PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	8/27/2019	**To:**	8/29/2019
AUDITOR INFORMATION			
Name of auditor:	Patrick J. Zirpoli	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	570-729-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-381-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	San Antonio Office		
Field Office Director:	Daniel Bible		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	1777 NE Loop 410, San Antonio, Texas 78217		
Mailing address: (if different from above)			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	El Valle Detention Facility		
Physical address:	1800 Industrial Drive, Raymondville, Texas 78580		
Mailing address: (if different from above)			
Telephone number:	956-689-9999		
Facility type:	IGSA		
PREA Incorporation Date:	7/18/2018		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	956-357-(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 number:**	956-357-(b) (6), (b)
ICE HQ USE ONLY			
Form Key:	29		
Revision Date:	08/14/2019		
Notes:			

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

Pre-Onsite Audit Phase

Audit Planning and Logistics:

On August 27-29, 2019 the Prison Rape Elimination Act (PREA) on-site audit of the El Valle Detention Center in Raymondville, Texas was conducted by Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditors for Creative Corrections, LLC, Patrick J. Zirpoli and (b) (6), (b) (7)(C) The Lead Auditor, Patrick J. Zirpoli, was provided guidance during the report writing and review process by the Immigration and Customs Enforcement (ICE) PREA Program Manager, (b) (6), (b) (7)(C) a DOJ and DHS certified PREA Auditor. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with ICE External Reviews and Analysis Unit (ERAU) during the audit report review process. The Program Manager completed the final version of the report due to unforeseen circumstances. This was the first DHS PREA audit for the El Valle Detention Center. The El Valle Detention Center is operated by the Management & Training Corporation (MTC) and contracted by ICE for the housing of male and female detainees. The audit period covered the previous twelve months from August 27, 2018 to August 29, 2019. The PREA incorporation date for the facility was July 18, 2018.

Posting Notice of the Audit:

The ERAU Team Lead (b) (6), (b) (7)(C) forwarded the audit notification poster to the facility. The poster, which was printed in English and Spanish, included the dates of the audit, the purpose of the audit, the Lead Auditor's contact information through Creative Corrections LLC, and a statement regarding the confidentiality of any communication received. The facility staff placed posters throughout the facility, including all housing units and all common areas. The Auditor verified the placement of the audit notification poster during the facility tour, and the detainee and staff interviews. The Auditor did not receive any letters from detainees.

Review of Facility Policies, Procedures, and Supporting Documentation:

The point of contact established for the audit was through (b) (6), (b) (7)(C) Before the onsite audit, (b) (6), (b) (7)(C) facilitated the upload of the completed Pre-Audit Questionnaire (PAQ) along with supporting documents to the ERAU SharePoint. The Auditor reviewed all facility supporting documentation, as well as, the policies and procedures. These documents included facility documentation and the facility's substantial compliance with the PREA standards. The Auditor listed the documentation utilized during the analysis of each standard within the standard narrative.

Onsite Audit Phase:

Site Review:

The onsite audit began on August 27, 2019 at 8:00 a.m. at which time (b) (6), (b) (7)(C) led a short in-briefing. In attendance were the Auditors and the following MTC and ICE Staff:

- Warden Francisco Venegas
- Deputy Warden (b) (6), (b) (7)(C)
- PSA Compliance Manager (b) (6), (b) (7)(C)
- ACA/Compliance Manager (b) (6), (b) (7)(C)
- Health Services Administrator (b) (6), (b) (7)(C)
- Administrative Lieutenant (b) (6), (b) (7)(C)
- Chief of Security (b) (6), (b) (7)(C)
- ICE Deportation Officer (DO)/ICE Contracting Officer's Representative (COR) (b) (6), (b) (7)(C)
- ICE DO (b) (6), (b) (7)(C)

Introductions were made, and the audit schedule was discussed. The Lead Auditor provided an overview of the audit process and how compliance could be accomplished. The Auditor explained that the PREA Audit: DHS Auditor Assessment Tool is utilized as a guide to ensure that all aspects of each standard are met. This assurance is made by triangulation of the policies and documentation reviewed, the Auditors personal observations during the onsite audit, and through the information received during the interviews. This triangulation is accomplished by ensuring that the policies and documentation, are compliant with the DHS PREA Standards, and the personal observations and interviews confirm the procedures outlined in the policy are in daily practice at the facility. The Auditor explained that the policies and procedures reviewed are in compliance with the standards, and the Auditors would evaluate if they are put into daily practice at the facility.

The Auditors with key staff, including the Warden, and PSA Compliance Manager conducted a facility tour. All areas of the facility were toured, including the housing units, laundry, intake area, administrative offices, control center, program areas, service areas, booking/intake, food service, and medical areas. During the tour, the Auditors made visual observations and closely examined the bathrooms, housing area sight lines, camera locations, and camera views. The Auditors spoke with random staff and detainees, reviewed all of the housing unit logbooks, examined the bulletin boards to ensure that the proper PREA posters and PREA audit notifications were posted, and made random phone calls on the detainee phones to ensure the detainees could contact the Office of Inspector General (OIG).

Working in partnership with the Federal Bureau of Prisons (BOP) and ICE, MTC was successfully able to modify the existing facility to create the El Valle Detention Center. The facility was opened on July 18, 2018 when the first detainees arrived at the facility.

The main compound consists of two buildings, a building that contains all administrative offices, courtrooms, intake, the main entrance, and medical. Entrance to the facility is controlled by secured fences and doors. The MTC Detention Officers working in the control center operate the locked main entrance doors and have to grant access to the facility. One MTC Detention Officer is stationed in the lobby, anyone entering the facility is subject to search, and must pass through a metal detector.

The intake area, where the detainees are processed into the facility, has multi-occupancy cells that are utilized when detainees are entering and leaving the facility. These cells have toilets located within the cells, the toilet is behind a metal divider or a wall, which completely blocks the toilet from view. The medical department has multi-occupancy cells; these are also treated in the same manner. The cell windows in the medical department have film that obscures the view of the toilet area. The courtroom area also has two multi-occupancy cells where detainees will be held pending video court. These cells have toilets, these toilets are behind a partition that blocks the view and provides privacy.

The second building contains eight dormitory style housing units, and two multi occupancy celled housing units. The dormitory style housing units are constructed in the same manner. The detainee bunks are located in the front and rear of the housing unit with a common area with tables located in the center of the unit. The shower/toilet area is located on either the left or right wall in the center of the housing unit. The shower/toilet area is located behind a concrete block wall which is approximately four feet tall. A barrier was added to the top of the wall, bringing the total height to approximately five feet tall. (b) (7)(E) This wall completely blocks the view of anyone showering or performing bodily functions. The facility added partitions between each shower and toilet to provide privacy from other detainees. The two celled housing units are constructed with the toilets within the cells, the toilets are located in the front corner out of view. The showers are located in alcove areas within the housing unit and have doors that provide privacy while showering.

(b) (7)(E)

All of the housing units throughout the facility have a gender announcement reminder posted at the entrance to the housing unit. The facility has a procedure where all cross-gender staff entering a housing unit must first contact the housing unit prior to entry. The housing unit officer will verify that the bathroom is clear, and all detainees are properly attired prior to allowing entry.

All of the housing units have a telephone available to the detainees. Posted by the telephones is the information on DHS OIG Poster, ICE Detention Reporting and Information Line (DRIL) Poster, including addresses and phone numbers, the instructions on how to report to the OIG using the telephone, and consulate information. The Rio Grande Valley Empowerment Zone information is also posted, they provide victim advocacy for the detainees.

The kitchen is located within the second building and prepares all meals for the detainees. The detainees will eat in the dining hall, unless the housing unit is under quarantine, if they are, they eat on the housing unit. The detainee bathroom in the kitchen has an operational door for privacy, the door does not lock.

The facility has a third building located outside of the secure fence area. This building contains offices, no detainees have access to this building.

The average detainee population for the last 12 months was 571 male detainees and 38 female detainees, with the average length of time in custody at the facility being 21 days. The facility has detained 7,849 adult detainees over the past 12 months. It should be noted that the facility has detained two juvenile detainees, these two detainees were unknowingly transported to the facility, and the facility identified them as juveniles upon intake. The juveniles were housed in the medical area under sight and sound separation from adults, and ICE was immediately notified. They were transferred from the facility within 24 hours.

The facility is staffed by 174 MTC security staff and 38 medical/mental health contracted staff. The facility does not have ICE Deportation Officer assigned permanently to the facility.

The facility has had 2 closed PREA related allegations over the past 12 months; one substantiated and one unsubstantiated. Both were detainee on detainee allegations; one detainee on detainee substantiated sexual harassment investigation and the other was a detainee on detainee unsubstantiated sexual abuse investigation, and not criminal in nature. The two allegations were investigated by the trained facility investigators, the substantiated investigation was investigated by the Raymondville Police Department (RPD), with no criminal prosecution. Both allegations were also investigated by specialty trained ICE employees, one investigation by a specialized trained investigator and the other investigation by an ICE Fact Finder. One investigation was determined unsubstantiated and the other unfounded. There was one open investigation.

The detainee interviews began immediately following the facility tour. The Auditors conducted interviews in separate offices; this provided privacy for the interviews. The detainees were randomly selected from detainees housed at the facility utilizing the main roster. Detainees from every pod were selected. During this process, detainees in the following categories were interviewed:

Number - Interview Type
- 3- Random Detainee Interviews
- 18-Detainees who are limited English proficient
- 2-Detainees with a Cognitive Disability
- 4-Detainees who identify as gay, or bisexual
- 3-Detainees who Reported Sexual Abuse History
- 30-Total Individual Detainee Interviews

During the interview process, several targeted categories of detainees were not being housed at the facility, these included detainees who filed a grievance related to sexual abuse, detainees who reported sexual abuse, and transgender and intersex detainees.

The Auditors conducted the interviews with all detainees, in the same manner, a preamble to the interview was relayed to the detainee by the Auditor explaining the purpose of the interview, and how they were selected, and explaining to them that they did not have to speak with the Auditors if they chose not to. No detainees refused to speak with the Auditors. All detainees were asked questions utilizing the Detainee Interview Guides for Immigration Detention Facilities. During the interviews, the Auditors utilized a copy of the initial PREA information provided to every detainee upon arrival at the facility, which includes the ICE National Detainee Handbook, El Valle Detention Center Supplement to the National Detainee Handbook, and the Sexual Abuse and Assault Awareness pamphlet. The Auditors further utilized a blank copy of the acknowledgment form they would sign for the PREA information received at intake. These materials were used to visually stimulate the detainee's recollection of their initial intake process. The

Auditors utilized Language Services Associates through a contract with Creative Corrections for multiple language interpretations during interviews with 18 limited English proficient (LEP) detainees.

Staff interviews were conducted over the three-day audit; all interviews were conducted in offices which allowed privacy for the interview. The staff interviews were conducted by both Auditors. Staff was randomly selected from those working during all shifts. Staff from the following categories were interviewed:

Number - Interview Type
- 12- Detention Officers
- 4- Supervisors
- 3- Medical/Mental Health
- 2- Intake Staff
- 2- Investigative staff
- Human Resources
- Warden
- PSA Compliance Manager
- 26- Total Staff Interviews

The Auditors conducted the interviews with all staff in the same manner, a preamble to the interview was relayed to the staff member by the Auditor explaining the purpose of the interview, and how they were selected, and explaining to them that they did not have to speak with the Auditors if they choose not to. No staff refused to speak with the Auditors. The Auditors asked all interviewed staff questions utilizing the various Staff Interview Guides for Immigration Detention Facilities.

The Auditors also reviewed staff personnel records, staff training records, and detainee files.

After the onsite audit, an exit briefing was held, (b) (6), (b) (7)(C) and the Auditors led the briefing, attending the briefing were:

- Warden Francisco Venegas
- Deputy Warden (b) (6), (b) (7)(C)
- PSA Compliance Manager (b) (6), (b) (7)(C)
- ACA/Compliance Manager (b) (6), (b) (7)(C)
- Health Services Administrator (b) (6), (b) (7)(C)
- Administrative Lieutenant (b) (6), (b) (7)(C)
- Chief of Security (b) (6), (b) (7)(C)
- ICE DO and COR (b) (6), (b) (7)(C)
- ICE DO (b) (6), (b) (7)(C)
- ICE Supervisory Detention and Deportation Officer (SDDO) (b) (6), (b) (7)(C)
- ICE SDDO (b) (6), (b) (7)(C)
- Office in Charge (OIC) ICE (b) (6), (b) (7)(C)

At this time, the Auditor provided an overview of the audit findings. The Auditor explained that overall, it was found the staff at the facility is extremely knowledgeable in the PREA Standards, sexual safety, and overall security. We further discussed the PREA Standards that the facility achieved a determination of Does Not Meet Standard. The issues causing deficiency ratings are procedural intake issues at the facility and reassessment issues. It should be noted that the issues were identified prior to the audit and corrective action was put into place.

The Auditors found that the facility has implemented a procedure to educate the detainees on PREA, this procedure includes placing television within all of the cells in the intake area. The facility plays an educational video on PREA in the cells, this video is in both English and Spanish. The Auditors found that the majority of the detainees speak either English or Spanish. The facility has a procedure in place to utilize the language line to read to detainees who speak other languages the information on PREA, these detainees are provided a copy of the reporting avenues in a language they understand. The facility needs to continue this process and provide the Auditor historical data showing the detainees have received the PREA information.

The second area of non-compliance is the reassessment of the detainees within 60-90 days of arrival. The detainees are initially screened during the intake process, this takes place upon arrival at the facility. The facility did not have a process in place to identify the detainees who were at the facility past 60 days and were not reassessing these detainees. Prior to the audit the PSA Compliance Manager identified all detainees who were at the facility over 90 days and reassessed these detainees. The facility needs to continue to track the length of time the detainees are in custody, and ensure the reassessments are being conducted within the 60 to 90-day period.

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: 4

§115.17 Hiring and promotion decisions
§115.31 Staff training
§115.32 Other training
§115.35 Specialized training: Medical and mental health care

Number of Standards Met: 32

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.34 Specialized training: Investigations
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 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
§115.87 Data collection
§115.201 Scope of audits.

Number of Standards Not Met: 3

§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.65 Coordinated response

Number of Standards Not Applicable: 2

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

PROVISIONS

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

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

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

Notes:

Documentation Reviewed:

- MTC policy Sexual Safety in Prisons (PREA) Policy# 903E.02 Effective Date November 1, 2018
- El Valle Detention Facility Organizational Chart
- MTC Organizational chart
- El Valle Detention Facility Policy Sexual Abuse and Assault Prevention and Intervention Policy# 2.11 Revision date October 23, 2018

(c): Policies 903E.02 and 2.11 mandates zero tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to incidents of sexual abuse and sexual harassment. The policy furthermore defines sexual abuse and sexual harassment. MTC and the facility updated the policies in 2018; the policy changes for policy 903E.02 were approved by the MTC President on November 1, 2018, policy 2.11 was approved by the El Valle Warden on October 23, 2018. The original policy date for MTC policy 903E.02 is August 1, 2016. MTC policy 903E.02 is published on the MTC website at https://www.mtctrains.com/prea/. The policy has not been reviewed and approved by the agency. It should be noted that the agency refers to ICE.

Recommendation: The agency needs to review and approve the facility's written policy.

(d): MTC employs a corporate level PSA Compliance Manager and Assistant PSA Compliance Manager that oversees the company's PREA compliance throughout all company facilities. Their roles are to assist facilities with any PREA technical assistance and ensure continuing compliance with the PREA Standards. They also complete the MTC Annual PREA reports and post them to the MTC website. At the facility level, the facility PSA Compliance Manager is responsible for overseeing policies and procedures related to the PREA standards and ensures facility compliance. The PSA Compliance Manager stated that she recently assumed all responsibilities for PREA at the facility, prior to her assuming the role the position was filled temporarily by a Shift Lieutenant. Both the PSA Compliance Manager and Shift Lieutenant stated that they had sufficient time to dedicate to PREA. The PSA Compliance Manager stated that her position is full time and her duties include making PREA rounds, reviewing policy, and ensuring that the facility is meeting all of its obligations. She stated that she has the authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. The Auditor found her to be very knowledgeable of the facility's PREA policies and procedures and her responsibilities for coordinating the facility's efforts to comply with the PREA standards. The PSA Compliance Manager was very knowledgeable and active in the audit process.

The Auditor reviewed the policies in their entirety, as well as questioned staff members on the content and applicable sections to their specific duties within the facility. The staff understood policies 903E.02 and 2.11 and their practical application to the daily operation of the facility.

Before the onsite audit, the Auditor reviewed all documentation. During the on-site portion, the Auditors observed policies 903E.02 and 2.11 in daily practice and further confirmed the daily practices during the interviews with both staff and detainees.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditors found that the facility has substantially met the requirements of this standard, and all provisions.

§115.13 - Detainee supervision and monitoring.

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

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- Staff Rosters
- El Valle Detention Facility Post orders
- Housing unit logbooks
- Staffing Plan
- Staffing Plan Review by the PSA Compliance Manager dated December 18, 2018
- Investigative Files

(a): The facility has developed facility staffing guidelines that provide for adequate levels of staffing, and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring the facility, the facility has taken into consideration all areas enumerated under this standard. (b) (7)(E) [redacted] Compliance was determined by also reviewing policies 903E.02 and 2.11. The Auditor further questioned the Warden and random staff on the policies and the ability to fully staff the facility at all times; they confirmed that shifts are filled with mandatory or voluntary overtime if needed. The facility security is overseen by the MTC staff, who deal directly with the detainees. During the interviews, the Auditor confirmed that they work (b) (7)(E) [redacted] They employ both female and male staff; these staffing guidelines provide direct supervision of the detainees, with staff assigned to the housing units, and to oversee detainee movement. The staffing guidelines were further confirmed during the on-site audit, where the Auditor observed staff supervising the detainee movement, housing unit supervision, video monitor review, and random cell checks taking place. The Auditor reviewed the investigative files, and reviews conducted by the administration at the facility. There were no recommendations made for changes in staffing or deployment of any

video monitoring. During the review of the investigations the Auditor concurred with the outcomes, and recommendations made during the review process.

(b): Policy 2.11 and the housing unit post orders outline the detainee supervision guidelines. The post orders outline the responsibility of the MTC Detention Officers to make 30-minute rounds through every housing unit and log the rounds in the logbook. All housing units are under direct supervision and have a detention officer on the housing unit at all times. The supervisors make rounds on each shift and log their rounds in the logbook. The Auditor reviewed the logbooks on every housing unit and confirmed these rounds are taking place; this practice was further confirmed during the staff interviews. An annual review of the staffing plan was conducted on December 18, 2018, by facility administration, including the PSA Compliance Manager. All post orders were reviewed for the assessment, as well as, all PREA incidents for the previous year. The assessment takes into consideration the reviews that occurred from July 2018 to December 2018. It should be noted that the facility opened in July 2018.

(c): The facility has developed a staffing plan that is based on the seven criteria of the standard to include generally accepted detention and correctional practices; any judicial finding of inadequacy; the physical layout; 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 any other relevant factors, including but not limited to, the length of time detainees spend in facility custody. During the staffing plan review period, which was from July 2018 to December 2018, the facility did not have any substantiated incidents of sexual abuse. The Auditor reviewed the two investigations at the facility for the auditing period, incident reviews were conducted by the PSA Compliance Manager and Facility Administration. The reviews did not recommend any staffing changes, and they found that staffing did not contribute to the incident. This process is outlined in policy 2.11. The staffing plan was developed by the facility administration, including the Warden, Assistant Warden, Chief of Security, and specific administrative staff which included input from the PSA Compliance Manager. During the interviews with the Warden, Assistant Warden, Chief of Security, and PSA Compliance Manager, the Auditor confirmed that all critical posts are being filled, and mandatory or voluntary overtime is utilized. They further stated that they have new hires who are in the ICE background process. These new hires are assigned duties outside of the secure area, they have no detainee contact. The new hires will help minimize any overtime usage. The review of the staffing plan on December 18, 2018, indicated that there were no deviations to the staffing plan; this was further confirmed during the Shift Supervisor, Chief of Security and Warden interviews. During the audit, the Auditor reviewed daily rosters and confirmed that all critical posts were being filled, this was being accomplished through the use of overtime if needed.

(d): The shift supervisors make unannounced rounds on the housing units during each shift, policy 2.11 prohibits staff from alerting anyone that these rounds are taking place. The supervisor logs the rounds into each housing unit logbook in red pen. The Auditors observed these log entries when examining the logbooks for each pod. The rounds were confirmed during the detainee and MTC staff interviews. The interviewed staff included supervisors and detention officers from all shifts.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- ICE Contract

The facility does not house juvenile or family detainees. This was confirmed during the interview with the PSA Compliance Manager who stated that if anyone under the age of 18 was brought to the facility, they would be immediately transferred. Policies 903E.02 and 2.11 and the ICE Contract further outlines that the facility will not house juveniles or family detainees.

During the Supervisor interviews the Auditor found that the facility has housed two juvenile detainees overnight until transport could be arranged from the facility. They stated that the juvenile detainees were housed in the medical area with sight and sound separation from adult detainees until they could be transported from the facility. They further stated that they frequently have juveniles who claim to be adults, these juvenile detainees are held in the medical area under sight and sound separation, until their adult status can be confirmed with ICE.

No detainees were being held at the facility under these circumstances during the audit.

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

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

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- El Valle Detention Facility Policy Searches of Detainees Policy# 2.10
- The Moss Group Training PowerPoint titled Guidance in Cross-Gender and Transgender Pat Searches
- PSA Compliance Manager memos to file

(b)(c)(d): Policy 2.10 states cross-gender pat searches of detainees shall not be conducted unless, after reasonable diligence, the staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. When exigent circumstances are present, a supervisor will be contacted before the search, and an incident report will be filed regarding all cross-gender searches. The staff interviewed indicated that they had not conducted or were aware of any cross-gender pat-down searches conducted. Detainees interviewed confirmed that they are only searched by same gender officers. During the audit year, there were no cross-gender pat-searches conducted. Interviews with the supervisors and PSA Compliance Manager confirmed that no cross-gender pat searches had taken place. Pat-down searches observed during the audit were conducted by the same gender staff member.

(e/f): Policy 2.10 outlines cross-gender strip searches or cross-gender body cavity searches shall not be conducted except in exigent circumstances and documented in an incident report. The medical staff and security staff interviewed were aware of the policy and understood the facility protocols for conducting strip or body cavity searches, and if performed, shall be approved by a supervisor and documented by incident reports and on the Cross-

Gender Pat Search Log. They further confirmed any body cavity search would be performed by medical personnel. No cross-gender strip or body cavity searches were conducted in the previous 12 months. This was confirmed through interviews with supervisors and PSA Compliance Manager.

(g): Policies 903E.02 and 2.11 outlines the policy and procedures which allow detainees to shower, perform bodily functions, and change clothing without employees of the opposite gender viewing them except in exigent circumstances or when incidental to routine cell checks. Detainees interviewed indicated they felt they had enough privacy to change their clothes, shower, and perform bodily functions. They are not observed by the staff of the opposite gender. Staff also confirmed the detainees have privacy for these functions. In the dormitory housing units, the showers and toilets have partitions and walls. In the cell pods, the toilet is located within the cell which has an operating door, and the showers have doors. The intake and medical cells have the windows obscured to a height where you cannot see the toilet and have walls and partitions to block the view. The policy also requires a staff of the opposite gender to announce their presence when entering detainee housing areas; this was observed during the audit. There is a sign posted on each housing unit door that states, "Opposite Gender Must Announce When Entering." Detainees interviewed stated that staff of the opposite gender announce when entering the housing unit by loudly stating female or male on the unit. The facility has put a procedure in place where any staff of the opposite gender must first confirm with the housing unit officer that no cross-gender viewing would take place if they entered. The housing unit officer will make sure the bathroom is clear before allowing entry. The LEP detainees stated that they recognize the female or male voices and other detainees will also announce in languages they understand. Staff is also provided training on unannounced rounds and during interviews indicated that announcements are made upon entering the housing units.

(h): This section is non-applicable. The facility is not a Family Residential Facility.

(i): Detainees will not be searched for the sole purpose of determining the detainee's genital status. Policy 2.10 prohibits staff from searching or physically examining a detainee to determine genitalia status. The review of the training lesson plan, Guidance in Cross-Gender and Transgender Pat Searches, documented these policies are covered in annual training. During interviews with detention and medical staff, they were aware of the policy and indicated that only medical could conduct such a search. No searches have occurred in the audit period per the interview with the PSA Compliance Manager. The facility's memos documented to file from the PSA Compliance Manager stated that the facility has not conducted any strip searches, visual body cavity searches, or cross gender pat searches on any detainees in the past twelve months. There were no transgender or intersex detainees housed during the audit to interview.

(j): Policy 2.10 states that security staff shall be trained in conducting pat-down searches, cross-gender pat-down searches, searches of transgender and intersex detainees in a professional and respectful manner. Other than annual training, this training is also part of the initial new hire training and covered frequently in shift briefings. The review of the training lesson plan, Guidance in Cross-Gender and Transgender Pat Searches, documented these policies are covered in annual training. During the interview with the facility training coordinator, he confirmed these practices and provided the Auditor with the signed training acknowledgment forms. The interviewed staff confirmed the training and understood the policy and indicated the transgender/intersex detainee could request the gender of the officer to conduct the pat-down search and the pat-down would be conducted using the back or blade of the hand.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

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

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

Notes:

Documentation Reviewed:

- Policies 903E.02, 301.06, and 2.11
- El Valle Detention Facility Policy Care: Disability Identification, Assessment and Accommodation Policy# 4.8
- ICE National detainee handbook in multiple languages
- Facility supplemental handbook
- PREA acknowledgment forms
- PREA Handout in multiple languages

(a) Policy 4.8 outlines the facility's procedures to ensure disabled detainees have equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. During the intake staff and medical personnel interviews, the Auditors confirmed the steps taken to effectively communicate with disabled detainees. Detainees who are deaf or hard of hearing would be provided the facility and the ICE Detainee handbooks and if needed sign language interpretation would be provided through video conference. A detainee with limited reading skills, cognitive disability, or blindness would have the materials read to them and explained in depth, so that they would understand. Medical staff confirmed that they evaluate all detainees during intake, and would identify any disability, and ensure the officers are aware of any disability. The intake officers stated for deaf or hard of hearing detainees they would write back and forth and have them read the material, read the materials to visually impaired detainees, and explain in a manner that detainees with cognitive issues could understand.

(b) Policy 301.06 outlines the procedure to ensure all LEP detainees have meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Upon entry into the facility the detainees are seated in cells where the PREA video is playing, this video plays both an English and Spanish version. The detainees are then individually evaluated by both intake officers and medical personnel. The intake officers provide the detainees the ICE National Detainee Handbook, the Facility Supplemental Handbook, and the ICE Sexual Abuse and Assault Awareness Pamphlet. These materials are provided in multiple languages, the staff confirmed that the ICE National Detainee Handbook is available in 11 languages, and they have the ability to print the other materials in multiple languages also. During the intake officers' interviews, they confirmed that they have not encountered a detainee they could not communicate with. They will utilize a language line for interpretation if needed to explain the material to them. They further confirmed that the majority of the detainees speak Spanish. DHS/ICE PREA posters were observed on the housing units, these posters were in both English and Spanish.

(c) Policy 903E.02 states that in matters relating to allegations of sexual abuse all staff will utilize a language line for translation services, except in limited circumstances where an extended delay in obtaining an interpreter would compromise the detainee's safety or investigation. During the staff interviews, they indicated that they would use a bilingual staff member or the language line for interpretation. The detainees interviewed who were LEP indicated they communicate with staff members through the language line. They further stated that they would ask for those services if an incident did

occur. The Auditor further confirmed with the investigators that they would not utilize any other interpretation method than a bilingual staff member or the language line. The investigators confirmed that they did not feel that utilizing another detainee, even if the victim wanted this, was appropriate. They stated that the information could not be controlled if another detainee was utilized for interpretation and felt this may put the victim at greater risk.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility is in compliance with the standard and all provisions.

§115.17 - Hiring and promotion decisions.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- Background Check Process Presentation on September 25, 2018 during the ICE PREA Training
- 45 Personnel files
- Training materials from ICE PREA Training on September 25, 2018
- Office of Personnel Management Part 731-Suitability
- Executive Order 10450- Security requirements for Government employment
- U.S. Immigration and Customs Enforcement Directive No.: 6-7.0
- U.S. Immigration and Customs Enforcement Directive No.: 6-8.0

(a), (b), (c), (d) The facility utilizes the ICE Personnel Security Unit (PSU) to conduct the background investigations on any applicant, employee, volunteer, or contractor who may have contact with a detainee. This investigation ensures that the facility does not hire or promote anyone who may have contact with detainees, nor 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 or who 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 who has been civilly or administratively adjudicated to have engaged in such activity. This unit promotes the integrity and efficiency of ICE by making risk-based decisions in evaluating whether applicants, employees, volunteers, and contractors meet suitability, security, and National Security Information access requirements. They conduct personnel security reviews on everyone that works for ICE by ensuring they are suitable for the position selected and that they maintain a high level of character. During the background process the applicant, employee or contractor is asked questions directly related to sexual abuse in confinement settings enumerated in the standard, these questions are asked both in a written form and in person by the assigned investigator who conducts the interviews. During the staff interviews at the facility, the Auditor confirmed that all contractors and employees were asked these questions. The facility imposes a continuing affirmative duty to disclose any misconduct, whether it is related to sexual misconduct or not. The standard addresses the utilization of this process in the promotional system. After reviewing the above policies, and during the PSA Compliance Manager and Human Resources interview, the Auditor confirmed if any employee or contractor that were involved in any misconduct of this nature, they would not be employed by MTC. The Auditor completed a PREA Audit: Background and Investigation for Employees and Contractors DHS Facilities forms. This form was submitted to the PSU. The Auditor confirmed the background investigations through review of 45 personnel files, and interviews with all staff at the facility. The facility opened on July 18, 2018, the Auditor confirmed during the personnel file review that the background process for all staff had taken place, the documents are contained in the personnel files. No staff member at the facility is due for a 5-year confirmation until 2023.

During this hiring process, and subsequent background investigation, the investigator asks questions related to character, integrity, and overall suitability for employment. The Auditor confirmed during the staff interviews at the facility that all interviewed staff had been asked the same questions during the background investigation process.

(e) & (f) The Auditor attended training in Arlington, Virginia where PSU Unit Chief (b) (6), (b) (7)(C) presented information on the background investigation process. During this training, he confirmed that any material omissions, intentional false statement, or deception is a factor that would make an applicant, employee, or contractor unsuitable for employment, and employees will be terminated. He further confirmed that they would, unless prohibited by law, provide information on a substantiated allegation of sexual abuse involving a former employee or contractor, to any requesting confinement facility. The Auditor confirmed with the facility's Human Resources staff that they would also follow the provisions of this standard and provide any information on a substantiated allegation of sexual abuse involving a former employee or contractor, to any requesting confinement facility. The prevention of sexual abuse in any agency begins with the hiring process and initial background investigation. ICE utilizes a system where not only current misconduct is identified, which will make the applicant, employee, or contractor unsuitable for employment, but continually monitors their employees and contractors for any misconduct or behavior that will make them unsuitable in the future. Due to the nature of the work DHS performs, this process is necessary to create a safe environment for detainees who are held in their custody or detained at a contracted facility. The process exceeds the language in the standards, they not only are considering sexual misconduct, but any misconduct, dishonesty, alcohol abuse, or any other behavior or activity that is considered unsuitable.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially exceeded the requirements of this standard, and all provisions. This decision was based on the overall commitment to safety; this commitment was shared by all staff who interacted with the Auditor.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The Warden confirmed that the facility has not expanded the facility, nor are they planning on any expansion. The facility has not updated the video monitoring system, nor are any upgrades planned.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- Memorandum of Understanding (MOU) with Rio Grande Valley Empowerment Zone Corporation
- Information for Valley Baptist Health System Child to Adult Abuse Response Team (CAART)
- ICE Policy 11062.2 Sexual Assault and Abuse Prevention and Intervention
- MOU with RPD
- ICE investigator training documentation on Sharepoint

(a): Any allegation at the facility is immediately reported to the PSA Compliance Manager, and an investigation is immediately started. The allegations are also reported to the RPD and ICE, including to the AFOD and ICE staff who monitor the facility for investigation and further action. The two reviewed investigations have been conducted by the facility trained investigators, but RPD, Office of Professional Responsibility (OPR), or OIG has the option to assume responsibility of the investigation. OIG declined to investigate; the RPD responded to the one detainee on detainee substantiated investigation but declined any prosecution. The other investigation was a detainee on detainee unsubstantiated investigation, and not criminal in nature. Both allegations were also investigated by specialty trained ICE employees, one investigation was determined unsubstantiated and the other unfounded. There was one open investigation. Policies 903E.02 and 2.11 outline the facility's evidence and investigation protocols. The facility utilizes the DOJ's National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents 2nd Edition for the uniform evidence protocol as indicated by the PSA Compliance Manager. The protocols are incorporated into the facility's policies which outline the coordinated response plan. The coordinated response plan provides a guideline for staff to follow when responding to an allegation. The protocols are approved by the MTC PSA Compliance Manager and ICE as part of the annual policy review. The facility does not house juvenile detainees. Per policy 11062.2, when OPR accepts a case, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel by OPR policies and procedures. The OPR will coordinate with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation.

(b/d): The facility has a MOU agreement with Rio Grande Valley Empowerment Zone Corporation for victim advocacy and would utilize the CAART at Valley Baptist Health System for SANE examinations. The MOU states that Rio Grande Valley Empowerment Zone Corporation will provide immediate advocacy, crisis intervention, information, and referrals if needed. They would have a qualified advocate respond in person to the facility or other locations as requested to provide advocacy and emotional support during the sexual assault examination and investigative interviews. The MOU was executed on September 21, 2018. The PSA Compliance Manager stated during her interview that the services are free of charge to the detainee, and the hotline is available 24-hours a day for the detainees. The hotline number and victim advocacy services are provided to the detainees on a poster in the pods in English and Spanish. The information on how to contact the Rio Grande Valley Empowerment Zone Corporation was provided to the detainees, but due to confidentiality, it is unknown if they were contacted.

(c): An alleged victim of sexual assault who requires and consents to a forensic exam are taken to Valley Baptist Health System for a forensic exam and emergency medical healthcare. The healthcare is provided at no cost to the detainee. Valley Baptist Health System has agreed to provide SANE services and agrees to comply with the provisions outlined in the Prison Rape Elimination Act. The services are available through the emergency department 24-hours a day 7 days a week. The medical staff interviewed state that the detainee would be taken to Valley Baptist Health System for an examination. No forensic exam services were utilized in the two reviewed investigation files based upon the type of allegations.

The Auditor contacted both the Valley Baptist Health System and Rio Grande Valley Empowerment Zone Corporation. The Auditor confirmed with a supervisor that the services are available as outlined above.

(e): The interviewed investigators which include the PSA Compliance Manager stated that all allegations are reported to the RPD and ICE, including to the AFOD and ICE staff who monitor the facility for investigation and further action. The facility does have an MOU with the RPD, the PSA Compliance Manager stated that they had reported one incident to them, in which they responded to the facility. The MOU states that the RPD will follow the requirements of the standards. The reviewed investigative files indicated the notification was made, and prosecution was declined.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

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

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

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- Facility PREA Investigation files
- ICE Policy 11062.2 Sexual Assault and Abuse Prevention and Intervention
- ICE investigator training documentation on Sharepoint

(a/d): Policies 903E.02 and 2.11 state all criminal allegations are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations. Upon a staff member receiving an allegation, they will immediately report the allegation to their supervisor, which will begin the investigative process. All investigations are immediately referred to the facility investigators and PSA Compliance Manager, who will notify the AFOD and the ICE staff at the facility. The PSA Compliance Manager stated that they would immediately begin the administrative investigation. All investigations are reviewed by the OPR. The Investigators stated that OPR would review all cases to determine if an investigation is required by OIG. All allegations involving agency and facility staff, volunteers, and contractors are investigated by OPR. ICE policy 11062.2 outlines the evidence and investigation protocols. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If the OPR investigators do not conduct the investigation, the criminal investigation will be conducted by the RPD, and the administrative investigation by the facility investigators. All reviewed investigations at the facility were conducted by the facility specialized trained investigators. Both allegations were also investigated by specialty trained ICE employees, one investigation by a specialized trained investigator and the other investigation by an ICE Fact Finder. . One investigation was determined unsubstantiated and the other unfounded. There was one open investigation. The PSA Compliance Manager stated that the RPD is notified of all investigations that are criminal in nature; RPD responded to one. While reviewing the investigations, the Auditor confirmed the investigation process, including the notifications to OPR, and the RPD.

(b): Policies 903E.02 and 2.11 outlines the responsibilities of the facility and other investigative agencies. The PSA Compliance Manager stated that she is notified of every allegation and will follow the policies to ensure the investigative steps are being followed, she is also a trained investigator. She also indicated that as per policy 903E.02, all investigations are stored for at least five years, facility policy dictates 10 years. While conducting her interview, she indicated that the investigations are stored in her office in a locked file cabinet. The Auditor viewed this filing cabinet during the audit.

Recommendation: The Auditor recommends the practice of maintaining investigation records storage for five years be changed to meet the facility's policy requirement of ten years or update policy to match practice.

(c): The Auditor reviewed the MTC website at https://www.mtctrains.com/prea/. The website has a page dedicated to PREA, PREA Policy 903E.02 is available to the public for review. The page contains the zero-tolerance policy, how to report sexual abuse or sexual harassment, and how an employee may report sexual abuse or sexual harassment. There is a paragraph that explains MTC will ensure an administrative or criminal investigation for all allegations of sexual abuse and sexual harassment. The ICE website, www.ice.gov/prea includes a PREA overview, PREA policies, reporting methods with addresses and phone numbers, ICE Policy 11062.2, ICE Detainee Handbook, ICE PREA poster, and ICE PREA pamphlet.

(e/f): Policies 903E.02 and 2.11 indicates that all incidents are promptly reported to the Joint Intake Center (JIC), ICE OPR, and/or DHS OIG, as well as, the appropriate ICE FOD. If the incident is potentially criminal and a staff member, contractor, volunteer, or detainee is alleged to be the perpetrator of sexual abuse the incidents are reported to the RPD for investigation. The PSA Compliance Manager stated that the notifications are being made as per policy; this was confirmed through review of the investigative files.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- MTC Employees training PowerPoint and training rosters
- Training PowerPoints for Cross-gender, Transgender, and Intersex Searches

(a): The facility has trained all employees, contractors, and volunteers who may have contact with facility detainees, on how to fulfill their responsibilities under these standards, this training included:

- MTC's zero-tolerance policy for all forms of sexual abuse and assault;
- The right of detainees and staff to be free from sexual abuse or assault;
- Definitions and examples of prohibited and illegal behavior;
- Dynamics of sexual abuse and assault in confinement;
- Prohibitions on retaliation against individuals who report sexual abuse or assault;
- Recognition of physical, behavioral, and emotional signs of sexual abuse or assault, situations in which sexual abuse or assault may occur, and ways of preventing and responding to such occurrences, including:
- Common reactions of sexual abuse and assault victims;
- How to detect and respond to signs of threatened and actual sexual abuse or assault;
- Prevention, recognition, and appropriate response to allegations or suspicions of sexual abuse and assault involving detainees with mental or physical disabilities; and
- How to communicate effectively and professionally with victims and individuals reporting sexual abuse or assault;
- How to avoid inappropriate relationships with detainees;
- Accommodating limited English proficient individuals and individuals with mental or physical disabilities;
- Communicating effectively and professionally with lesbian, gay, bisexual, transgender, intersex, or gender non-conforming individuals, and members of other vulnerable populations;
- Procedures for fulfilling notification and reporting requirements under this directive;
- The investigation process; and
- The requirement to limit reporting of sexual abuse or assault to personnel with a need-to-know to make decisions concerning the victim's welfare and for law enforcement or investigative purposes.

During the interview with the facility training officer he outlined the training program for all employees, contractors, and volunteers. They attend an in-person training conducted in the facility classroom. The training is provided through PowerPoint, video, and verbal explanation.

(b): All training is completed every year, and refresher training is provided during roll call. The training was verified through interviews and reviewing signed training certification forms for 50 staff members. The training certificates reviewed date back to calendar year 2018, the year of incorporation of PREA at the facility. The PREA training requirements are outlined in policies 903E.02 and 2.11.

(c): The facility documents the training on a roster, they further provide refresher training to ensure that all employees know MTC's current sexual abuse and assault policies and procedures. The Auditor reviewed the training materials; these were provided to the Auditor before the onsite audit. The Auditor further reviewed the training retention schedule for the facility, which indicates the records will be retained for five years. During the staff interviews, the Auditor verified they had received the training. They verified that they had viewed the training and were able to explain their responsibility under the standards.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially exceeded the requirements of this standard, and all provisions. This decision was based on the facility's overall commitment to safety, this commitment was shared by all staff who interacted with the Auditor. The facility trains all staff yearly and provides refresher training on their obligations under PREA, this far exceeds the standard requirement of training every two years.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- MTC Employees training PowerPoint utilized for contractor and volunteer training materials

(a)(b)(c): The facility trains all contractors and volunteers who may have contact with detainees on their responsibility under the facility's zero-tolerance policy. The facility ensures the contractors attend the same training as the staff, this training far exceeds the training requirements under the standard. The Auditor confirmed with the interviewed contractors that they received the same training as the staff, all interviewed understood their responsibility under the PREA policies. Policies 903E.02 and 2.11 outlines their responsibility to train the contractors and volunteers who may have contact with the detainees. The facility maintains written confirmation that the contractors and volunteers attend the training. These confirmations are stored by the facility training officer, the Auditor reviewed these training documents for contractors trained, during the onsite audit.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially exceeded the requirements of this standard, and all provisions. This decision was based on the facility's overall commitment to safety, this commitment was shared by all staff who interacted with the Auditor.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- ICE Detainee National Handbook
- Facility Supplemental Handbook
- PREA Video

(a)(b)(c) Policies 903E.02 and 2.11 outlines the facility intake process that ensures all detainees are notified of the agency's and the facility's zero-tolerance policies for all forms of sexual abuse. This process includes instruction on prevention and intervention strategies, self-protection and indicators, definitions, examples of detainee-on-detainee sexual abuse, and staff-on-detainee sexual abuse, and coercive sexual activity. They also inform the detainees of reporting methods which include reporting to staff, the DHS OIG, and the JIC. Prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. Upon initial intake, all detainees view a PREA Video which is playing in all of the holding cells in the intake area, this video plays in both an English and Spanish version. The detainee would then sign a form indicating they watched the video, the Auditor reviewed 30 signed forms. The detainees who speak other languages are educated by the intake officers utilizing the interpretation line, these detainees will sign a form indicating that they were educated in a language they understood. All detainees are given a copy of the ICE National Detainee Handbook which is translated into 11 languages. The interviews with intake staff confirmed this process. This process includes detainees who are deaf, visually impaired, or otherwise disabled, as well as, to detainees who have limited reading skills. The intake officers stated for deaf or hard of hearing detainees they would write back and forth and have them read the material, read the materials to visually impaired detainees, and explain in a manner that detainees with cognitive issues could understand. The facility self-identified the detainee education issue of not documenting the detainee education with the training in July of 2019. Prior to that, the facility had no historical documentation to demonstrate detainee education. They are now correctly providing and documenting education; however, at the time of the audit this process was only in place for a couple of weeks. The facility needs to continue the process they put in place to create historical data that they are educating the detainees.

Corrective Action: The facility recently developed the education process for all detainees enumerated in the standard. They need to continue to document the education, and ensure the detainees understand the zero-tolerance policy and the PREA information. The facility needs to provide further documentation to document the education process over a time period to substantiate a sustained functioning process.

(d) The facility has posted on all housing units the DHS-prescribed sexual assault awareness notice; the PSA Compliance Manager contact information; and name of Rio Grande Valley Empowerment Zone Corporation that can assist detainees who have been victims of sexual abuse. These postings are in both English and Spanish.

(e) Upon intake the facility provides the DHS-prescribed "Sexual Assault Awareness Information" pamphlet to detainees; this is provided in either English or Spanish. The intake staff confirmed that they can print other languages if needed, they would have the document translated into other languages.

(f) Information about reporting sexual abuse is included in the ICE National Detainee Handbook. The ICE National Detainee Handbook is translated into 11 languages and provided to the detainees upon intake. This was confirmed during the detainee interviews, all reported receiving the ICE National Detainee Handbook in a language they could understand.

§115.34 - Specialized training: Investigations.

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

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- Training certificates
- Training materials for PREA: Investigating Sexual Abuse in Confinement Settings, online course offered by the National institute of Corrections.
- ICE investigator training documents on Sharepoint

(a)(b): Policies 903E.02 and 2.11 outlines the training requirements for the investigators and ensures they are qualified to investigate sexual abuse and sexual harassment in confinement settings. The investigators participate in the National Institute of Corrections PREA Investigators Course. All of the supervisors at the facility have been trained as facility PREA investigators. The Auditor interviewed investigators during the audit and found them knowledgeable, and understood their responsibilities being the immediate responding investigator. They also confirmed that if there was any indication the incident was criminal, they would immediately stop the administrative investigation and notify the RPD and OIG. The Auditor reviewed the training materials utilized for the investigators course and verified it covered all provisions of the standard. The reviewed investigations were investigated by the trained facility investigators and ICE trained staff. The ICE staff conducting investigations included a specialized trained investigator and an ICE Fact Finder. Documentation of ICE specialty training was provided in the Sharepoint files.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- Training materials for Specialized Medical and Mental Health PREA Training
- Training certificates for medical and mental health staff

(a)(b): There are no ICE Health Services Corps. (IHSC) staff working at the facility making sections (a) and (b) non-applicable.

(c): During the interviews with the medical and mental health staff, they confirmed that they received the Specialized Medical and Mental Health PREA Training. The Auditor reviewed the training materials and found that the lesson plan meets the requirements of provision (b) of the standard. This was further confirmed during the interview with the facility training officer, who provided the Auditor with the training certificates for medical and mental health staff. The Auditor reviewed ten training certificates. This training is outlined in the facility's policies 903E.02 and 2.11, which was approved by the agency. The medical staff do not conduct sexual assault examinations.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially exceeded the requirements of this standard, and all provisions. This decision was also based on the facility's overall commitment to safety in their facilities; this commitment was shared by all staff who interacted with the Auditor.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- Intake screening for risk of sexual victimization or abusiveness
- Detainee Risk Assessments
- Memo from PSA Compliance Manager stating 60-90-day reassessments began on July 19, 2019

(a)(b)(c)(d): Policies 903E.02 and 2.11 outlines the process utilized to assess a detainee's risk of victimization or abusiveness. The facility screens all detainees upon arrival at the facility utilizing the PREA Risk Assessment. This assessment identifies those likely to be sexual aggressors or sexual victims and enables the facility to house detainees appropriately to prevent sexual abuse and mitigate any such danger. The process is to have the detainee screened by classification upon arrival at the facility. The PREA Risk Assessment tool takes into consideration the following:

- 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;
- 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 concerns about his or her physical safety.

They also take into consideration prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility. This assessment takes place prior to the detainee being placed in general population and is completed within 12 hours of arrival. The detainees are placed in holding cells in the intake area until the assessment takes place. The Auditor reviewed 30 detainee files and found that all initial assessments took place within 12 hours of arrival.

(e): The PSA Compliance Manager confirmed that the facility has not been conducting any reassessments on a regular basis. The Auditor randomly selected 30 detainee files and found that most of the 60-90-day reassessments were conducted after July 19, 2019 when the reassessment process was put in place. At that time the facility went back and completed 60-90-day reassessments on detainees, most of these were well beyond the 90 days.

Corrective action: The facility was not conducting 60-90-day reassessments prior to July 19, 2019. The facility needs to create a tracking system to identify any detainee at the facility between 60 and 90 days, and ensure a reassessment is conducted and documented on all detainees who are held at the facility for this period.

(f): The PSA Compliance Manager and Intake Officers stated that no detainee is disciplined for refusing to answer, or for not disclosing complete information in the PREA risk assessment screening process. This is further outlined in policy policies 903E.02 and 2.11.

(g): The PSA Compliance Manager also confirmed that the information from the risk assessment is not available to the general staff, and is limited to medical, intake staff, mental health, and classification. The assessments are stored in the classification department in filing cabinets, which are not accessible to general staff. These files include the initial PREA assessment, the reassessment, and other detainee information. The files are stored in locked filing cabinets, the classification personnel stated that when she is not in her office, the filing cabinets and her office door are locked.

§115.42 - Use of assessment information.

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

Notes:

Documents Reviewed

- Policies 903E.02 and 2.11

(a): Policies 903E.02 and 2.11 states that the information from the PREA Risk Assessment is utilized to inform assignment of detainees to housing, recreation, activities, and voluntary work. The PSA Compliance Manager and Classification Personnel stated that these determinations are on an individualized basis. While onsite, the Auditor reviewed 30 completed screening tools and reassessment documentation in the detainee files. It should be noted that prior to July 19, 2019 the facility was not conducting any detainee reassessments. On that date the facility implemented a process of conducting 60-90-day reassessments. They further stated that all housing decisions are made on a one-on-one basis, and any indication of the detainee being at high risk for victimization or abusiveness is taken into consideration when determining where to house them.

(b): The PSA Compliance Manager and Classification Personnel stated that when making an assessment and housing decision for a transgender or intersex detainee, they consider the detainee's gender self-identification and how any placement will affect the detainee's health and safety. They also confirmed that the placement is not based solely on the identity documents or physical anatomy of the detainee, and their self-identification of his/her gender and self-assessment of safety is always taken into consideration, and all placements are consistent with the facility's safety and security. The medical staff conducts the initial assessments and consults with mental health; this was confirmed during their interviews. The placement of a transgender or intersex detainee is reassessed at least twice each year to review any threats to safety experienced by the detainee. The PSA Compliance Manager confirmed that they have not housed any transgender or intersex detainee in the last 12 months where a reassessment needed to take place. She further relayed that an individual who identified as transgender or intersex would be placed in general population. The PSA Compliance Manager understood her obligations under the policy.

(c): Through policy review and officer interviews, the Auditor confirmed that transgender and intersex detainees are allowed to shower separately from other detainees. They would have the detainee shower during count time when the other detainees were not in the showers, or they have the option to allow the detainee to shower in medical.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.43 - Protective custody.

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

Notes:

Documents Reviewed

- Policies 903E.02 and 2.11

(a)(b)(c)(d)(e): Policies 903E.02 and 2.11 govern the management of the administrative segregation unit. These procedures were developed in consultation with the ICE FOD. The PSA Compliance Manager stated that they would document detailed reasons for the placement of an individual in administrative segregation on the basis of vulnerability to sexual abuse or assault, and as per policy 903E.02 notify the ICE AFOD within 72 hours. Policies 903E.02 and 2.11 states that the use of administrative segregation to protect vulnerable detainees is restricted to those instances where reasonable efforts have been made to provide appropriate housing and would be for the least amount of time practicable, and when no other viable housing options exist, as a last resort. The facility would assign detainees to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged; this would not last more than 30 days. The detainees would be provided access to programs, visitation, counsel, and other services available to the general population. The assignment of a detainee to administrative segregation under these circumstances would be documented within 24 hours by a supervisor and emailed to the PSA Compliance Manager, and the status is reviewed within 72 hours. The PSA Compliance Manager would conduct this review within seven days, and every week after that for the first 30 days, and every ten days after that. The PSA Compliance Manager understood the policy, and her obligations if this occurred. She confirmed that they had not placed any detainees in segregated housing under these conditions during the audit period.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.51 - Detainee reporting.

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

Notes:

Documentation Reviewed

- Policy 2.11
- Facility Handbook
- ICE National Detainee Handbook
- DHS/ICE reporting posters and local reporting avenue and victim advocacy numbers on housing units

(a)(b): Policy 2.11 established the facility's procedures for detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The facility provides instructions through the written materials provided at intake, DHS/ICE reporting posters on housing units on how detainees may contact their consular official, the DHS OIG or, confidentially and, if desired, anonymously, report these incidents. The DHS/ICE PREA Poster as well as the facility PREA Reporting Posters indicates that reports can be made anonymously. The facility has also developed internal reporting avenues where the detainees can report directly to a staff member, and in writing. The Auditor found that the information is being provided to all detainees in a language they can understand. The information is provided in English and

Spanish, and if needed the intake officer can provide the information in other languages. The ICE National Detainee Handbook is printed in 11 languages and represents the languages at the facility. The Auditor tested the third-party reporting line in four housing units and found the phone number goes to the DHS OIG. The DHS OIG is the outside entity reporting avenue.

(c): Policy 2.11 states that staff will accept reports made verbally, in writing, anonymously, and from third parties. They will promptly document any verbal reports and notify their Supervisor. The interviewed officers and supervisors understood their obligation under this standard.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.52 - Grievances.

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

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- Facility Handbook

(a)(b): Policies 903E.02 and 2.11 and the facility handbook address the detainee grievance procedure regarding sexual abuse. The facility does not impose a time limit for the submission of the grievance, the grievance would be considered an emergency grievance, and no informal grievance procedures are applied. The PSA Compliance Manager and Grievance Coordinator stated that there are no time limits for sexual abuse grievances; if they received a grievance of this nature, it would immediately be investigated.

(c)(d): Policies 903E.02 and 2.11 outline the written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. The PSA Compliance Manager stated that she would take immediate corrective action to protect the detainee. She further stated that all medical emergencies would be brought to the immediate attention of proper medical personnel. When reviewing the investigations, the Auditor found that the investigations were not reported through a grievance.

(e): Policies 903E.02 and 2.11 states that the grievance is initially responded to in 48 hours, and a final decision is provided within 5 days. As per policy, any appeal would be responded to within 30 days. The PSA Compliance Manager confirmed the FOD would be notified at the end of the grievance process.

(f): Policies 903E.02 and 2.11 and the facility handbook state that a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives in preparing a grievance. The interviewed staff understood their obligations to expedite a grievance, and to assist if need be. They confirmed they would assist in preparing the grievance if asked, and ensure the grievance is immediately forwarded to the Grievance Coordinator.

The facility has not had any grievances filed within the last 12 months for sexual abuse. The Auditor confirmed this during the interview with the PSA Compliance Manager and Grievance Coordinator.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

Documentation Reviewed:

- Policy: 2.11
- MOU with Rio Grande Valley Empowerment Zone Corporation

(a)(b)(c)(d): The facility has entered into an MOU with Rio Grande Valley Empowerment Zone Corporation to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and prosecution of sexual abuse perpetrators. The MOU is dated September 21, 2018. The information, including mailing address and contact number, are posted in the housing units and further provided to victims of sexual abuse as indicated in the investigations reviewed. Policy 2.11 establishes the procedures which include the outside agencies in the facility's sexual abuse prevention and intervention protocols. During the interview with the PSA Compliance Manager, she stated that all victims of sexual abuse are given the contact information for Rio Grande Valley Empowerment Zone Corporation, and informed that they could contact them at any time. She further confirmed that they would inform detainees, prior to giving them access to outside resources, of the facility procedures which govern monitoring of communications and when reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The PSA Compliance Manager confirmed that the calls would not be monitored in real time, a detainee at the facility does not need a pin to operate the telephones. The phone calls are recorded but not monitored in real time. This was confirmed when the Auditor utilized the detainee telephone. The contact information for the Rio Grande Valley Empowerment Zone Corporation is also posted on the housing units. The investigative files reviewed indicated that the detainees were given the contact information for Rio Grande Valley Empowerment Zone Corporation, but due to confidentiality, it is unknown if they were utilized.

After the onsite audit, the Auditor contacted Rio Grande Valley Empowerment Zone Corporation and confirmed these procedures.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.54 - Third-party reporting.

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

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11

- OIG Poster
- ICE DRIL Poster
- MTC website www.mtctrains.com/prea

The facility has established several methods for third-party reporting. The posters for the OIG and ICE DRIL Line are posted in the visiting room and front entrance to the facility. MTC has placed the following reporting steps on its website:

> To make an allegation of detainee-on-detainee or staff-on-detainee sexual abuse or sexual harassment, please contact via email the MTC Prison Rape Elimination Act (PREA) coordinator. MTC will ensure an administrative or criminal investigation for all allegations of sexual abuse and sexual harassment. MTC PREA contact:
>
> (b) (6), (b) (7)(C) MTC PREA Compliance Manager, (b) (6), (b) (7)(C)
> (b) (6), (b) (7)(C) Assistant PREA Compliance Manager, (b) (6), (b) (7)(C)

The agency has posted the third-party reporting avenues on the agency's website, www.ice.gov/prea. These reporting avenues include the DHS OIG, ICE OPR, and the ICE DRIL. The website provides explicit instructions on how to make a report.

The Auditor confirmed that the telephone numbers provided by the agency are operational. During the PSA Compliance Manager's interview, she confirmed if a third-party report was received, they would immediately begin an investigation.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.61 - Staff reporting duties.

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

Documentation Reviewed:
- Policies: 903E.02 and 2.11
- MTC website www.mtctrains.com/PREA

(a)(b):Policies 903E.02 and 2.11 outlines the requirement of all staff to report immediately and according to policy any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The reporting requirement portion of the policy was reviewed and approved by MTC administration on November 1, 2018. Policy 2.11 was reviewed by facility administration, including the PSA Compliance Manager on October 23, 2018. There was no documentation provided that the agency had reviewed and approved the policy. As per the standard the Agency needs to review and approve the facility policies regarding staff reporting duties. The staff are able to report outside of the chain of command. The Warden and PSA Compliance Manager stated that the staff can report directly to them or are authorized to utilize the email addresses for the MTC PSA Compliance Manager. The interviewed staff understood the reporting avenues available to them.

Recommendation: The Agency needs to review and approve the facility policies regarding staff reporting duties.

(c): Policies 903E.02 and 2.11 further states that staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, make medical treatment, investigation, law enforcement, or other security and management decisions. During all of the staff interviews, the Auditors confirmed that the staff understood their reporting requirements, reporting avenues available to them, and the requirement to not reveal any information to those without a need to know. These procedures were further verified during the review of the investigative reports; the reports indicated only the staff directly involved in the incident were notified.

(d) The facility does not house juveniles nor family units. The PSA Compliance Manager confirmed that they would notify the appropriate state agency if a detainee who is considered a vulnerable adult was the victim of a sexual abuse. This is further outlined in policy 903E.02 and 2.11. She further confirmed that they have not made any notification of this type within the past 12 months since no incidents of this nature occurred.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.62 - Protection duties.

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

Documentation Reviewed:
- Policies: 903E.02 and 2.11

Policies 903E.02 and 2.11 outlines that if a staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee. During the staff interviews, they stated that they would make the safety of the detainee their priority and ensure they were separated from the other detainees and contact their supervisor. During the supervisor interviews, they stated that they could separate detainees through housing unit moves. Any separation for these reasons would be immediately reported to the PSA Compliance Manager. The PSA Compliance Manager stated that she would respond immediately or be available by phone to discuss the incident. She further stated that they have not had a separation made for these reasons during the auditing period.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.63 - Report to other confinement facilities.

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

Documentation Reviewed:
- Policies: 903E.02 and 2.11

(a)(b)(c)(d): Policies 903E.02 and 2.11 outlines the facility's obligation to report allegations that had occurred at another confinement facility. The facility will document the allegation and the facility administrator or his designee would immediately contact the facility head where the allegation took place. This notification will be made immediately to the ICE Field Office, but not more than 72 hours. The facility administrator confirmed he would immediately document this notification and copies will be forwarded to the PSA Compliance Manager. The PSA Compliance Manager confirmed that if an allegation was received from another facility, she would immediately begin an investigation as outlined in policy 2.11 and notify the ICE Field Office.

The audited facility has not received notification from another facility, nor notified another facility under these circumstances in the last 12 months. This was confirmed during the Warden and PSA Compliance Manager interviews.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.64 - Responder duties.

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

Documentation Reviewed:
- Policy: 903E.02
- Investigative files
- MTC Employees training PowerPoint and training rosters

(a) Policy 903E.02 and training received by the staff outlines their response to a detainee who has been sexually abused. The staff is instructed through policy and training to hold the detainee in a place of safety with sight and sound separation from other detainees and make immediate notification to their supervisor. Upon the arrival of assistance, they would preserve any potential crime scene, and the initial responders would make an initial inquiry as to the events. If the incident occurred within the last 96 hours, they would also request that the victim and abuser not do anything that may destroy potential evidence including, washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating. The Warden and PSA Compliance Manager would be notified immediately; they would then contact the ICE Field Office and implement a coordinated response as outlined in policy 903E.20. The interviewed staff understood their obligations as an initial responder, and all who were interviewed were able to outline the first responder obligations.

(b) Policies 903E.02 and 2.11 outlines that if the first staff responder is not a security staff member; the responder shall be required to request that the alleged victim and abuser not take any actions that could destroy physical evidence and then notify security staff. The interviewed non-security staff understood their requirements under the policy.

The reviewed investigations indicated that the responding staff followed policy, immediate notifications were made to supervisors, and the requirements of the policy were followed.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.65 - Coordinated response.

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

Documentation Reviewed:
- Policies: 903E.02 and 2.11
- Investigative files

(a)(b): Policies 903E.02 and 2.11 outlines the facility's coordinated response to a sexual abuse or sexual harassment incident. The plan utilizes a multi-disciplinary approach which includes the first responders, Facility Administrator, Chief of Security, PSA Compliance Manager, Facility Investigator, and Health Services Administrator. The plan further details each team member's responsibility during an incident. The implementation of this plan was verified through the interviews with the PSA Compliance Manager and review of the investigation files. The coordinated response was further verified during the investigative file review, all of the necessary team members were involved.

(c)(d) The PSA Compliance Manager confirmed that if a victim of sexual abuse is transferred between their facility and a DHS immigration detention facility covered by either subpart A or B of the DHS PREA Standards, or to a non-DHS facility, they notify the facility of the potential need for medical or social services unless the victim requests this notification not be made. Initially, tThe facility provided the Auditor with documentation that they had not made a notification under these circumstances during the auditing period because they have not transferred a victim to another detention facility. However, through further questions with the facility related to the closed investigations, documentation was provided that one detainee was released on bond and the other was transferred to another detention facility. Per documentation provided by the facility, there is no documentation the transferred detainee was informed of the outcome of the investigation.This was further confirmed during the PSA Compliance Manager's interview. Of the two closed investigations, documentation was provided after the on-site audit that showed one detainee was released on bond and the other detainee was transferred to another detention facility. Further documentation was requested to determine if the facility upon transfer provided information to the receiving facility on any potential need for medical and/or social services. Through an email with the facility, the PSA Compliance Coordinator could not find any PREA information shared upon the transfer.

Does Not Meet: The sending facility must notify the facility the victim is transferred to of any information for the potential need for medical and/or social services unless the victim requests this notification not be made. The facility must document the notification of this information to the receiving facility or the victim's refusal of the sharing of information.

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

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

Documentation Reviewed:
- Policy: 903E.02

Policy 903E.02 states that all employees, contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. The PSA Compliance Manager and Warden confirmed that they have non-contact detainee posts where the individual would be placed until the investigation was completed. They also confirmed that the facility has not entered in, nor renewed, any collective bargaining agreement that prevents them from removing staff from contact with detainees.

The facility has not had any incidents within the past 12 months where an employee, contractor, or volunteer was removed from contact with a detainee, because none of the investigations involved a staff member.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.67 - Agency protection against retaliation.

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

Documentation Reviewed:
- Policy: 903E.02

(a)(b)(c): Policy 903E.02 outlines the facility's protection against retaliation. The policy states that employees, 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 activity as a result of force, coercion, threats, or fear of force. The PSA Compliance Manager and Warden confirmed that they would utilize multiple protection measures including housing changes, removal of staff, and emotional support services. The PSA Compliance Manager stated that for at least 90 days following a report of sexual abuse, the facility will continually monitor to see if there are any disciplinary reports, housing or program changes, negative performance reviews or reassignments of staff; that may suggest possible retaliation by detainees or staff. If this is indicated the facility will act promptly to remedy any such retaliation. Policy 903E.02 outlines the monitoring process and indicates that detainee disciplinary reports, housing or program changes or negative performance reviews or reassignments of staff would all be monitored. If a need is indicated the monitoring would continue beyond the 90 days.

During the onsite audit the Auditor reviewed the documented monitoring for a detainee involved in an incident; the monitoring was conducted in accordance with the policy and standard. The PSA Compliance Manager met with the detainee monthly for a 90-day period and documented these meetings. The documentation noted no indications of retaliation were identified. This documentation was contained in the investigative file. The second unsubstantiated incident had no monitoring, the detainee left the facility custody immediately after the incident.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.68 - Post-allegation protective custody.

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

Documentation Reviewed:
- Policy: 903E.02
- Investigative Files
- Memo from PSA Compliance Manager stating no occurrences

(a)(b)(c)(d): Policy 903E.02 outlines the facility post-allegation protective custody. The detainee would be placed in the least restrictive and supportive environment subject to the requirements of 115.43. They would not be held for more than five days in any type of administrative restriction, unless under unusual circumstances or at the request of the detainee. The PSA Compliance Manager and Classification Personnel confirmed that if a detainee were held in this manner, they would be reassessed utilizing the initial screening tools, before being returned to the general population. The policy further states that the ICE AFOD will be notified within 72 hours if a detainee was placed in protective custody under these circumstances. The PSA Compliance Manager understood the requirements for housing detainees under these circumstances; she further confirmed they had not had a detainee in post allegation protective custody within the past 12 months. The PSA Compliance Manager confirmed that if they needed to place a detainee in protective custody of this nature, they would utilize the medical unit, which is a smaller unit and under direct supervision by staff. A memo from the PSA Compliance Manager confirmed the facility has not housed any detainees under these circumstances.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.71 - Criminal and administrative investigations.

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

Documentation Reviewed:
- Policies: 903E.02 and 2.11
- Investigative files
- PREA Allegation Spreadsheet

(a)(b): Policies 903E.02 and 2.11 outlines the facility investigators responsibility to conduct prompt, thorough, and objective administrative investigations into alleged sexual assault. The facility has trained the supervisors as investigators to conduct administrative investigations, this allows an immediate response upon receipt of any allegation. The PSA Compliance Manager, who is also a trained investigator, stated that all allegations are responded to immediately, and ICE is notified. If the allegation is criminal, they will stop the administrative investigation and let OIG or the RPD conduct the criminal investigation. The Auditor confirmed with three of the investigators that if a criminal investigation were either unsubstantiated or substantiated, they would still conduct an administrative investigation. The PSA Compliance Manager confirmed the administrative investigations in these cases would be conducted after consultation with the OIG, OPR, or the RPD. During the review of the substantiated investigation, the Auditor found that the administrative investigation was stopped until the RPD started the criminal investigation. The administrative investigation was concluded only after the RPD was consulted. Both allegations were also investigated by specialty trained ICE employees, one investigation was determined unsubstantiated and the other unfounded. There was one open investigation at the time of the audit. Upon review of the investigative files the Auditor found that the investigations were conducted promptly, objectively and were very thorough.

(c): Policies 903E.02 and 2.11 outlines the investigative procedure for administrative investigations. This policy provides provisions for the following:
- Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data;
- Interviewing alleged victims, suspected perpetrators, and witnesses;
- Reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator;
- Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph;
- An effort to determine whether actions or failures to act at the facility contributed to the abuse; and
- Documentation of each investigation by a written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and
- Retention of such reports for as long as the alleged abuser is detained or employed by the facility, plus five years
- The procedures in the policy govern the coordination of the administrative and criminal investigation, procedures to ensure that the criminal investigation is not compromised by an internal administrative investigation.

During their interviews, the facility investigators confirmed the investigative procedures for the administrative investigations. This procedure was further outlined in the written administrative reports.

(e)(f): Policies 903E.02 and 2.11 states that the investigation will not be terminated if the alleged abuser or victim leaves employment or control of the facility. The PSA Compliance Manager confirmed that the investigation would be conducted. She further stated that if an outside entity conducted a criminal investigation, she would stay in contact with them to ascertain the progress of the investigation. This was further confirmed during the review of the investigative files. The two investigations from the last 12 months have been investigated by the facility investigators. The one investigation that involved the RPD included email documentation of contact between the PSA Compliance Manager and investigator, updating the facility on the investigation.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Documentation Reviewed:
- Policy: 903E.02
- Investigative file

Policy 903E.02 states that during an administrative investigation, the investigator shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The facility investigators stated that they do not impose any higher of a standard than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. This was further confirmed during the review of the investigative files.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.73 - Reporting to detainees.

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

Notes:

Documentation Reviewed
- Policies: 903E.02 and 2.11
- Investigative files
- Notification of outcome of allegations

Policies 903E.02 and 2.11 outlines the procedure for reporting the results of an investigation to a detainee. The policy directs the PSA Compliance Manager to inform the detainee in writing whether the allegation has been substantiated, unsubstantiated, or unfounded. This process is completed in writing. The detainee will receive the notification in person by the PSA Compliance Manager and the detainee will sign the bottom of the notification acknowledging receipt. If a criminal investigation takes place and the determination is different, an updated notification will be provided to the

detainee. The detainee would keep a copy, and the original is placed in the investigative file. The PSA Compliance Manager confirmed this procedure; it was further confirmed by reviewing the completed notification of outcome of allegation documents in the investigative files.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.76 - Disciplinary sanctions for staff.

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

Documentation Reviewed
- Policies: 903E.02 and 2.11
- Memo to Auditor from the PSA Compliance Manager

(a)(b)(c)(d): Policies 903E.02 and 2.11 outlines the facility response to staff discipline of a substantiated allegation of violating facility sexual abuse policies. The staff member would be subject to disciplinary or adverse action up to and including removal from their position and the Federal service. The PSA Compliance Manager and Warden confirmed that removal from their position is the presumptive discipline for a violation of the sexual abuse policies. Policy 903E.02 was approved by the MTC President on November 1, 2018, policy 2.11 was approved by the El Valle Warden on October 23, 2018. The PSA Compliance Manager and Warden confirmed that the facility would report all removals or resignations by staff prior to removal for violations of facility sexual abuse policies to the OIG and the RPD, unless clearly not criminal, and confirmed if the staff member was licensed, the licensing body would be notified. The facility provided the Auditor with a memo stating that no staff members have been disciplined within the last 12 months. The Auditor reviewed the two investigations for the past 12 months and confirmed that no investigation involved staff. The agency has not reviewed or approved the policy per standard. As per the standard the Agency needs to review and approve the facility policies regarding disciplinary or adverse actions for staff.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

Recommendation: The agency needs to review and approve the facility's policies regarding disciplinary or adverse actions for staff.

§115.77 - Corrective action for contractors and volunteers.

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

Documentation Reviewed
- Policies: 903E.02 and 2.11
- Memo to Auditor from PSA Compliance Manager

(a): Policies 903E.02 and 2.11 addresses the procedures when any contractor or volunteer has engaged in sexual abuse. The policy directs the facility to prohibit the contractor or volunteer from having any contact with detainees. The PSA Compliance Manager and Warden stated that the facility would also make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. These incidents, if criminal, will also be reported to law enforcement agencies.

(b)(c): The PSA Compliance Manager and Warden confirmed that contractors and volunteers suspected of perpetrating sexual abuse would be removed from all duties requiring detainee contact pending the outcome of an investigation. They further confirmed that as per policies 903E.02 and 2.11, the facility would take appropriate remedial measures and will consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within these standards. The PSA Compliance Manager and Warden both confirmed if a contractor or volunteer violated any provisions of the standards their facility security clearance would be immediately revoked.

The facility did not have any incidents of contractor or volunteer corrective action for the past 12 months. This was confirmed through interviews with the PSA Compliance Manager and Warden, and through a memo from the PSA Compliance Manager.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.78 - Disciplinary sanctions for detainees.

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

Documentation Reviewed
- Policies 903E.02 and 2.11
- Policy 3.1 Disciplinary System
- Investigative files

(a)(b)(c)(d): Policy 3.1 addresses the facility disciplinary sanctions following an administrative or criminal investigation that finds a detainee engaged in sexual abuse. The disciplinary process outlined in policy 3.1 ensures that the discipline is commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform to rules and regulations in the future. The policy further outlines the progressive levels of reviews, appeals, procedures, and documentation procedure. It was confirmed during the interview with the PSA Compliance Manager and Disciplinary Officer that this discipline process would be utilized for disciplining any detainee; there was one detainee disciplined as a result of a PREA investigation during the audit period. The discipline received was commensurate with the acts committed. This detainee was placed in the restrictive housing unit for 15 days. The overall detainee discipline is progressive, due to the severity of the acts committed, and the amount of times the detainee is disciplined. The Auditor confirmed this discipline during the investigative file review.

During the interviews with medical and mental staff they confirmed any detainee involved in an incident, whether victim or offender, would be evaluated. The PSA Compliance Manager confirmed, as per policies 903E.02 and 2.11, they would consider any mental disabilities or mental illness that

may have contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The detainees, both victim and abuser, in the investigations were offered mental health evaluations.

(e)(f): The PSA Compliance Manager and Disciplinary Officer stated that the facility follows policies 3.1 and 903E.02 for detainee discipline, which states that the facility will not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. They also confirmed that a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred would not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. This is further outlined in policies 903E.02 and 2.11. The Auditor further confirmed this during the investigation review.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

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

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

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- Detainee files

(a)(b)(c): Policies 903E.02 and 2.11 outlines the medical and mental health screenings for a history of sexual abuse. If the detainee has experienced prior sexual victimization or perpetrated sexual abuse, they will be referred to a qualified medical or mental health practitioner for follow-up. The medical evaluation will occur immediately, and the mental health evaluation will occur within 72 hours. The detainees at the facility are screened under 115.41 by intake officers. If they experienced prior sexual victimization or perpetrated sexual abuse, they would receive any immediate medical attention as deemed necessary. If mental health were available, they would see them immediately, if not they would be tasked with seeing the detainee within 72 hours. This process was confirmed during the interviews with medical and mental health staff. They also confirmed that they would notify the PSA Compliance Manager and classification personnel. The Auditors confirmed this process during the detainee interviews, several detainees indicated they had reported prior victimization, they confirmed they were evaluated by medical and mental health. This was further confirmed during the review of the 30 detainee files.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

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

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

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- MOU with Rio Grande Valley Empowerment Zone Corporation
- Information for Valley Baptist Health System CAART
- Investigative files

(a)(b): Policies 903E.02 and 2.11 states that a detainee who is a victim of sexual abuse will have timely, unimpeded access to emergency medical treatment and crisis intervention services, which include emergency contraception and sexually transmitted infections prophylaxis, by professionally accepted standards of care. The services would be conducted at the Valley Baptist Health System facility, and any follow-up care would be provided by the facility providers. The services are provided to the detainee without financial cost and regardless of whether they name the abuser or cooperates with any investigation arising out of the incident. The Auditor confirmed with the medical staff that the above procedures would be followed. The facility has a MOU agreement with Rio Grande Valley Empowerment Zone Corporation for victim advocacy. All sexual assault examinations would take place at the Valley Baptist Health System facility utilizing the CAART.

The Auditor reviewed the investigative files and found that treatment services at the hospital were not utilized due to the nature of the incident. The information on how to contact the Rio Grande Valley Empowerment Zone Corporation was provided to the detainees, but due to confidentiality, it is unknown if they were contacted.

The Auditor contacted both the Valley Baptist Health System and Rio Grande Valley Empowerment Zone Corporation. The Auditor confirmed with a supervisor that the services are available as outlined above.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

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

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

Notes:

Documentation Reviewed
- Policies 903E.02 and 2.11
- Investigative Files

(a)(b)(c)(d)(e)(f)(g): Policies 903E.02 and 2.11 outlines ongoing medical and mental health care for those detainees who have been victimized by sexual abuse while in immigration custody, regardless of whether the victim names the abuser or cooperates with any investigation of the incident. The medical and mental health departments are part of the coordinated response to an incident and would be immediately involved with the detainee and make any treatment determinations. These determinations will include 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. The Health Service Administrator confirmed that the medical and mental health services offered at the facility are consistent with the community level of care. They have 38 total staff which includes physicians, nurses, and clinical staff. The detainee would be offered tests for sexually transmitted infections and all of the treatment services are offered at no cost to the detainee. If vaginal penetration occurs a pregnancy test will be offered. If pregnancy results, the detainee will receive timely and comprehensive access and information about lawful pregnancy related medical services, this treatment will also be at no cost to the detainee. The Health Services Administrator confirmed that the detainee would return from the hospital and all testing for sexually transmitted infections, pregnancy tests, or follow up treatment would be provided by the facility medical providers. The facility also attempts to provide a mental health evaluation and offer treatment to all known detainee-on-detainee abusers within 60 days of learning of the abuse history. The process was confirmed during the interviews with the PSA Compliance Manager and medical and mental health staff.

During the investigative file and medical records review, the Auditor confirmed medical and mental health services were provided for the detainees involved in the two investigations. Medical services were provided to the alleged victim and alleged abuser within 60 days of the allegation. The detainees in the aforementioned incidents were also evaluated by mental health. This was documented in the detainee's medical record and investigative file; this documentation further confirmed the services within 60 days.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.86 - Sexual abuse incident reviews.

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

Documentation Reviewed
- Policies 903E.02 and 2.11
- 2018 Annual Review of Sexual Abuse Investigations and Corrective Actions
- Investigative files with incident reviews

(a)(b): Within 30 days of the conclusion of an investigation, the facility conducts an incident review of every investigation of sexual abuse; these investigations include substantiated, unsubstantiated, and unfounded. During the past 12 months, the facility had 2 investigations one unsubstantiated investigation and one substantiated. The review team consists of upper-level management, the PSA Compliance Manager, and medical and mental health practitioners. The review is documented on a PREA incident report form. As per policies 903E.02 and 2.11, the report is submitted to the facility head and FOD within ten days of completion. All investigations and reviews are forwarded to OPR who are directed by 11062.2: Sexual Abuse and Assault Prevention and Intervention to forward a copy to the ICE PSA Coordinator for review. This report indicates if any changes need to be made in policy or practice that could better prevent, detect, or respond to sexual abuse. The Auditor confirmed with the Warden and PSA Compliance Manager the recommendations for improvement would be made if there were any. The review considers whether the incident or allegation was motivated by race-ethnicity or gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The Auditor reviewed the two incident reviews conducted, and the report documenting the review and the recommendations from the reviews; these recommendations were for additional training and more frequent staff rounds. These changes were made and the documentation confirming the changes was in the investigative file.

(c): The facility provided the Auditor with the 2018 Annual Review of Sexual Abuse Investigations and Corrective Actions report, which evaluates the 2018 data. The review of the Annual Report indicated issues that were identified during the review. These issues included blind spots, camera clarity, enforcement of dormitory rules, and conducting security rounds. These issues were identified in the individual incident review and corrective action had taken place. The report was submitted to the MTC PSA Compliance Manager, FOD, and the ICE PSA Coordinator; this is also outlined in policy 903E.02. The Auditor confirmed the recommended changes were in place.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.87 - Data collection.

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

Documentation Reviewed
- Policy 903E.02

(a): Policy 903E.02 outlines the procedures for the facility data collection. The facility collects and retains data related to sexual abuse as directed by the MTC PSA Compliance Manager. The facility PSA Compliance Manager collects and retains all data including case records associated with claims of sexual abuse including investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary. The PSA Compliance Manager stated that she is responsible for compiling data collected on sexual activity and sexual abuse incidents. She forwards the DHS Monthly PREA Incident Tracking Log, to the Corporate PSA Compliance Manager monthly. During her interview, the PSA Compliance Manager showed the Auditor the filing cabinet she secures all information. This filing cabinet is located (b) (7)(E) . The established facility retention schedule is ten years for these files.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially met the requirements of this standard, and all provisions.

§115.201 - Scope of audits.

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

Notes:

(d) During the audit tour, the facility provided the Auditors full access to all areas of the facility and the ability to ensure policies and procedures were in daily practice.

(e) Before the audit, during the on-site audit, and during the post-audit phase all relevant documentation was made available through the ICE ERAU SharePoint. Additional documentation was requested by the Auditor which was provided promptly.

(i) The Auditors was permitted to conduct private interviews with the detainees and staff. These interviews were conducted in various offices throughout the facility.

(j) PREA Auditor Notifications were posted throughout the facility providing the Auditor contact information. Interviewed staff and detainees confirmed the PREA Auditor Notifications were posted well before the audit, but they could not recall the date.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	4
Number of standards met:	32
Number of standards not met:	3
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Patrick J. Zirpoli 11/22/2019

Auditor's Signature & Date

(b) (6), (b) (7)(C) 12/23/2019

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Margaret L. Capel	**Organization:**	Creative Corrections, LLC
Email [redacted]	[redacted]	**Telephone number:**	479-521-[redacted]

AGENCY INFORMATION	
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)

FIELD OFFICE INFORMATION	
Name of Field Office:	San Antonio Field Office
Field Office Director:	Daniel Bible
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1777 NE Loop 410, San Antonio, Texas 78217
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	El Valle Detention Facility		
Physical address:	1800 Industrial Drive, Raymondville, Texas 78580		
Mailing address: *(if different from above)*			
Telephone number:	956-689-999		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email [redacted]	[redacted]	**Telephone number:**	956-357-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Lieutenant/PREA Coordinator
Email [redacted]	[redacted]	**Telephone number:**	956-689-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) site audit of the El Valle Detention Facility (EVDF) in Raymondville, Texas was conducted on August 27 – 29, 2019. Patrick Zirpoli and (b) (6), (b) (7)(C) PREA Auditors contracted through Creative Corrections, LLC conducted the audit. This was the first PREA audit for this facility. The facility is an Immigration and Custom Enforcement (ICE) contract adult facility, operated by Management & Training Corporation (MTC) with a design capacity of 1,185 beds. The facility houses adult male and female detainees. Juveniles and family units are not housed at this facility. The purpose of this audit was to determine compliance with the Department of Homeland Security (DHS) PREA standards.

Of the 41 standards reviewed, the Auditor found the facility exceeded four standards, 115.17 Hiring and promotions decisions, 115.31 Staff training, 115.32 Other training, and 115.35 Specialized training: Medical and mental health care. Thirty-two standards were found to meet the standards. Two standards were not applicable to the facility, 115.14 Juvenile and family detainees and 115.18 Upgrades to facilities and technologies. Three standards were found non-compliant, 115.33 Detainee education, 115.41 Assessment and risk of victimization and abusiveness, and 115.65 Coordinated response.

The ERO Custody Management Division coordinates with the facility to develop the Corrective Action Plan (CAP). The CAP was forwarded by (b) (6), (b) (7)(C) Inspections and Compliance Specialist to the Auditor for review and approval. The plan addressed the three non-compliant standards. The Auditor reviewed the CAP and agreed the recommendations met the standard requirements for each deficient standard.

The Inspections and Compliance Specialist, (b) (6), (b) (7)(C) provided supporting documentation during the CAP process and on March 26, 2020, the Auditor received the final supporting documentation to bring each of the non-compliant standards into compliance.

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. 33 - Detainee education

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

Notes:

Documentation Reviewed:

- Policies 903E.02 and 2.11
- ICE Detainee National Handbook
- Facility Supplemental Handbook
- PREA Video

(a)(b)(c) Policies 903E.02 and 2.11 outlines the facility intake process that ensures all detainees are notified of the agency's and the facility's zero-tolerance policies for all forms of sexual abuse. This process includes instruction on prevention and intervention strategies, self-protection and indicators, definitions, examples of detainee-on-detainee sexual abuse, and staff-on-detainee sexual abuse, and coercive sexual activity. They also inform the detainees of reporting methods which include reporting to staff, the DHS OIG, and the JIC. Prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. Upon initial intake, all detainees view a PREA Video which is playing in all of the holding cells in the intake area, this video plays in both an English and Spanish version. The detainee would then sign a form indicating they watched the video, the Auditor reviewed 30 signed forms. The detainees who speak other languages are educated by the intake officers utilizing the interpretation line, these detainees will sign a form indicating that they were educated in a language they understood. All detainees are given a copy of the ICE National Detainee Handbook which is translated into 11 languages. The interviews with intake staff confirmed this process. This process includes detainees who are deaf, visually impaired, or otherwise disabled, as well as, to detainees who have limited reading skills. The intake officers stated for deaf or hard of hearing detainees they would write back and forth and have them read the material, read the materials to visually impaired detainees, and explain in a manner that detainees with cognitive issues could understand. The facility self-identified the detainee education issue of not documenting the detainee education with the training in July of 2019. Prior to that, the facility had no historical documentation to demonstrate detainee education. They are now correctly providing and documenting education; however, at the time of the audit this process was only in place for a couple of weeks. The facility needs to continue the process they put in place to create historical data that they are educating the detainees.

Corrective Action: The facility recently developed the education process for all detainees enumerated in the standard. They need to continue to document the education, and ensure the detainees understand the zero-tolerance policy and the PREA information. The facility needs to provide further documentation to document the education process over a time period to substantiate a sustained functioning process.

(d) The facility has posted on all housing units the DHS-prescribed sexual assault awareness notice; the PSA Compliance Manager contact information; and name of Rio Grande Valley Empowerment Zone Corporation that can assist detainees who have been victims of sexual abuse. These postings are in both English and Spanish.

(e) Upon intake the facility provides the DHS-prescribed "Sexual Assault Awareness Information" pamphlet to detainees; this is provided in either English or Spanish. The intake staff confirmed that they can print other languages if needed, they would have the document translated into other languages.

(f) Information about reporting sexual abuse is included in the ICE National Detainee Handbook. The ICE National Detainee Handbook is translated into 11 languages and provided to the detainees upon intake. This was confirmed during the detainee interviews, all reported receiving the ICE National Detainee Handbook in a language they could understand.

Corrective Action Taken: The facility provided 56 examples of the New Arrival Intake Orientation forms, showing examples of detainee education completed between October and December 2019. The examples included education provided to Limited English Proficient (LEP) detainees. The facility has demonstrated the detainee education plan implemented in July 2019 is continuing to be provided to detainees as part of the intake process. This documentation demonstrates the facility has achieved compliance with this standard.

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

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

Notes:

Documentation Reviewed

- Policies 903E.02 and 2.11
- Intake screening for risk of sexual victimization or abusiveness
- Detainee Risk Assessments
- Memo from PSA Compliance Manager stating 60-90-day reassessments began on July 19, 2019

(a)(b)(c)(d): Policies 903E.02 and 2.11 outlines the process utilized to assess a detainee's risk of victimization or abusiveness. The facility screens all detainees upon arrival at the facility utilizing the PREA Risk Assessment. This assessment identifies those likely to be sexual aggressors or sexual victims and enables the facility to house detainees appropriately to prevent sexual abuse and mitigate any such danger. The process is to have the detainee screened by classification upon arrival at the facility. The PREA Risk Assessment tool takes into consideration the following:

- 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;
- 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 concerns about his or her physical safety.

They also take into consideration prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility. This assessment takes place prior to the detainee being placed in general population and is completed within 12 hours of arrival. The detainees are placed in holding cells in the intake area until the assessment takes place. The Auditor reviewed 30 detainee files and found that all initial assessments took place within 12 hours of arrival.

(e): The PSA Compliance Manager confirmed that the facility has not been conducting any reassessments on a regular basis. The Auditor randomly selected 30 detainee files and found that most of the 60-90-day reassessments were conducted after July 19, 2019 when the reassessment process was put in place. At that time the facility went back and completed 60-90-day reassessments on detainees, most of these were well beyond the 90 days.

Corrective action: The facility was not conducting 60-90-day reassessments prior to July 19, 2019. The facility needs to create a tracking system to identify any detainee at the facility between 60 and 90 days, and ensure a reassessment is conducted and documented on all detainees who are held at the facility for this period.

(f): The PSA Compliance Manager and Intake Officers stated that no detainee is disciplined for refusing to answer, or for not disclosing complete information in the PREA risk assessment screening process. This is further outlined in policy policies 903E.02 and 2.11.

(g): The PSA Compliance Manager also confirmed that the information from the risk assessment is not available to the general staff, and is limited to medical, intake staff, mental health, and classification. The assessments are stored in the classification department in filing cabinets, which are not accessible to general staff. These files include the initial PREA assessment, the reassessment, and other detainee information. The files are stored in locked filing cabinets, the classification personnel stated that when she is not in her office, the filing cabinets and her office door are locked.

Corrective Action Taken: Initially the facility developed procedures in which the PSA Coordinator would be required to print a PREA roster weekly and identify those detainees who had been at the facility 60 – 90 days. The PSA Coordinator is then responsible to complete reassessments for each of these detainees. The facility provided copies of a weekly roster with highlighted detainee names. The highlights indicated that a reassessment had been completed. The Auditor required the facility to develop a procedure to include the date the 60 –90-day reassessment was completed, to further ensure all detainees residing in the facility 60 – 90 days from admission receive a reassessment. The Auditor also required Initial Risk Screening and Reassessments of ten randomly selected detainees.

The facility provided the revised procedure which includes the date the reassessment was completed. The facility provided the Initial Risk Screening and reassessments for the ten randomly selected detainees. Four reassessments were conducted prior to the 60-90 days. The facility resubmitted an additional ten reassessments on March 26, 2020. These reassessments were conducted between 60-74 days within the appropriate time frame. This documentation verifies the facility complies with this standard.

§115. 65 - Coordinated response

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

Notes:

Documentation Reviewed:

- Policies: 903E.02 and 2.11
- Investigative files

(a)(b): Policies 903E.02 and 2.11 outlines the facility's coordinated response to a sexual abuse or sexual harassment incident. The plan utilizes a multi-disciplinary approach which includes the first responders, Facility Administrator, Chief of Security, PSA Compliance Manager, Facility Investigator, and Health Services Administrator. The plan further details each team member's responsibility during an incident. The implementation of this plan was verified through the interviews with the PSA Compliance Manager and review of the investigation files. The coordinated response was further verified during the investigative file review, all of the necessary team members were involved.

(c)(d) The PSA Compliance Manager confirmed that if a victim of sexual abuse is transferred between their facility and a DHS immigration detention facility covered by either subpart A or B of the DHS PREA Standards, or to a non-DHS facility, they notify the facility of the potential need for medical or social services unless the victim requests this notification not be made. Initially, the facility provided the

Auditor with documentation that they had not made a notification under these circumstances during the auditing period because they have not transferred a victim to another detention facility. However, through further questions with the facility related to the closed investigations, documentation was provided that one detainee was released on bond and the other was transferred to another detention facility. Per documentation provided by the facility, there is no documentation the transferred detainee was informed of the outcome of the investigation. This was further confirmed during the PSA Compliance Manager's interview. Of the two closed investigations, documentation was provided after the on-site audit that showed one detainee was released on bond and the other detainee was transferred to another detention facility. Further documentation was requested to determine if the facility upon transfer provided information to the receiving facility on any potential need for medical and/or social services. Through an email with the facility, the PSA Compliance Coordinator could not find any PREA information shared upon the transfer.

Does Not Meet: The sending facility must notify the facility the victim is transferred to of any information for the potential need for medical and/or social services unless the victim requests this notification not be made. The facility must document the notification of this information to the receiving facility or the victim's refusal of the sharing of information.

Corrective Action Taken: The facility revised policy EVDF 2.11 Sexual Abuse and Assault Prevention and Intervention to include the requirement that notification will be made to the receiving facility if a victim is transferred to another facility, if requested by the victim. This revision included a form entitled Detainee Transfer/Service Request. This form serves as notification to the receiving facility that the victim has requested or refused services from that facility. The facility also provides verification of training for affected staff. This documentation serves as verification that this standard complies with the PREA standards.

§115.
Outcome:
Notes:

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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.

Margaret L. Capel March 27, 2020
Auditor's Signature & Date

(b) (6), (b) (7)(C) March 30, 2020
Program Manager's Signature & Date