random COs indicated if a detainee is blind, staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. An interview with an Intake Officer indicated the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlets are available on the facility computer system and could be printed in the most prevalent languages encountered by ICE, and other languages, should the need arise. During the on-site audit, the Auditor confirmed the ICE National Detainee Handbook was uploaded on the computer system in 17 most prevalent languages encountered by ICE to include English, Spanish, Arabic, Bengali, French, Haitian Creole, Hindi, K'iche' (Quiché)/Kxlantzij, Portuguese, Pulaar, Punjabi, Romanian, Russian, Simplified Chinese, Turkish, Vietnamese and Wolof and the DHS-prescribed SAA Information pamphlet was available in 15 languages, to include English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Ukrainian, and Vietnamese. The Auditor reviewed the ICE National Detainee Handbook and confirmed the handbook includes information about reporting sexual abuse. During the on-site audit, the Auditor further observed the CCCC Handbook Supplement available in English and Spanish. In an interview with the PSA Compliance Manager, it was indicated the facility can convert the handbook to the preferred language of any detainee; and therefore, the Auditor requested the facility to provide a copy of the CCCC Handbook Supplement in Russian which the facility provided within a short period of time. In addition, during the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area and confirmed the video was available in English and Spanish and included ASL; however, the facility did not have a transcript of the video to

accommodate those detainees whose preferred language was other than English or Spanish. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. During the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet located in the audit binder available in English and Spanish and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abuse; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet available to detainees during the on-site audit. An interview with the PSA Compliance Manager indicated detainees are asked to sign a SAAPI Education Acknowledgement and an Orientation Acknowledgement. The Auditor reviewed the acknowledgement and confirmed the acknowledgement requires the detainee sign to acknowledge he has received the "CoreCivic Zero Tolerance PREA Pamphlet, the ICE Sexual Assault Awareness Pamphlet, the ICE Detainee Facility Handbook, ICE National Handbook, and has watched the Video "PREA What you need to know" Zero Tolerance." In addition, a review of the acknowledgment confirms the acknowledgement includes whether the facility utilized the language line and in what language. The Auditor further reviewed the Unit Admission and Orientation Acknowledgement and confirmed the acknowledgement includes "I have been orientated in all areas above and have had an opportunity to discuss with orientation staff." During the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day and the Auditor reviewed a video of the intake process. A review of the video confirmed copies of the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the facility Handbook Supplemental were on a rolling table taken to each holding cell and handed out to the incoming detainees; however, the Auditor could not confirm if the detainee had signed either acknowledgment or if the information was distributed in a manner each detainee could understand. As per the PSA Compliance Manager, the detainee does not sign for the information until they meet with Classification staff at later date. In an interview with the Intake Officer, it was indicated she does not have the detainee sign the SAAPI Education Acknowledgement as the document is completed later by classification staff; however, she has the detainee sign the Receiving and Discharge checklist which includes a statement confirming the detainee received a handbook. The Auditor reviewed the Receiving and Discharge checklist and could not confirm if the handbook received was the ICE National Detainee Handbook or the facility Supplement to the Handbook nor could the Auditor confirm in what language the detainee received the handbook. A review of the Receiving and Discharge checklist further confirmed the checklist does not document the detainee participated in orientation during the intake process. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability and neither of the detainees had the provided information read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed each file contained the SAAPI Education Acknowledgement and the Unit Admission and Orientation Acknowledgement; however, all the acknowledgements had been signed and dated by the detainee, between three weeks and a month after the detainee arrived at the facility.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (c) of the standard. During the on-site audit, the Auditor observed a PREA Video, which is played for the detainees while in holding cells within the Intake area

and confirmed the video was available in English and Spanish and included ASL; however, the facility did not have a transcript of the video to accommodate those detainees whose preferred language was other than English or Spanish or those who were deaf or hard of hearing. Prior to the conclusion of the on-site audit, the facility had obtained a transcript of the video and confirmed they had the ability to convert the transcript into other languages; however, the Auditor could not confirm the facility established a practice to do so. During the on-site audit, the Auditor reviewed the CoreCivic Zero Tolerance PREA Pamphlet located in the audit binder available in English and Spanish and confirmed the pamphlet informs the detainee, he has a right to report sexual abuse, how to report, calls made to the RCC are not monitored or recorded, their right to be free from retaliation for reporting sexual abuse, definitions of sexual abuse, tips for avoiding sexual abuse and what to do if you have been sexually abused; however, the Auditor did not observe the CoreCivic Zero Tolerance PREA Pamphlet available to detainees during the on-site audit. In an interview with the Intake Officer, it was indicated she does not have the detainee sign the SAAPI Education Acknowledgement as the document is completed later by classification staff; however, she has the detainee sign the Receiving and Discharge checklist which includes a statement confirming the detainee received a handbook. The Auditor reviewed the Receiving and Discharge checklist and could not confirm if the handbook received was the ICE National Detainee Handbook or the facility Supplement to the Handbook nor could the Auditor confirm in what language the detainee received the handbook. A review of the Receiving and Discharge checklist further confirmed the checklist does not document the detainee participated in orientation during the intake process. The Auditor interviewed 20 detainees (17 Spanish, 1 French, 2 English) which had been randomly chosen from the detainee rosters and confirmed all were provided the PREA information in Spanish; however, Spanish was not the preferred language of 3 of the detainees (1 French and 2 English). In an interview with one detainee, it was confirmed his preferred language was French and he received all documentation, to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and the CCCC Handbook Supplement in Spanish. An interview with one detainee whose preferred language was French further confirmed he watched the orientation video in Spanish, and did not fully understand the video's content. In interviews with three detainees, although the facility reported there were no detainees with disabilities housed at the facility, it was confirmed none of the three detainees could read or write in any language. Interviews with three detainees further confirmed one of the detainees did not disclose this disability to the facility staff; however, two of the detainees both confirmed they informed staff of the disability and neither of the detainees had the provided information read to them. During the on-site audit, the Auditor reviewed 30 detainee files and confirmed each file contained the SAAPI Education Acknowledgement and the Unit Admission and Orientation Acknowledgement; however, all the acknowledgements had been signed and dated by the detainee, between three weeks and a month after the detainee arrived at the facility. To become compliant, the facility must develop and implement a process to ensure during the intake process, all detainees receive an orientation which notifies and informs detainees of all elements required by subsections (a) of the standard and CoreCivic policy 14-2-DHS. The process shall include the steps to be taken to provide all detainees notification, orientation, and instruction in formats accessible to all detainees, including those who are LEP, are deaf, or hard of hearing, blind or have low vision, have limited reading skills, or have an intellectual, psychiatric, or speech disability and the standards requirement to document the completion of orientation during the intake process. Once implemented the facility must submit documentation which confirms all applicable staff, to include staff assigned to intake and classification, have received training on the implemented procedure. The facility must submit 20 detainee files, which occur during the CAP period to include the intake date, documentation of the detainee participation in the intake process orientation, and documentation the orientation was delivered in a manner the detainee could understand. In addition, if applicable, the facility shall provide the Auditor five detainee files to include detainees whose preferred language is other than English or Spanish and, if applicable, five detainee files which include detainees who are deaf, or hard of hearing, blind or have low vision, have limited reading skills, or have an intellectual, psychiatric, or speech disability.

§115.34 - Specialized training: Investigations.

Outcome: Meets Standard

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, "The facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training covers, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process." The Auditor reviewed the facility PAQ and confirmed the facility employs one investigator who investigates allegations of sexual abuse. Interviews with the facility PSA Compliance Manager and the facility Investigator indicated investigators are required to receive specialized training prior to conducting administration investigations into allegations of sexual abuse. The Auditor reviewed the training certificate of the facility Investigator and confirmed the facility Investigator received specialized training through the National Institute of Corrections (NIC) Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting and had received the general PREA training as required by standard §115.31. The Auditor reviewed the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting training curriculum and confirmed the curriculum contains all elements required by subsection (a) the standard. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed all investigations were conducted by a previous facility Investigator who no longer is employed by the facility; however, the Auditor reviewed the training certificate of the previous facility Investigator and confirmed he had received the required specialized training through the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting training and the general PREA training as required by standard §115.31.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b): The Auditor reviewed a memorandum to the file which states, "CCCC does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners; and therefore, subsections (a) and (b) of the standard are not applicable.

(c): CoreCivic policy 14-2-DHS states, "In addition to the general training provided to all employees, all full and part-time Qualified Health Care Professionals and Qualified Mental Health Professionals, who work in the facility, shall receive specialized medical training as outlined below: How to detect and assess signs of sexual abuse; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to victims of sexual abuse; How and to whom to report allegations of sexual abuse; and How to preserve physical evidence of sexual abuse." An interview with the facility PSA Compliance Manager indicated all medical and contractor medical staff are required to complete the specialized PREA Medical and Mental Health course through the NIC. The Auditor reviewed the NIC PREA Medical and Mental Health training curriculum and confirmed the curriculum includes how to detect and assess signs of sexual abuse and assault, how to preserve physical evidence of sexual abuse and assault, how to respond effectively and professionally to victims of sexual abuse and assault, and how and to whom to report allegations or suspicions of sexual abuse and assault. The Auditor reviewed two medical and five contracted medical staff files and confirmed each file contained documentation of completion of the specialized PREA Medical and Mental Health training; however, CoreCivic policy requires the medical staff also complete general training provided to all employees who are full-time or part-time professionals, and a review of the files indicated none of the five contracted medical staff have received general training. The Auditor reviewed a 2023 Policy Document Review/Revision Request and an email string from the facility to ICE ERO confirming CoreCivic policy 14-2-DHS has been submitted and approved by the Agency.

Recommendation: The Auditor recommends all medical staff, to include both full and part-time contracted staff complete general training provided to all employees, as per standard 115.31 and CoreCivic policy 14-2-DHS.

Corrective Action:

No corrective action needed.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(f)(g): CoreCivic policy 14-2-DHS states, "All detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within twelve (12) hours of admission to the facility." CoreCivic policy 14-2-DHS further states, "The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated or detained; the nature of the detainee's criminal history; whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization; and the detainee's own concerns about his or her physical safety" and "the initial screening shall consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive." In addition, CoreCivic policy 14-2-DHS states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to items listed above in section" and "appropriate controls shall be implemented within the facility regarding the dissemination of responses to questions asked pursuant to screening for risk of victimization and abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees to the detainee's detriment." An interview with the PSA Compliance Manager indicated detainees are assessed to identify those likely to be sexual aggressors or sexual abuse victims utilizing the Assessment Questionnaire-Initial Screening Tool and the information gained from the assessment is contained in the detainee's electronic file in the facility Offender Management System (OMS); however, a review of the facility OMS during the on-site audit, confirmed the electronic system carries over alerts identified at previous CoreCivic facilities; and therefore, the Auditor could not confirm if during CCCC's initial detainee risk assessment, the information would update and/or change the posted alerts based on entry of CCCC's initial assessment. An interview with an Intake Officer indicated when detainees arrive at the facility, they are placed into holding cells and are provided a Cibola County Assessment Questionnaire Information form. An interview with an Intake officer further indicated the detainee will be taken out of the holding cell, one by one, to an office where the assessment will be conducted in private utilizing the paper version of the assessment handed to the detainee which will be added into the OMS system. In addition, an interview with an Intake Officer indicated if a detainee is LEP, Intake staff will utilize the facility language line or a staff interpreter to interpret the risk assessment questions and detainees are not disciplined for refusing to answer or for not giving complete answers to the questions. The Auditor reviewed the Sexual Abuse Screening Tool and confirmed the tool includes all required elements of subsections (c) and (d) of the standard. The Auditor reviewed the Cibola County Assessment Questionnaire Information and confirmed the paper version of the assessment contains the same questions as the Assessment Questionnaire-Initial Screening Tool; however, the Cibola County Assessment Questionnaire Information requires the reader circle a yes or no answer to the question, does not have a date or signature line, and each question on the assessment is in English and Spanish. During the on-site audit, the Auditor was not able to observe an intake of a detainee; however, detainees had arrived at the facility the previous day; and therefore, the Auditor was able to review a video of the intake process. A review of the video confirmed

a detainee had been taken into an office to conduct the initial risk assessment. During the on-site audit the Auditor requested the Intake Officer describe how information gained from the initial risk assessment is utilized to determine a detainee's initial housing and confirmed Intake staff are aware of the detainee's initial housing assignment prior to their arrival at the facility; and therefore, information gained from the initial risk assessment is not utilized to determine initial housing. An interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility is not utilizing all known information to inform housing so necessary steps can be taken to mitigate any such danger. An interview with the PSA Compliance Manager indicated the OMS system would flag the detainee file with an alert if they scored as a victim or a predator and will not allow the housing of the two detainees together; however, a review of the detainee files confirmed the alert occurs after the detainee had received his initial housing. The Auditor interviewed 20 detainees and confirmed 2 of the detainees interviewed were taken to the office where the initial risk assessment was conducted utilizing the language line; however, 18 of the detainees interviewed, to include 1 detainee who arrived the previous day, had been given the form with a pen, and advised to complete the initial risk assessment without staff assistance. During an interview with one detainee, it was further confirmed during his intake, other detainees did not understand the initial risk assessment questions; and therefore, he needed to explain the initial risk assessment to them so they could answer appropriately. In an interview with one detainee, it was confirmed he had not been asked whether he experienced prior sexual abuse by intake staff; however, he had been asked the questions during his medical assessment. The Auditor reviewed 30 detainee files, to include the file of the detainee who was not asked about previous sexual abuse, and confirmed each file contained the Cibola County Assessment Questionnaire Information and the Assessment Questionnaire-Initial Screening Tool and the initial assessment had been completed during the intake process and within twelve hours of intake; however, a review of the detainee's file who indicated he had not been asked about previous sexual abuse by Intake staff confirmed the detainee's initial risk assessment indicated he had responded "no", when asked if he had experienced previous sexual abuse; and therefore, the Auditor cannot confirm medical had shared the information with staff responsible to utilize the information gained from the initial risk assessment to determine to house detainees to prevent sexual abuse taking necessary steps to mitigate such danger. The Auditor reviewed 30 detainee files and confirmed each file contained the Cibola County Assessment Questionnaire Information and the Assessment Questionnaire-Initial Screening Tool and the initial assessment had been completed during the intake process and within twelve hours of intake.

(e): CoreCivic policy 14-2-DHS states, "The facility shall reassess each detainee's risk of victimization or abusiveness between sixty (60) and ninety (90) days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." An interview with the PSA Compliance Manager indicated all detainees risk of victimization and abusiveness is reassessed between 60 and 90 days after the initial assessment. The Auditor reviewed 30 detainee files and confirmed of the 15 files where a reassessment was required, 2 detainees were reassessed, 10 detainee files did not have documentation of a re-assessment, and 3 files indicated a re-assessment had been completed after 90 days. In addition, the Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed none of the detainees had been re-assessed following an incident of sexual abuse.

Corrective Action:

The facility is not in compliance with subsections (a) of the standard. During the on-site audit the Auditor requested the Intake Officer describe how information gained from the initial risk assessment is utilized to determine a detainee's initial housing and confirmed Intake staff are aware of the detainee's initial housing assignment prior to their arrival at the facility; and therefore, information gained from the initial risk assessment is not utilized to determine initial housing. An interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility is not utilizing all known information to inform housing so necessary steps can be taken to mitigate any such danger. An interview with the PSA Compliance Manager indicated the OMS system would flag the detainee file with an alert if they scored as a victim or a predator and will not allow the housing of the

two detainees together; however, a review of the detainee files confirmed the alert occurs after the detainee had received his initial housing. The Auditor interviewed 20 detainees and confirmed 2 of the detainees interviewed were taken to the office where the initial risk assessment was conducted utilizing the language line; however, 18 of the detainees interviewed, to include 1 detainee who arrived the previous day, had been given the form with a pen, and advised to complete the initial risk assessment without staff assistance. During an interview with one detainee, it was further confirmed during his intake, other detainees did not understand the initial risk assessment questions; and therefore, he needed to explain the initial risk assessment to them so they could answer appropriately. In an interview with one detainee, it was confirmed he had not been asked whether he experienced prior sexual abuse by intake staff; however, he had been asked the questions during his medical assessment. The Auditor reviewed 30 detainee files, to include the file of the detainee who was not asked about previous sexual abuse, and confirmed the detainee's initial risk assessment indicated he had responded "no", when asked if he had experienced previous sexual abuse; and therefore, the Auditor cannot confirm medical had shared the information with staff responsible to utilize the information gained from the initial risk assessment to determine to house detainees to prevent sexual abuse taking necessary steps to mitigate such danger. To become compliant, the facility must implement a procedure to ensure the facility is utilizing the information gained from the initial risk assessment to inform housing, so necessary steps can be taken to mitigate any such danger, to include intake staff participating in conducting the initial risk assessment, in the detainee's preferred language, and in a private setting. In addition, the facility must implement a procedure to require upon learning a detainee has experienced previous sexual abuse, or perpetrated sexual abuse, medical and mental health staff will inform staff responsible for detainee housing to ensure detainees are housed to prevent sexual abuse and to take necessary steps to mitigate any such danger. Once implemented, the facility must submit documentation which confirms all Intake, Classification, medical, and mental health staff have received training on the implemented procedure. In addition, the facility shall provide the Auditor 20 detainee files, to include detainees who do not speak English or Spanish, and 5 detainee files identified as likely to be a victim of sexual abuse, or perpetrated sexual abuse, and the corresponding medical files.

The facility is not in compliance with subsection (e) of the standard. The Auditor reviewed 30 detainee files and confirmed of the 15 files where a reassessment was required, 2 detainees were reassessed, 10 detainee files did not have documentation of a re-assessment, and 3 files indicated a re-assessment had been completed after 90 days. In addition, the Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed none of the detainees had been re-assessed following an incident of sexual abuse. In addition, the Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed none of the detainees had been re-assessed following an incident of sexual abuse. To become compliant, the facility must submit documentation to confirm all applicable staff, to include classification and the facility Investigator, have received training on subsection (e) of the standard and CoreCivic policy 14-2-DHS which require each detainee to be re-assessed between 60 and 90 days of the detainee's initial assessment or at any other time when warranted based upon the receipt of new information or following an incident of abuse or victimization. The facility must submit the files of 20 detainees who require a reassessment between 60 and 90 days, which occur during the CAP period, to confirm a re-assessment had been completed between 60 and 90 days. If applicable, the facility must submit all closed sexual abuse allegation investigation files to confirm a re-assessment had been completed following an incident of sexual abuse or victimization. In addition, if applicable, the facility must submit the files of any detainees who were reassessed following the receipt of additional information which occurred during the CAP period.

§115.42 - Use of assessment information.

Outcome: Does Not Meet Standard

Notes:

(a): CoreCivic policy 14-2-DHS states, "The facility shall use the information from the 14-2 DHS Sexual Abuse Screening Tool conducted at initial screening in the consideration of housing recreation, work program and other activities." An interview with the PSA Compliance Manager indicated detainees are assessed to identify those

likely to be sexual aggressors or sexual abuse victims utilizing the Assessment Questionnaire-Initial Screening Tool located on the facility OMS system. An interview with the PSA Compliance Manager further indicated the OMS system would flag the detainee file with an alert if they scored as a victim or a predator; and therefore, will not allow the housing of detainees who identify as being at risk for sexual victimization with detainees who identified as being likely to be sexual abuse aggressors. The Auditor reviewed the Assessment Questionnaire-Initial Screening Tool Sexual Abuse Screening Tool and confirmed the tool includes all requirements of subsections (c) and (d) of standard 115.41; however, a review of the facility OMS during the on-site audit, confirmed the electronic system carries over alerts identified at previous CoreCivic facilities; and therefore, the Auditor could not confirm if during CCCC's initial detainee risk assessment, the information would update and/or change the posted alerts based on entry of CCCC's initial assessment. In an interview with an Intake Office, it was confirmed she could not articulate if, or how, the information gained from the initial risk assessment could, or would, change the detainee's predetermined housing assignment, recreation or other activities, or voluntary work assignments. In addition, an interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility is not utilizing all known information to determine housing, recreation and other activities, and voluntary work assignments.

(b)(c): CoreCivic policy 14-2-DHS states, "In deciding whether to house a transgender/intersex detainee in a male or female unit, pod, cell, or dormitory within the facility subsequent to arrival, or when making other housing and programming assignments for such detainees, the facility shall consider the transgender or intersex detainee's gender self-identification and self-assessment of safety needs. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. Placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review whether any threats to safety were experienced by the detainee." An interview with the PSA Compliance Manager indicated the facility would consider the detainee's own views of his/her safety at the facility and a transgender or intersex detainee's self-identification is considered when making housing decisions and not based solely on the detainee's genitalia. An interview with the PSA Compliance Manager further indicated medical and mental health would be consulted to determine the effects the assignment would have on the detainee's health and safety. An interview with the HSA indicated medical and mental health participates on a transgender committee and would provide input on a detainee's housing assignment. An interview with the PSA Compliance Manager indicated the facility has not housed a transgender or intersex detainee during the audit period; however, an assessment would be completed every six months if a transgender or intersex detainee were to be housed at the facility for longer than six months. An interview with the PSA Compliance Manager further indicated a transgender or intersex detainee would be given an opportunity to shower separately during count time. During the on-site audit, Auditor observations and formal and informal interviews with staff confirmed the were no transgender or intersex detainees housed at the facility.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated detainees are assessed to identify those likely to be sexual aggressors or sexual abuse victims utilizing the Assessment Questionnaire-Initial Screening Tool located on the facility OMS system. An interview with the PSA Compliance Manager further indicated the OMS would flag the detainee file with an alert if they scored as a victim or a predator; and therefore, will not allow the housing of detainees who identify as being at risk for sexual victimization with detainees who identified as being likely to be sexual abuse aggressors. The Auditor reviewed the Assessment Questionnaire-Initial Screening Tool Sexual Abuse Screening Tool and confirmed the tool includes all requirements of subsections (c) and (d) of standard 115.41; however, a review of the facility OMS during the on-site audit, confirmed the electronic system carries over alerts identified at previous CoreCivic facilities; and therefore, the Auditor could not confirm if during CCCC's initial detainee risk assessment, the information would update and/or change the posted alerts based on entry of CCCC's initial assessment. In an interview with an Intake Officer, it was confirmed she could not articulate if, or how, the

information gained from the initial risk assessment could, or would, change the detainee's predetermined housing assignment, recreation or other activities, or voluntary work assignments. In addition, an interview with the HSA indicated if a detainee reports he has experienced previous sexual abuse, the medical staff will not share the information with the facility intake staff; and therefore, the facility is not utilizing all known information to determine housing, recreation and other activities, and voluntary work assignments. To become compliant the facility must implement a procedure to ensure information gained from the initial risk assessment under §115.41, is utilized to determine housing, recreation or other activities, and voluntary work assignments to ensure individualized determinations are made to ensure the detainee's safety. Once implemented, the facility must submit documentation which confirms, all applicable staff, to include but not limited to intake, classification, medical, and mental health staff. The facility, if applicable, must submit 15 files of detainees identified during the initial risk assessment as likely to be a victim of sexual abuse or a sexual abuse aggressor, and the corresponding OMS report, who arrive during the CAP period to confirm information gained from the initial risk assessment is utilized to determine housing, recreation and other activities, and voluntary work assignments.

§115.43 - Protective custody.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "Use of Administrative Segregation to protect detainees at high risk for sexual abuse and assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. Detainees considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate. If appropriate custodial options are not available at the facility, the facility will consult with the ICE Field Office Director to determine if ICE can provide additional assistance. Such detainees may be assigned to Administrative Segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of thirty (30) days." A review of CoreCivic policy 14-2-DHS confirmed the policy does not include the facility must document detailed reasons for the placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not placed a detainee in protective custody/administrative segregation during the audit period. Cibola County Correctional Center has not had to notify the Field Office of the same, however if it did, the Warden or designee would email the AFOD and the SDDO of the placement." Interviews with the facility Warden and PSA Compliance Manager indicated administrative segregation and/or protective custody is restricted to those instances where reasonable efforts have been made and as a last resort for housing of a detainee who is vulnerable to sexual abuse. Interviews with the facility Warden and PSA Compliance Manager further indicated if a detainee is assigned to administrative segregation and/or protective custody due to being vulnerable to sexual abuse the assignment would be documented to include detailed reasons for the placement and would not exceed 30 days. During the on-site audit, the Auditor observed the facility administrative segregation unit and confirmed there were no detainees vulnerable to sexual abuse assigned to administrative segregation and/or protective custody. The Auditor reviewed a 2023 Policy Document Review/Revision Request and an email string from the facility to ICE ERO confirming CoreCivic policy 14-2-DHS was developed in consultation with the ICE ERO FOD having jurisdiction over the facility.

(d)(e): CoreCivic policy 14-2-DHS states, "A supervisory staff member shall conduct a review within seventy-two (72) hours of the detainee's placement in segregation to determine whether segregation is still warranted; and a supervisory staff member shall conduct, at a minimum, and identical review after the detainee has spent seven (7) days in Administrative Segregation, and every week thereafter for the first thirty (30) days and every ten (10) days thereafter. Facilities shall notify the appropriate ICE Field Office Director no later than seventy-two (72) hours after the initial placement into segregation, whenever a detainee has been placed in segregation on the basis of a vulnerability to sexual abuse or assault. Detainees placed in segregated housing for this purpose shall have

access to programs, privileges, education, and work opportunities to the extent possible." Interviews with the facility Warden and the PSA Compliance Manager, indicated any placement of a detainee vulnerable to sexual abuse into administrative segregation and/or protective custody would require immediate notification to the ICE FOD, regular reviews would be conducted as required by CoreCivic policy 14-2-DHS, and detainees would be provided access to programming, visitation, counsel, and all other services available to other detainees. During the on-site audit, the Auditor confirmed through direct observation there were no detainees vulnerable to sexual abuse housed in administrative segregation or protective custody.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. A review of CoreCivic policy 14-2-DHS confirmed the policy does not include the facility must document detailed reasons for the placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. To become compliant, the facility must revise CoreCivic policy 14-2-DHS in conjunction with the ICE ERO FOD having jurisdiction over the facility to include the facility must document detailed reasons for the placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Once updated the facility must submit documentation to confirm all applicable staff have been trained on the revised policy. In addition, if applicable, the facility must submit the files of any detainees placed into administrative segregation due to being vulnerable to sexual abuse which occur during the CAP period.

§115.51 - Detainee reporting.

Outcome: Meets Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "Detainees shall be encouraged to immediately report pressure, threats, or incidents of sexual abuse and assault, as well as possible retaliation by other detainees or employees for reporting sexual abuse and staff neglect, or violation of responsibilities that may have contributed to such incidents. The facility shall provide instructions on how detainees may contact their consular official, the DHS Office of the Inspector General, and the ICE Hotline. Reporting will be confidential, and if desired, anonymous. Detainees who are victims of sexual abuse have the option to privately report an incident to a designated employee other than an immediate point-of-contact line officer by using any of the following methods: Submitting a request to meet with Health Services staff and/or reporting to a Health Services staff member during sick call; Calling the facility twenty-four (24) hour toll-free notification telephone number; Verbally telling any employee, including the facility Chaplain; Forwarding a letter (including anonymously), sealed and marked "confidential", to the Facility Administrator or any other employee; Calling or writing someone outside the facility who can notify facility staff; Forwarding a letter to the CoreCivic FSC PSA Coordinator…" CoreCivic policy 14-2-DHS further states, "Detainees shall have at least one way to report sexual abuse to a public or private entity or office that is not part of CoreCivic, and that is able to receive and immediately forward detainee reports of sexual abuse and assault to facility officials, allowing the detainee to remain anonymous upon request…" During the on-site audit, the Auditor observed information on how to contact consular officials, the DRIL, the DHS OIG, RCC, and a PREA hotline number to anonymously report an allegation of sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to incidents of sexual abuse. The information was posted in all detainee housing units and other common areas throughout the facility. During the on-site audit, utilizing the detainee telephones, the Auditor tested each number provided and confirmed all were in good working order. Interview with the PSA Compliance Manager and four random COs confirmed their knowledge of the multiple ways a detainee could report an allegation of sexual abuse including the requirement for staff to accept reports made verbally, in writing, anonymously, and through a third party. Interview with the PSA Compliance Manager and four random COs further confirmed all allegations reported are immediately documented through an incident report. Interviews with 20 detainees confirmed they were knowledgeable on how to report an allegation of sexual abuse and could articulate how to report anonymously, if desired.

Corrective Action:

No corrective action needed.

§115.52 - Grievances.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): CoreCivic policy 14-2-DHS states, "Formal Grievances filed by detainees involving allegations of an immediate threat to a detainee's health, safety, or welfare, related to sexual abuse will be removed from the grievance process and will be forwarded immediately to the facility investigator or Administrative Duty Officer. Detainees will be permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. To prepare a grievance a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility shall issue a decision on the grievance within five (5) days of receipt and shall respond to an appeal of the grievance decision within thirty (30) days. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process." An interview with the facility GO indicated a detainee can file a grievance alleging sexual abuse at any time, there are no time limits imposed, and detainees are not required to follow the informal grievance process prior to filing a formal grievance. An interview with the facility GO further indicated detainees have multiple ways to file a grievance to include the use of the detainee tablets or placing a grievance in grievance boxes available in the housing units which would be collected daily by her or a backup GO in her absence. In addition, an interview with the facility GO indicated if a detainee expressed the need for assistance in filing a grievance, she would facilitate the detainee request and ensure he received needed assistance. An interview with the facility GO further indicated, grievances alleging sexual abuse are considered time-sensitive and an immediate threat to detainee health, safety and welfare; and therefore, if she were to receive a grievance alleging sexual abuse, after ensuring the detainee was safe, she would forward the grievance to the Shift Commander and the PREA Investigator to ensure immediate action is taken to include taking the detainee to medical for an assessment. In addition, an interview with the GO indicated the detainee would be issued a notice to confirm the grievance has been closed and forwarded to the facility Investigator to investigate the allegation of sexual abuse. An interview with the facility Investigator indicated a grievance alleging sexual abuse, and the decision, would be forwarded to the FOD with the completed sexual abuse allegation investigation report. Interviews with 20 detainees confirmed they were aware of the process for filing a grievance related to sexual abuse. During the on-site audit, the Auditor placed two test grievances in two different housing unit grievance boxes and the following morning, the GO returned the test grievances to the Auditor. A review of four sexual abuse allegation investigation files confirmed three of the allegations had been report through the grievance process and the sexual abuse allegation investigation was conducted in accordance with standard 115.52.

Corrective Action:

No corrective action needed.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): CoreCivic policy 14-2-DHS states, "CoreCivic shall maintain, or attempt to enter into, Memorandums of Understanding (MOU) or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support for immigrant victims of crimes. Before developing or attempting to enter into an MOU, the facility shall contact the CoreCivic FSC Legal Department. CoreCivic shall maintain copies of agreements or documentation

showing attempts to enter into such agreements. Each facility shall establish, in writing, procedures to include outside agencies in the facility sexual abuse prevention and intervention protocols, if such resources are available. Detainees shall be provided access to outside victim advocates for emotional support services related to sexual abuse. Detainees will be provided with mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, state, or national victim advocacy or rape crisis organizations. Such information shall be included in the facility's Detainee Handbook. The facility shall enable reasonable communication between detainees and these organizations and agencies, in as confidential a manner as possible." The Auditor reviewed an MOU between CoreCivic and the RCC, dated August 1, 2019, which is open ended, with the clause either party can terminate the agreement with a 30-day written notice, and confirmed the MOU indicates RCC will provide access to victim advocates for confidential emotional support services through a 24-hour sexual abuse/assault crisis hotline number and a mailing address which may be posted throughout the facility. The Auditor reviewed the facility Handbook Supplement which states, "You can also contact the Rape Crisis Center or [sic] Central New Mexico, in writing or by telephone as follows: 24-hour hotline: 505-266-7711, address: Rape Crisis Center of Central New Mexico, 9741 Candeleria NE, Albuquerque, New Mexico 87112;" however, a review of the flyer and the facility supplemental handbook confirmed neither the flyer or the supplemental handbook includes the extent to which communications to the RCC will be monitored or the extent reports of abuse will be forwarded to authorities according to New Mexico mandatory reporting laws. During the on-site audit, utilizing the detainee telephones, the Auditor spoke with a victim advocate from RCC who confirmed RCC provides detainees with access to victim advocates for crisis intervention and counseling utilizing a sexual assault crisis line and RCC advocates have access to a language line to assist with any calls received from detainees who are LEP.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. The Auditor reviewed the facility Handbook Supplement and the RCC flyer and confirmed neither the flyer or the supplemental handbook includes the extent to which communications to the RCC will be monitored or the extent reports of abuse will be forwarded to authorities according to New Mexico mandatory reporting laws. To become compliant, the facility must submit documentation confirming prior to giving detainees access to outside resources, the facility informs detainees the extent to which communications to the RCC will be monitored and the extent reports of abuse will be forwarded to authorities according to New Mexico mandatory reporting laws in a manner all detainees can understand.

§115.54 - Third-party reporting.

Outcome: Meets Standard

Notes:

CoreCivic policy 14-2-DHS states, "The facility shall establish a method to receive third-party reports of sexual abuse and assault and shall post this information on the facility PREA link www.CoreCivic.ethicspoint.com." The Auditor reviewed the CoreCivic website at www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea and confirmed the website gives the public several ways to make a report of sexual abuse on behalf of a detainee to include sending a letter to the facility Warden with a link to the facility's address, calling the CoreCivic's Ethics and Compliance Hotline with a number provided, and if the third party clicks on the www.CoreCivic.ethicspoint.com link, the user is taken a report an incident screen. During the on-site audit, the Auditor completed a test report which included a button to allow the Auditor to remain anonymous. In addition, the Auditor observed, once the report is submitted the user is given log in information to check the status of the report. Within a few hours of submitting the test report, the Auditor received a response from the CoreCivic Director of Ethics and Compliance indicating the test report had been received and would be forwarded to the CoreCivic Director of PREA Programs and Compliance, the facility Warden, and the PSA Compliance Manager for investigation. During the on-site audit, the Auditor observed third-party reporting information in the facility visitation area and on the front lobby bulletin board to include contact information for the DRIL and the DHS OIG.

Corrective Action:

No corrective action needed.

§115.61 - Staff reporting duties.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "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 participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." CoreCivic policy 14-2-DHS states, "The facility shall require all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Employees shall take all allegations of sexual abuse and assault seriously, including verbal, anonymous and third-party reports, and treat them as if the allegation is credible. Staff shall promptly document any verbal reports." CoreCivic policy 14-2-DHS further states, apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, and as specified in this policy, to make treatment, investigation, and other security and management decisions. Employees may privately report sexual abuse and assault of detainees by forwarding a letter, sealed and marked "Confidential", to the Facility Administrator" and "reports of Sexual Abuse may also be reported to the CoreCivic Ethics Hotline at www.CoreCivic.ethicspoint.com. In addition, CoreCivic policy 14-2-DHS states, "If the alleged victim is under the age of eighteen (18) or considered a vulnerable adult under a state or local vulnerable person's statute, the allegation shall be reported to the designated state or local services agency under applicable mandatory reporting laws." During the on-site audit the Auditor tested the www.CoreCivic.ethicspoint.com link and confirmed facility staff can submit an anonymous report through CoreCivic ethicspoint.com. Interviews with four random COs confirmed they were knowledgeable on how to report an allegation of sexual abuse to include utilizing the same reporting options available to detainees or reporting outside the chain of command to the CoreCivic "ethics line." Interviews with four random COs further confirmed they were aware information regarding an allegation of sexual abuse is to remain confidential and could not be shared with others unless there was a need-to-know to protect the detainee or prevent further victimization of other detainees or staff in the facility. Interviews with the facility Warden and the PSA Compliance Manager indicated the facility does not house juvenile detainees as per the contract and if a vulnerable adult were to experience sexual abuse, the New Mexico reporting laws would require notification to the New Mexico Adult Protection Services. An interview with the facility SDDO confirmed he was knowledgeable in his responsibilities as required by Agency policy 11062.2. A review of four sexual abuse allegation investigation files confirmed none of the investigations included a vulnerable adult; and therefore, notifications did not need to be made. The Auditor reviewed a 2023 Policy Document Review/Revision Request and an email string from the facility to ICE ERO confirming CoreCivic policy 14-2-DHS has been submitted and approved by the Agency.

Corrective Action:

No corrective action needed.

§115.62 - Protection duties.

Outcome: Does Not Meet Standard

Notes:

CoreCivic policy 14-2-DHS states, "When it is learned that a detainee is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the detainee." Interviews with the PSA Compliance Manager and four random COs indicated if they became aware a detainee is at substantial risk of sexual abuse, they would immediately separate the detainee from the threat and notify a supervisor. An interview with the facility Warden indicated all staff are required to take immediate action to protect detainee victims of sexual abuse. A review of four sexual abuse allegation investigation files indicated in two of the files the detainee victim was removed and immediately taken to medical for an emergency medical assessment; however, in a review of the two remaining investigative files, the Auditor could not confirm staff took immediate measures to protect the detainee.

Corrective Action:

The facility is not in compliance with this standard. A review of four sexual abuse allegation investigation files indicated, in two of the files, the detainee victim was removed and immediately taken to medical for an emergency medical assessment; however, in a review of the two remaining investigative files, the Auditor could not confirm staff took immediate measures to protect the detainee. To become compliant, the facility must submit documentation which confirms all applicable staff have received training on standard 115.62 which requires when staff learns a detainee is the subject to substantial risk of imminent sexual abuse, immediate action is taken to protect the detainee. In addition, if applicable, the facility must submit all closed sexual abuse allegation investigation files that occur during the CAP period.

§115.63 - Reporting to other confinement facilities.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): CoreCivic policy 14-2-DHS states, "Upon receiving an allegation that a detainee currently at the facility was sexually abused while housed at another facility (e.g. state, federal, local, or other private operator) the following actions shall be taken: The Facility Administrator of the facility that received the allegation shall contact the Facility Administrator or appropriate headquarters office of the facility where the alleged abuse took place as soon as possible, but no later than seventy-two (72) hours after receiving the allegation" and "upon receiving notification from another agency or another facility (e.g. state, federal, local, or other private operator) that a detainee currently at their facility reported an incident/allegation of sexual abuse that occurred while the subject was a detainee at the CoreCivic facility, …the facility staff shall initiate reporting and investigation procedures in accordance with this policy." An interview with the facility Warden indicated if he receives an allegation of sexual abuse from another facility administrator indicating an alleged sexual abuse had occurred at CCCC, he will immediately refer the allegation to the facility Investigator for investigation and would notify the FOD. An interview with the facility Warden further indicated if a detainee reported an allegation of sexual abuse which occurred at another facility, he would notify, via telephone, the appropriate agency officials where the alleged sexual abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation, and would follow up with an email for documentation. The Warden provided the Auditor, a copy of the notification which had been made to another facility, after a detainee had reported he suffered sexual abuse at their facility. The Auditor reviewed the notification and confirmed the Warden had emailed the facility Assistant Warden, who was acting in the capacity of Warden, while the Warden of the facility was on approved leave within 72 hours as required by subsection (b) of the standard.

Corrective Action:

No corrective action needed.

§115.64 - Responder duties.

Outcome: Meets Standard

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, "Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or his or her supervisor, shall ensure that the alleged victim and perpetrator are separated and that the alleged victim is kept safe, and has no contact with the alleged perpetrator. The responder shall, to the greatest extent possible, preserve and protect any crime scene until appropriate steps can be taken to collect evidence. Alleged victims shall be immediately escorted to the Health Services Department. The Health Services Department is responsible for medical stabilization and assessment of the victim until transported to an outside medical provider if determined necessary for medical treatment. If medically indicated, or necessary for the collection of evidence as determined by law enforcement, victim examinations shall be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE). If a SAFE or SANE provider is not available, the examination may be performed by other qualified medical practitioners. Facility security staff shall transport the detainee to the location where such services are provided. If the abuse occurred within a time period that still allows for the collection of physical evidence, employees shall, request that the alleged victim not take any actions that could destroy physical evidence including as appropriate washing, brushing teeth, showering, changing clothing without medical supervision, urinating, defecating, smoking, drinking or eating. When the alleged perpetrator is a detainee, he/she shall be removed from the general population or otherwise separated and held in a medical unit in the event evidence collection is required. If the abuse occurred within a time period that still allows for the collection of physical evidence, responders shall, ensure that the alleged perpetrator not take any actions that could destroy physical evidence including as appropriate washing, brushing teeth, showering, changing clothing without medical supervision, urinating, defecating, smoking, drinking or eating. If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." Interviews with four random COs, and two non-security staff members, confirmed all staff interviewed were knowledgeable regarding their duties as first responders.

Corrective Action:

No corrective action needed.

§115.65 - Coordinated response.

Outcome: Meets Standard

Notes:

(a)(b): Policy 14.2-DHS states, "Each CoreCivic facility will establish a Sexual Abuse Response Team (SART) to identify roles and provide a coordinated response to incidents of sexual abuse. The SART shall include the following multi-disciplinary team: PSA Compliance Manager; Medical representative; Security representative; Mental health representative; and Victim Services Coordinator. **NOTE:** The medical and/or mental health professional may serve as the facility's Victim Services Coordinator. The Victim Services Coordinator will not be a member of security. The SART responsibilities shall include, but are not limited to, the following: Responding to reported incidents of sexual abuse and assault; Responding to victim assessment and support needs; Ensuring policy and procedures are enforced to enhance detainee safety; and Participating in the development of practices and/or procedures that encourage prevention and intervention of sexual abuse and assault and enhance compliance with DHS PREA Standards." Interviews with the facility Warden, PSA Compliance Manager, and the facility Investigator indicated the facility has established a Sexual Abuse Response Team (SART) to identify roles and responsibilities in response to an incident of sexual abuse which includes the PSA Compliance Manager, administrators, medical and mental health staff, security staff, and the facility Investigator. The Auditor reviewed the facility coordinated response plan and confirmed the plan coordinates the action taken by the first responders, medical and mental health practitioners, facility Investigators, and facility leadership in response to an incident of sexual abuse. The Auditor reviewed four sexual abuse allegation

investigation files and confirmed in all incidents the facility followed a multi-disciplinary coordinated response.

(c)(d): CoreCivic policy 14-2-DHS states, "If a victim of sexual abuse is transferred from this facility to a facility covered by DHS SAAPI 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. If a victim of sexual abuse is transferred from this facility to a facility not covered by DHS SAAPI Standards, the sending the sending facility will, 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 Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not had an instance where a victim of sexual abuse was transferred to a facility covered by the DHS PREA standards during the audit period. In the event of an incident, the facility would inform the administrator of the receiving facility about the occurrence and the victim's potential need for medical or social services, unless the victim requests otherwise." An interview with the facility HSA confirmed she is aware of the requirements of subsections (c) and (d) of the standard and could articulate the standard's requirements if a detainee is transferred to a facility covered by the DHS PREA standards, she would inform the receiving facility of the incident and the victim's potential need for medical or social services and if the victim is transferred to a facility not covered by DHS PREA standards, she would obtain the detainee's consent before providing the information to the receiving facility. A review of four sexual abuse allegation investigation files confirmed none of the detainees were transferred due to being a victim of sexual abuse.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

CoreCivic policy 14-2-DHS states, "Staff suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation." CoreCivic policy 14-2-DHS further states, "Contractors and civilians suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation." Interviews with the facility Warden and PSA Compliance Officer indicated staff and contractors suspected of perpetrating sexual abuse would be removed from all contact with detainees until the outcome of the investigation. An interview with the HRM confirmed if a staff member is suspected of sexually abusing a detainee, they would immediately be placed on administrative leave and subject to termination if the investigation was substantiated. An interview with the HRM further confirmed if a contractor was suspected of sexually abusing a detainee, they would be immediately escorted off the facility grounds, until the conclusion of the investigation and if substantiated, the contractor's contract would be terminated. The Auditor reviewed four sexual abuse allegation investigation files and confirmed none of the four sexual abuse allegation investigation files involved a staff member or contractor. In an interview with the PSA Compliance Manager, it was confirmed the facility did not utilize the services of volunteers during the audit period.

Corrective Action:

No corrective action needed.

§115.67 - Agency protection against retaliation.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): Agency policy 11062.2 states, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." CoreCivic policy 14-2-DHS states, "Staff, contractors, volunteers, and detainees shall not retaliate against any person,

including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least ninety (90) days following a report of sexual abuse, the 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. Items the facility should monitor include detainee disciplinary reports, housing or program changes, or negative performance reviews, or reassignments of staff. The facility shall continue such monitoring beyond ninety (90) days if the initial monitoring indicates continuing need. The PSA Compliance Manager shall ensure that thirty/sixty/ninety (30/60/90) day retaliation monitoring is conducted by the designated staff, following a report of sexual abuse, to protect against potential retaliation against detainees or employees. This shall include periodic status checks of detainees and review of relevant documentation. Monitoring is documented on the 14-2D DHS PREA Retaliation Monitoring Report (30/60/90) form." The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not had an instance where monitoring for retaliation occurred for at least 90 days during the audit period. This is due to detainees' release." The Auditor reviewed the PREA Retaliation Monitoring Report (30/60/90) and confirmed staff monitoring retaliation are required to monitor detainee disciplinary reports, housing, and program changes and for staff monitoring will include the review of any reassignments or negative performance reviews. In an interview with the PSA Compliance Manager, it was indicated the facility has designated a retaliation monitor for detainee and a retaliation monitor for staff and monitoring would be completed at 30, 60, and 90 days and longer if needed. In an interview with the PSA Compliance Manager, it was further indicated the monitoring would consist of meeting with the detainee, reviewing disciplinary reports, detainee housing, and any programming changes which may have occurred and for staff reviewing any negative reviews or reassignments which may have occurred because of reporting an allegation of sexual abuse or cooperating in a sexual abuse allegation investigation. During an interview with a Retaliation Monitor the interview was not completed due to unforeseen circumstances; and therefore, compliance could not be determined based on an interview. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed each investigation file included the PREA Retaliation Monitoring Report (30/60/90); indicating the detainee victims had been monitored for retaliation up to their release from the facility custody; however, the review indicated the Retaliation Monitor did not begin monitoring the detainees until 30 days following the allegation of sexual abuse.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed each investigation file included the PREA Retaliation Monitoring Report (30/60/90); indicating the detainee victims had been monitored for retaliation up to their release from facility custody; however, the review confirmed the Retaliation Monitor did not begin monitoring the detainees until 30 days following the allegation of sexual abuse. To become compliant, the facility must implement a practice which ensures retaliation monitoring begins immediately following an allegation of sexual abuse. Once implemented the facility must submit documentation which confirms all applicable staff, to include staff responsible for monitoring both detainees and staff, have received training on the implemented practice. In addition, the facility must submit all sexual abuse allegations, and the corresponding monitoring documentation, which occur during the CAP period to confirm monitoring of both detainees and/or staff begins immediately upon receipt of the allegation.

§115.68 - Post-allegation protective custody.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): CoreCivic policy 14-2-DHS states, "The facility shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. Detainee victims shall not be held for longer than five (5) days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee. 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 re-assessment

taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse." Policy 14-2 DHS further states, "Facilities shall notify the appropriate ICE Field Office Director no later than seventy-two (72) hours after the initial placement into segregation, whenever a detainee has been placed in segregation on the basis of a vulnerability to sexual abuse or assault." The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center had not had an instance where segregated housing was used to protect a detainee victim of sexual abuse. If a detainee victim was held in segregation housing for 72 hours, the appropriate Filed Officer Director would be notified." An interview with the PSA Compliance Manager indicated detainee victims of sexual abuse would only be placed in administrative segregation if there were no other options available. An interview with the PSA Compliance Manager further indicated the facility had recently placed a detainee victim of sexual abuse into administrative segregation for less than 24 hours. The Auditor reviewed the detainee victim's Confinement Record and Administrative Segregation Order and confirmed the detainee victim had been placed in Administrative Segregation Involuntary PREA Placement as there were no other options except to place the detainee into administrative segregation as other units were under a quarantine order. The Auditor's review of the detainee victim's Confinement Record and Administrative Segregation Order further confirmed the detainee was to be given access to all programming. In addition, a review of the detainee victim's Confinement Record and Administrative Segregation Order confirmed within 24 hours the quarantine order had been lifted and the detainee was released from segregation on October 10, 2024. During the on-site audit, the Auditor requested to review a copy of the detainee's re-assessment prior to returning the detainee to population and confirmed the re-assessment was completed after being requested by the Auditor and not prior to releasing the detainee to general population.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. During the on-site audit, the facility placed a detainee in protective custody due to being a victim of sexual abuse for a period of 24 hours. The Auditor requested to review a copy of the detainee's re-assessment prior to returning the detainee to general population and confirmed the re-assessment was completed after being requested by the Auditor and not prior to releasing the detainee to general population. To become compliant, the facility shall submit documentation which confirms all applicable staff have received training on the standard's requirement to re-assess a detainee who is placed in protective custody due to being a victim of sexual abuse prior to being release to general population. If applicable, the facility must submit the files of all detainees placed in protective custody during the CAP period due to being a victim of sexual abuse to confirm compliance with subsection (c) of the standard.

§115.71 - Criminal and administrative investigations.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(e)(f): CoreCivic policy 14-2-DHS states, "The Facility Administrator shall ensure that an administrative investigation and a referral for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators." CoreCivic policy 14-2-DHS further states, "Upon conclusion of a criminal investigation where the allegation was Substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was Unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate." CoreCivic policy 14-2-DHS further states, "Administrative investigations will include: Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility

contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment and investigation facts and findings; and Retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years." CoreCivic policy 14-2-DHS further states, "Discussions with ICE and local law enforcement should articulate a delineation of roles of the facility investigator and the law enforcement investigator to coordinate and sequence administrative and criminal investigations, to ensure that the criminal investigation is not compromised by an internal administrative investigation." An interview with the PSA Compliance Manager and the facility Investigator indicated all allegations of sexual abuse are immediately reported to the Joint Intake Center, the ICE Office of Professional Responsibility, the ICE Field Office Director/designee, and if the allegation involved criminal behavior the facility would notify the MPD. If the MPD investigates an allegation in the facility, the PSA Compliance Manager and the Investigator would keep in contact with the MPD to remain informed and would begin an administrative investigation, as soon as MPD, and ICE, notify the facility, they can proceed. In an interview with the facility Investigator, it was indicated the administrative investigation would be prompt, thorough, and objective and would be completed even if the detainee victim or the perpetrator is no longer housed or employed at the facility. Interviews with the facility PSA Compliance Manager and the facility Investigator indicated investigators are required to receive specialized training prior to conducting administration investigations into allegations of sexual abuse. The Auditor reviewed four sexual abuse allegation investigation files and confirmed all four investigations had been completed by a facility Investigator no longer assigned to the role. The Auditor reviewed the training certificate of the prior facility Investigator and confirmed the prior facility Investigator received specialized training through the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting. The Auditor reviewed the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting training curriculum and confirmed the curriculum contains all elements required by subsection (a) the standard. In addition, the Auditor reviewed the training certificate of the current facility Investigator and confirmed the current facility Investigator has received specialized training through the NIC Prison Rape Elimination Act (PREA) Investigating Sexual Abuse in a Confinement Setting. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews.

Corrective Action:

The facility is not in compliance with subsections (a), (c), and (e) of the standard. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews. To become compliant, the facility must submit documentation to confirm the current facility Investigator has been trained on standard 115.71 and CoreCivic policy 14-2-DHS which require all

investigations into allegations of sexual abuse be prompt, thorough and objective. In addition, the facility must submit documentation which confirms the current facility Investigator has been trained on the provisions of standard 115.71 and CoreCivic policy 14-2-DHS which includes the preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; an effort to determine whether actions or failures to act at the facility contributed to the abuse; documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessment and investigation facts and findings; and retention of all reports and referrals of allegations for as long as the alleged perpetrator is detained or employed by the agency or facility, plus five (5) years. In addition, the facility must submit all sexual abuse allegation investigation files closed by the Agency during the CAP period.

§115.72 - Evidentiary standard for administrative investigations.

Outcome: Does Not Meet Standard

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." Policy 14-2 DHS states, "When an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse and assault are Substantiated." An interview with the facility PREA Investigator indicated the facility will not impose a standard higher than a preponderance of evidence when determining whether allegations of sexual abuse are substantiated. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews.

Corrective Action:

The facility does not meet standard 115.72. The Auditor reviewed four sexual abuse allegation investigations and further confirmed the outcome of one sexual abuse allegation investigation was determined to be unsubstantiated, despite having video evidence, confirming the reported allegation had occurred, noting the outcome was determined due to the detainee victim and the detainee perpetrator being released from the facility. In addition, a review of the sexual abuse allegation investigation file indicated the Warden, and ERO, changed the finding to substantiated after reviewing the investigative report. A review of four sexual abuse allegation investigation files further confirmed in one investigation the detainee victim and the detainee perpetrator had been interviewed; however, the facility Investigator made no indications of the credibility of either detainee and determined the investigation to be unsubstantiated based solely on the video monitoring system being out of service at the time of the allegation without considering the facts learned during the interviews. To become compliant the facility must submit documentation which confirms the current facility Investigator has received training on standard 115.72 and CoreCivic policy 14-2-DHS which require when an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse and assault are substantiated.

§115.73 - Reporting to detainees.

Outcome: Meets Standard

Notes:

CoreCivic policy 14-2-DHS states, "Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken. If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee. All detainee notifications or attempted notifications shall be documented on the 14-2E Detainee Allegation Status Notification. The detainee shall sign the 14-2E Detainee Allegation Status Notification verifying that such notification has been received. The signed 14-2E Detainee Allegation Status Notification shall be filed in the detainee's file." Interviews with the PSA Compliance Manager and the facility PREA Investigator, indicated notification is made to each detainee victim of an alleged sexual abuse to include any responsive action taken on the case. The Auditor submitted a Notification to Detainee of PREA Investigation Results form to the ERAU TL for confirmation of the notifications to the victims of four allegations. The response indicated three of the detainee victims had been released from facility, prior to the completion of the investigation, and one indicated the victim detainee had been given notification of the results of the allegation; however, the outcome was unsubstantiated; and therefore, no facility action was required.

Corrective Action:

No corrective action needed.

§115.76 - Disciplinary sanctions for staff.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): CoreCivic policy 14-2-DHS states, "Employees shall be subject to disciplinary sanctions up to and including termination for violating CoreCivic's sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse. Disciplinary sanctions for violations of CoreCivic policies relating to sexual abuse (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the employee's disciplinary history, and the sanctions imposed for comparable offenses by other employees with similar histories. All terminations for violations of CoreCivic sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, to the extent known. The facility shall also report all such incidents of Substantiated abuse, removals, or resignations in lieu of removal to the ICE Field Office Director, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known." A review of the facility policy indicates it does not include that "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, termination is greater than removal from Federal Service; and therefore, the Auditor finds the facility to be substantial compliance with subsections (a) and (b) of the standard. The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not had an instance where a staff member has been found in violation of sexual abuse policies during the audit period. In the event of an occurrence, Cibola County Correctional Center shall report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies, unless the activity was clearly not criminal." Interviews with the facility Warden and HRM indicated if there was an allegation of sexual abuse alleged against a staff member, the staff member would be prohibited from having any further detainee contact and/or placed on administrative leave, until the outcome of the investigation. Interviews with the facility Warden and the HRM further indicated all terminations and resignations in lieu of termination would be reported to law enforcement and any licensing bodies. Interviews with four random COs confirmed they could articulate engaging in sexual abuse with a detainee is against the law

and they would be terminated from employment. The Auditor reviewed four sexual abuse allegation investigation files and confirmed none of the allegations involved a staff member. The Auditor reviewed a 2023 Policy Document Review/Revision Request and an email string from the facility to ICE ERO confirming CoreCivic policy 14-2-DHS has been submitted and approved by the Agency.

Corrective Action:

No corrective action needed.

§115.77 - Corrective action for contractors and volunteers.

Outcome: Meets Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "Contractors and civilians suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards. Incidents of Substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall report such incidents to the ICE Field Office Director/designee regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." The Auditor reviewed a memorandum to the file which states, "Cibola County Correctional Center has not had an instance where a contractor or volunteer has been found in violation of sexual abuse policies during the audit period." The Auditor review sample letters, that would be utilized if a contractor has violated the sexual abuse policy which states, "This is to notify you that you are named in a PREA allegation. You are removed from all duties requiring detainee contact pending the outcome of the investigation. At the investigation's end, a determination will be made of your eligibility for a position requiring detainee contact." In addition, the Auditor reviewed a sample letter to a licensing body which states, "This is to notify your licensing body/agency that it has been determined that an investigation has been completed into an allegation of sexual misconduct with a detainee by a contractor (name). It has been determined that the allegation is substantiated." Interviews with the facility Warden and HRM indicated a contractor suspected of engaging in sexual abuse would be prohibited from contact with detainees and would be removed from the facility pending an investigation into the allegation of sexual abuse. Interviews with the facility Warden and HRM further indicated if an allegation of sexual abuse is substantiated, the incident would be reported to the contractor's employer, law enforcement, and any licensing bodies. The Auditor reviewed four sexual abuse allegation investigation files and confirmed none of the allegations of sexual abuse involved a contractor. In an interview with the PSA Compliance Manager, it was confirmed the facility did not use the services of volunteers during the audit period.

Corrective Action:

No corrective action needed.

§115.78 - Disciplinary sanctions for detainees.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): CoreCivic policy 14-2-DHS states, "Detainees shall be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories. If a detainee is mentally disabled or mentally ill, but competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Because the burden of proof is

substantially easier to prove in a detainee's disciplinary case than in a criminal prosecution, a detainee may be institutionally disciplined even though law enforcement officials decline to prosecute. A detainee may be disciplined for sexual conduct with an employee only upon a finding that the employee did not consent to such contact. Detainees who deliberately allege false claims of sexual abuse can be disciplined. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The Facility Administrator or designee may contact law enforcement to determine if a deliberately false accusation may be referred for prosecution." Interviews with Warden and the PSA Compliance Manager indicated the facility has a disciplinary process in place and all sanctions are commensurate with the severity of the committed act. Interviews with Warden and the PSA Compliance Manager further indicated the facility disciplinary process has progressive levels of reviews and appeals and considers whether a detainee's mental disabilities or mental illness contributed to his behavior and a detainee would not be disciplined for sexual contact with a staff member unless there is a finding the staff member did not consent to the contact. In addition, interviews with Warden and the PSA Compliance Manager indicated the facility would not discipline a detainee for falsely reporting an incident or lying if he made a report of sexual abuse in good faith based on a reasonable belief the alleged conduct had occurred. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files and confirmed one sexual abuse allegation investigation files investigation had been determined to be substantiated; however, the perpetrator had been deported; and therefore, was not subjected to a disciplinary sanction.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "If screening indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, 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. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two (2) working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than seventy-two (72) hours after the referral." An interview with an Intake Officer indicated each detainee is assessed for risk of victimization and abusiveness; however, she could not articulate the circumstances which would require an immediate referral to a qualified medical or mental health indicating referrals to medical and mental health are completed by medical during the medical assessment. Interviews with the PSA Compliance Manager and the MHC indicated if a detainee identifies as having previously experienced sexual abuse or previously perpetrated sexual abuse against a child or an adult, a referral is immediately made to mental health by Intake staff. Interviews with the PSA Compliance Manager and the MHC further indicated intake staff will complete the SAAPI Medical and Mental Health Referral form and the referral, and initial risk assessment, are emailed to medical and mental health staff. During the on-site audit, the Auditor requested the MHC provide the Auditor a sample of the email, SAAPI Medical and Mental Health Referral form, and the assessment, which he receives, and the Auditor was provided a sample received earlier in the day. The Auditor reviewed the sample email and confirmed the email was from the Intake Officer previously interviewed by the Auditor. An interview with the PSA Compliance Manager indicated the electronic system would flag the detainee file with an alert if they scored as a victim or a predator on the initial risk assessment. The alerts will indicate a P if the detainee is identified as a perpetrator, an PV if the detainee is identified as a potential victim, and a V if the detainee is identified as victim. An interview with the PSA Compliance Manager further indicated PREA Alert Rosters are exported and sent daily to medical and mental health staff. An interview with the MHC indicated he reviews the rosters and if the review determines there are detainees who need to be referred to medical or mental health for assessments, either medical or mental

health staff will create an order (referral) within Allscripts, which is the medical and mental health electronic management system. Based on the order, medical staff will conduct a medical assessment of the detainee within two days and mental health staff will conduct a mental health evaluation within 14 days. Utilizing the PREA Alert Rosters the Auditor attempted to review medical and mental health files of those detainees who had been identified as a victim or an abuser. The Auditor reviewed four detainees' medical and mental health files who were identified on the roster as previous victims of sexual abuse, and confirmed in two of the files the medical and mental health assessment notes were completed by the facility where the detainee had been previously housed and no evaluations were completed based on the initial risk assessment conducted during the detainee's intake into CCCC; and two medical and mental health files confirmed both detainees had received a medical assessment within 2 days of the initial risk assessment, however, neither of the mental health assessments had been completed within 72 hours of the initial risk assessment. The Auditor reviewed three additional medical and mental health files which included detainees who were identified on the rosters as sexual abuse aggressors and confirmed all three files indicated medical and mental health assessments had been completed by the facility where the detainees were previously housed and not based on the initial assessment from CCCC; and in one file the medical assessment had been completed within two days of the initial assessment, however, the mental health assessment had not been completed within 72 hours of the initial assessment. In an interview with a detainee who arrived at the facility during the on-site audit, it was indicated he had reported previous sexual abuse during his initial risk assessment, however, the facility had not offered him a mental health evaluation although he did want to talk with mental health. The Auditor requested the facility provide the Auditor with the detainee's initial risk assessment, and the medical and mental health referral completed during the detainee's intake into the facility and confirmed the initial risk assessment indicated it had been completed on October 23, 2024; however, the SAAPI Medical and Mental Health Referral had been completed on October 24, 2024, following the Auditor's request for the documents.

Corrective Action:

The facility is not in compliance with subsections (a), (b), and (c) of the standard. An interview with the MHC indicated he reviews the rosters and if the review determines there are detainees who need to be referred to medical or mental health for assessments, either medical or mental health staff will create an order (referral) within Allscripts, which is the medical and mental health electronic management system. Based on the order, medical staff will conduct a medical assessment of the detainee within two days and mental health staff will conduct a mental health evaluation within 14 days. Utilizing the PREA Alert Rosters the Auditor attempted to review medical and mental health files of those detainees who had been identified as a victim or an abuser. The Auditor reviewed four detainees' medical and mental health files who were identified on the roster as previous victims of sexual abuse, and confirmed in two of the files the medical and mental health assessment notes were completed by the facility where the detainee had been previously housed and no evaluations were completed based on the initial risk assessment conducted during the detainee's intake into CCCC; and two medical and mental health files confirmed both detainees had received a medical assessment within 2 days of the initial risk assessment, however, neither of the mental health assessments had been completed within 72 hours of the initial risk assessment. The Auditor reviewed the medical and mental health files of three detainees who were identified on the rosters as sexual abuse aggressors and confirmed the files indicated medical and mental health assessments had been completed by the facility where the detainees were previously housed and not based on the initial assessment from CCCC; and in one file the medical assessment had been completed within two days of the initial assessment, however, the mental health assessment had not been completed within 72 hours of the initial assessment. In an interview with a detainee who arrived at the facility during the on-site audit, it was indicated he had reported previous sexual abuse during his initial risk assessment, however, the facility had not offered him a mental health evaluation although he did want to talk with mental health. The Auditor requested the facility provide the Auditor with the detainee's initial risk assessment, and the medical and mental health referral completed during the detainee's intake into the facility and confirmed the initial risk assessment indicated it had been completed on October 23, 2024; however, the SAAPI Medical and Mental Health Referral had been completed on October 24, 2024, following the Auditor's request for the documents. To become compliant, the

facility must submit documentation which confirms all applicable staff, to include Intake, medical, and mental health have received training on subsections (a), (b) and (c) of standard 115.81 which requires an immediate referral to medical and mental health staff if the detainee risk assessment pursuant to §115.41 indicates the detainee has experienced sexual victimization or has previously perpetrated sexual abuse. In addition, the facility, if applicable, must submit the files of 15 detainees, and corresponding medical and mental health records, who during the CCCC initial risk assessment were identified as likely to be a victim of sexual abuse or perpetrated sexual abuse to confirm compliance with standard 115.81.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b): CoreCivic policy 14-2-DHS states, "Detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." An interview with the HSA indicated if a detainee victim needed emergency medical treatment, they would be transported to the Cibola General Hospital and then transported to the Albuquerque Family Advocacy Center for a SANE Exam. An interview with the HSA further indicated the detainee victim would have unimpeded access to emergency medical treatment and crisis intervention services, free of charge, to include emergency contraceptives and sexually transmitted infections prophylaxis, according to professionally accepted standards of care and the detainee victim is not required to name the abuser or cooperate with an investigation to receive the required care. An interview with the Executive Director of the Albuquerque SANE Collaborative, confirmed all detainee victims of sexual abuse would be offered tests for sexually transmitted infections and provided infections prophylaxis and emergency contraceptives, at no cost to the detainee regardless of the detainee naming his abuser or cooperating with an investigation. The Auditor reviewed four sexual abuse allegation investigation files and the corresponding medical file for each detainee and confirmed three of the detainee victims who reported an allegation of sexual abuse were immediately taken to medical and seen by medical and mental health staff at the time the allegation was reported; however, neither of the three required a SANE exam. A review of one sexual abuse allegation investigation file confirmed following an incident of sexual abuse the facility neglected to take the alleged victim to medical; and therefore, the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required by subsection (a) of the standard. During the on-site audit, the Auditor's observations, and informal interviews with staff, confirmed the facility does not house female detainees.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. A review of one sexual abuse allegation investigation file confirmed following an incident of sexual abuse the facility neglected to take the alleged victim to medical; and therefore, the detainee was not provided timely, unimpeded access to emergency medical treatment and crisis intervention services as required by subsection (a) of the standard. To become compliant the facility must submit documentation to confirm all applicable staff to include, but not limited to, security supervisors and the facility Investigator have received training on the standard's requirement to offer timely, unimpeded access to emergency medical treatment and crisis intervention services. In addition, the facility must submit all sexual abuse allegation investigation files closed during the CAP period.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): Policy 14-2 DHS states, "The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. The facility shall provide victims with medical and mental health services consistent with the community level of care. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment

plans and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate." CoreCivic policy 14-2-DHS further states, "All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall provide such victims with medical and mental health services consistent with the community level of care." An interview with the HSA indicated a detainee victim of sexual abuse would receive timely emergency access to medical and mental health treatment, at no cost to the detainee, and regardless of the detainee victim naming his abuser. Interviews with the HSA and the Mental Health Coordinator indicated that all treatment received at the facility is consistent, if not better, than the community level of care. A detainee victim would be offered a medical and mental health evaluation and if needed, the evaluation and treatment would include follow-up services, treatment plans, and referrals for continued care. If a sexual assault were to occur at the facility, the detainee victim would be transported to the Cibola General Hospital, for emergency medical treatment, and once stable would be transferred to the Albuquerque Family Advocacy Center, for a SANE exam. An interview with the Executive Director or the Albuquerque SANE Collaborative, confirmed all detainee victims of sexual abuse are offered tests for sexually transmitted infections, at no cost to the detainee. During the on-site audit, Auditor observations and informal interviews with staff, confirmed that the facility does not house female detainees, and the Auditor did not observe a transgender male detainee housed at the facility; therefore, subsection (d) of this standard is not applicable. The Auditor reviewed four detainee-on-detainee sexual abuse allegation investigation files, and the corresponding medical files, and confirmed three of the detainee victims who reported an allegation of sexual abuse were immediately taken to medical and seen by medical and mental health staff at the time the allegation was reported; however, a review of one sexual abuse allegation investigation file confirmed the facility neglected to take the alleged victim to medical following an incident of sexual abuse; and therefore, the detainee was not offered a medical and/or mental health evaluation to determine any necessary treatment as deemed appropriate by medical and/or mental health staff.

(g): Policy 14-2 DHS states, "The facility shall attempt to conduct a mental health evaluation of all known Detainee-on-Detainee abusers within sixty (60) days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." An interview with the MHC indicated detainee perpetrators of sexual abuse would receive an evaluation immediately upon learning about the detainee's sexual abuse history and a treatment plan would be established if the abuser is willing to participate. The Auditor reviewed one substantiated detainee-on-detainee sexual abuse allegation investigation files however, the detainee perpetrator was released the day after the allegation had been made; and therefore, mental health did not conduct an evaluation.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed one sexual abuse allegation investigation file and confirmed the facility neglected to take the alleged victim to medical following an incident of sexual abuse; and therefore, the detainee was not offered a medical and/or mental health evaluation to determine any necessary treatment deemed appropriate by medical and/or mental health staff. The Auditor reviewed the single investigative file and determined that the detainee was not taken to medical for evaluation as required by subsection (a). To become compliant the facility must train all applicable to staff, including but not limited to all supervisory staff and the facility Investigator in the standard's requirement to offer a medical and/or mental health evaluation to all victims of sexual abuse to determine any necessary treatment as deemed appropriate by medical and/or mental health staff. In addition, the facility must submit all sexual abuse allegation investigation files closed during the CAP period.

§115.86 - Sexual abuse incident reviews.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CoreCivic policy 14-2-DHS states, "The Facility Administrator will ensure that a post investigation review of a sexual abuse incident is conducted at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be Unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation. In addition to the Facility Administrator, the incident review team shall include upper-level facility management and the facility SART, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or Gender Non-Conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; and Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. All findings and recommendations for improvement will be documented on the 14-2F-DHS Sexual Abuse Incident Review Report. Completed 14-2F-DHS forms will be forwarded to the Facility Administrator, the facility PSA Compliance Manager, and the FSC PSA Coordinator. The facility shall implement the recommendations for improvement or shall document reasons for not doing so. The 14-2F-DHS Sexual Abuse Incident Review Report shall be forwarded to the FSC PSA Coordinator and the ICE Prevention of Sexual Assault (PSA) Coordinator through the local ICE Field Office. Each facility shall conduct an annual review of all sexual [sic] abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the Facility Administrator, FSC PSA Coordinator, and the ICE PSA Coordinator through the local ICE Field Office." Interviews with the PSA Compliance Manager and facility Investigator, both of which are members of the incident review team, indicated the facility has established a review team consisting of upper-level management and allows for input from custody staff, the facility Investigator, and medical and mental health practitioners. An interview with the facility Investigator indicated the facility review team would conduct a sexual abuse incident review 30 days after the conclusion of every administrative investigation, regardless of the outcome the investigation, utilizing the ICE Sexual Abuse or Assault Incident Review Form. The Auditor reviewed the ICE Sexual Abuse or Assault Incident Review Form and confirmed the form requires the facility consider if the incident was motivated by race, ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or motivated or otherwise caused by other group dynamics at the facility. The Auditor reviewed four sexual abuse allegation investigation files and confirmed three files did not include an incident review and one file had a review which was completed; however, not within 30 days of the conclusion of the investigation as required by the standard. In addition, a review of the one completed incident review could not confirm the report and the facility's response had been forwarded to the Agency PSA Coordinator. During the on-site audit, the Auditor reviewed the facility's 2024 Annual Audit Report Memo from the facility Warden and confirmed the report had been forwarded to the Field Office Director (FOD) and the Agency PSA Coordinator.

Corrective Action:

The Facility is not in compliance with subsection (a) of the standard. The Auditor reviewed four sexual abuse allegation investigation files and confirmed three files did not include an incident review and one file had a review which was completed; however, not within 30 days of the conclusion of the investigation as required by the standard. In addition, a review of the one completed incident review could not confirm the report and the facility's response had been forwarded to the Agency PSA Coordinator. To become compliant, the facility must submit documentation which confirms all applicable staff, to include the PSA Compliance Manager, have received training on subsection (a) of the standard which requires a sexual abuse incident review be conducted at the conclusion of every sexual abuse investigation, where the allegation was not determined to be unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation, and both the report and

responses to be forwarded to the Agency PSA Coordinator. If applicable, the facility must submit all closed sexual abuse allegation investigation files, and the corresponding incident review, which occurred during the CAP period. In addition, the facility must submit documentation to confirm the four incident reviews, and responses, not submitted to the Agency PSA Coordinator noted during the on-site audit were ultimately submitted.

§115.87 - Data collection.

Outcome: Meets Standard

Notes:

(a): CoreCivic policy 14-2-DHS states "All case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be retained in accordance with CoreCivic Policy 1-15 Retention of Records. The Facility Administrator shall maintain files, chronologically and in a secure location, regarding incidents of sexual abuse and assault…" During the on-site audit, Auditor observations and interviews with the facility PSA Compliance Manager and facility Investigator confirmed all case records associated with allegations of sexual abuse are maintained in the office of the facility Investigator under lock and key.

Corrective Action:

No corrective action needed.

§115.201 - Scope of audits.

Outcome: Meets Standard

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 a private office, and have 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 detainees, outside entity, or staff correspondence was received prior to the on-site audit or during the post audit review.

Corrective Action:

No corrective action needed.

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 12/11/2024

Auditor's Signature & Date

(b) (6), (b) (7)(C) 12/12/2024

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 12/11/2024

Assistant Program Manager's Signature & Date

U.S. Immigration and Customs Enforcement

Office of Professional Responsibility