PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	9/13/2022	**To:**	9/15/2022
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Phoenix Field Office
Field Office Director:	John E. Cantu
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	2035 North Central Avenue, Phoenix, AZ 85004
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Florence Service Processing Center (FSPC)		
Physical address:	3250 N. Pinal Parkway, Florence, AZ 85132		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	520-868-8377		
Facility type:	SPC		
	6/11/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer In Charge (OIC)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-868-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer (SDDO)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	Click or tap here to enter text.

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	Click or tap here to enter text.

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the FSPC was conducted on September 13-15, 2022, by U.S. Department of Justice (DOJ) and DHS-certified PREA Auditor, Thomas Eisenschmidt, employed by Creative Corrections, LLC. The Auditor was guided in the audit report writing and review process by the U.S. ICE PREA Program Manager (PM), (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C) both DOJ, and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards for the audit period of September 15, 2021, through September 15, 2022. The FSPC is an ICE-operated facility with security and support service supplied by Akima Global Service (AGS) under contract with the DHS, ICE, Office of Enforcement and Removal Operations (ERO). The facility processes and detains male adult detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at FSPC are from Guatemala, India, and Peru.

On September 13, 2022, an entrance briefing was held in the FSPC staffing conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C), opened the briefing via telephone and then turned it over to the Auditor. In attendance were:

AGS Staff

(b) (6), (b) (7)(C) Assistant Project Manager
(b) (6), (b) (7)(C) Quality Assurance Manager (QAM)
(b) (6), (b) (7)(C) Detention Officer
(b) (6), (b) (7)(C) Detention Officer

ICE Staff

(b) (6), (b) (7)(C) OIC
(b) (6), (b) (7)(C) Assistant Field Office Director (AFOD)
(b) (6), (b) (7)(C) Assistant Health Services Administrator (AHSA), ICE Health Services Corp (IHSC)
(b) (6), (b) (7)(C) Detention Services Manager (DSM)
(b) (6), (b) (7)(C) SDDO/ Prevention of Sexual Assault (PSA) Compliance Manager
(b) (6), (b) (7)(C) SDDO
(b) (6), (b) (7)(C) Deportation Officer (DO)
(b) (6), (b) (7)(C) III, DO
(b) (6), (b) (7)(C) Inspections and Compliance Specialist (ICS), OPR/ERAU

Creative Corrections

Thomas Eisenschmidt - Certified PREA Auditor

The Auditor introduced himself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. Approximately three weeks before the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's PAQ, agency policies, and other pertinent documents through ERAU's SharePoint site. The main policies that provide facility direction for PREA are Agency policy 11062.2, Sexual Abuse and Assault Prevention and Intervention (SAAPI), and FDC policy 2.11, Sexual Abuse and Assault Prevention and Intervention (SAAPI). All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Lead Auditor for the interviews with staff and detainees. The Auditor also reviewed the facility's website, https://www.ice.gov/detain/prea. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. He further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews.

On the first day of the audit, there were 256 detainees housed at the FSPC located at 3250 N. Pinal Parkway, Florence, Arizona. The rated capacity for the facility is 392 adult detainees. The detainee in-processing area consists of 3 hold rooms holding up to 100 detainees. Each of these rooms is equipped with sexual abuse reporting signage, victim advocate contact information, six toilets, five showers, eight telephones, a television, and bunk beds. The detainees remain in this area until they are individually classified and receive a risk assessment and then are placed in their general population housing. FSPC housing consists of eight male general population dormitories (A, B, C, D, E, J1, J2, and J3). FSPC has 13 Special Management Unit (SMU) cells and no medical beds. During

the site visit, the Auditor observed signage requiring opposite-gender staff to announce themselves before entering the living areas. The Auditor also observed female staff announcing themselves before entering male living areas during the tour. (b) (7)(E) [redacted] The Auditor reviewed each camera assigned to areas that monitored detainees and found no privacy concerns. FSPC maintains a staff complement of 283 security positions, 48 medical positions, and 3 mental health staff contracted through STG International.

After the tour, the Auditor was provided with staff and detainee rosters and randomly selected personnel from each to participate in formal interviews. A total of 29 staff were interviewed, including 12 random staff (line staff and first-line supervisors) and 17 specialized staff. Those specialized staff interviews covered 19 questionnaires for the AFOD, PSA Compliance Manager, Human Resources Manager (HRM), Training Administrator, Retaliation Monitor, Incident Review Team member, Intake staff (2), Classification, Facility Investigator, ICE Investigator, Grievance Coordinator, SDDO, Non-Security First Responder (2), medical staff, and mental health staff. A total of 20 random detainees were interviewed. Eighteen detainees interviewed were limited English proficient (LEP) and required the use of a language interpreter through Language Services Associates, provided by Creative Corrections. There were no transgender or intersex detainees available for interview at the time of the site visit. There were also no detainees alleging prior victimization at FSPC during the audit period. There was one allegation (detainee on detainee) of sexual abuse reported at FSPC for the audit period and it was determined to be unsubstantiated after the investigation.

On September 15, 2022, an exit briefing was held in the FSPC visiting room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing (via telephone) and then turned it over to the Auditor. In attendance were:

AGS

(b) (6), (b) (7)(C) Project Manager
(b) (6), (b) (7)(C) Assistant Project Manager
(b) (6), (b) (7)(C) QAM
(b) (6), (b) (7)(C) Detention Officer
(b) (6), (b) (7)(C) Detention Officer

ICE Staff

(b) (6), (b) (7)(C) OIC
(b) (6), (b) (7)(C) AFOD
(b) (6), (b) (7)(C) AHSA, IHSC
(b) (6), (b) (7)(C) DSM
(b) (6), (b) (7)(C) SDDO
(b) (6), (b) (7)(C) SDDO
(b) (6), (b) (7)(C) DO
(b) (6), (b) (7)(C) DO
(b) (6), (b) (7)(C) DO
(b) (6), (b) (7)(C) DO
(b) (6), (b) (7)(C) ICS, OPR/ERAU

Creative Corrections

Thomas Eisenschmidt, Certified PREA Auditor

The Auditor spoke briefly about the staff and detainee knowledge of the FSPC PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit and that he would need to discuss his findings and review interviews conducted (staff and detainee) prior to making a final determination on compliance. The Auditor explained the audit report process time frames and thanked all present for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2
§115.31 Staff training
§115.35 Specialized training: Medical and Mental Health Care

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

Number of Standards Met: 38
§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
§115.17 Hiring and promotion decisions
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.71 Criminal and 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

Number of Standards Not Met: 0

PROVISIONS

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

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

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

(c) The Auditor determined compliance with this subpart of the standard based on the review of ICE policy 11062.2, Sexual Abuse and Assault Prevention Intervention, that requires ICE has a zero-tolerance policy for all forms of sexual abuse or assault. It is ICE policy to provide effective safeguards against sexual abuse and assault of all individuals in ICE custody, including concerning screening, staff training, detainee education, response and intervention, medical and mental health care, reporting, investigation, and monitoring and oversight. The AFOD confirmed that the policy was reviewed and approved by the agency. The ICE and AGS staff when questioned formally or informally were aware of the facility's zero-tolerance policy on sexual abuse.

(d) The Auditor determined compliance with this subpart of the standard based on a review of policy FDC 2.11, SAAPI, that requires the OIC to designate a PSA Compliance Manager who shall serve as the facility point of contact for the ICE PSA Coordinator and who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. An SDDO has been assigned at FSPC as the PSA Compliance Manager. He informed the Auditor that he has sufficient time and authority to effectively complete his duties as the PSA Compliance Manager. He further stated he is the point of contact for the agency's PREA Coordinator. A review of the facility organizational chart confirmed his position as a direct report to the AFOD.

§115.13 - Detainee supervision and monitoring.

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

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on the interviews with the AGS Project Manager and PSA Compliance Manager. They confirmed that FSPC utilizes direct supervision along with video monitoring for the supervision of detainees to protect them from sexual abuse. Both stated that a staff member would be present anytime a detainee is present in any area of FSPC. The Project Manager also stated that AGS and ICE established the number of AGS Detention Officers during the contract discussions. She indicated that the current staffing level and video monitoring equipment are based on subpart (c) requirements. The Auditor believes that the detainee supervision level appeared appropriate for the facility and the type of detainees FSPC receives. The Auditor randomly reviewed detainee supervision guidelines for the housing unit posts. The Auditor also reviewed the supervision guidelines annual review for FSPC completed in 2021. The review of the one sexual abuse allegation confirmed that staffing was not a factor in the allegation.

(d) The Auditor based compliance with this subpart of the standard based on the interview with the PSA Compliance Manager and Project Manager, who confirmed that shift supervisors are required to make frequent unannounced security rounds to identify and deter sexual abuse of detainees. The Project Manager further stated that the rounds are to be conducted on night and day shifts and confirmed that staff is prohibited from alerting others that these inspections are occurring unless a such announcement is related to the legitimate operational functions of the facility. The PSA Compliance Manager confirmed that this is a requirement of ICE. The supervisory AGS interviews confirmed they are required to make daily rounds in every area of the facility that detainees are permitted access to. Examples of officer post descriptions provided to the Auditor require rounds to be conducted throughout the shift, ensuring that safety and security measures are being adhered to. These were documented as well. Furthermore, a random sampling of area logbooks was examined during the site visit; the Auditor found supervisor signatures documenting unannounced security rounds on each shift in these books. The random staff interviews confirmed their knowledge of not alerting other staff supervisors are making rounds.

§115.14 - Juvenile and family detainees.

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

FSPC does not accept juveniles or family detainees. This was confirmed in the PAQ and with interviews conducted with the AFOD, PSA Compliance Manager, and on-site personal observations.

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

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

(b)(d) The Auditor determined compliance with this subpart of the standard based on the reviews of policy FDC 2.10, Searches, that require cross-gender pat-down searches of male detainees not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required, or in exigent circumstances; all cross-gender pat-down searches shall be documented. The 12 random AGS staff interviewed, both male and female, detailed the search training received, confirming under what conditions these pat searches could be performed and that they must be documented. Each response complied with the subpart requirements for male and female detainees, even as FSPC is an adult male facility. There were no cross-gender pat searches

conducted during the audit period, according to documentation provided to the Auditor. The random detainee interviews confirmed that detainees were pat searched by the same gender.

(c) FSPC is an all-male facility; therefore, this provision is not applicable.

(e)(f) The Auditor determined compliance with these subparts of the standard based on the review of policy FDC 2.10 that requires strip searches be conducted by an officer of the same gender as the detainee unless a staff member of the same gender is not present at the facility at the time that the strip search is required. The officer must document the search on form G-1025. The shift SDDO, or higher, must authorize reasonable suspicion searches in writing before the search is conducted and documentation of such authorization is to be maintained in the detainee's detention file. The Authority and documentation for all reasonable suspicion searches must be submitted on a memorandum to the OIC. If the OIC reasonably believes that a detainee is concealing contraband in or on his person, he may authorize a designated qualified health professional (for example, a physician, physician assistant, or nurse) to conduct an inspection for contraband or any other foreign item in a body cavity of a detainee by use of fingers or simple instruments, such as an otoscope, tongue blade, short nasal speculum, or simple forceps. A body-cavity search is considered the most intrusive type of search. The AFOD, AGS staff, PSA Compliance Manager, and the PAQ confirmed that the facility had no instances of cross-gender strip searches or body cavity searches conducted during the audit period. There were no strip searches or body cavity searches conducted during the audit period, according to the documentation provided to the Auditor. The random detainee interviews also confirmed this.

(g) The Auditor determined compliance with this subpart of the standard based on the review of policy FDC 4.5, Personal Hygiene, which requires staff shall ensure that detainees are permitted to shower perform bodily functions, and change clothing without being viewed by a staff member of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine hold room checks, or is otherwise appropriate, in connection with a medical exam or monitored bowel movement under medical supervision. All staff of the opposite gender of the detainee must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing. The Auditor toured each of the living areas observing the restroom and shower facilities. The shower curtains provided privacy during showers and the toilets had privacy barriers. During the tour, female staff were heard and observed making announcements before entering detainee living areas. The random male staff and detainee interviews confirmed that female staff announcements are made before entering their unit. The review of the camera system and observations during the site visit revealed no privacy concerns, generally or specifically, with the shower or toilet areas.

(h) This subpart is non-applicable. FSPC is not a Family Residential Facility.

(i) The Auditor determined compliance with this subpart of the standard based on the review of policy FDC 2.10, which requires the facility not to search or physically examine a detainee for the sole purpose of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. In addition, the 12 random security staff, when questioned, were aware of the facility's prohibition on physically examining a detainee for the sole purpose of determining their genital characteristics from the review of the search policy and their search training. The training curriculum was reviewed and found to address this prohibition.

(j) The Auditor determined compliance with this subpart of the standard based on the review of policy FDC 2.10 and policy FDC 2.11.1, Care of LGBTI Detainees. These policies indicate that searches may be traumatic for an LGBTI detainee and should be conducted respectfully. The policies require all pat searches be completed professionally and respectfully and in the least intrusive manner possible, consistent with security needs, including consideration of officer safety. As noted earlier, the AGS security staff detailed the search training they received to include instruction for conducting all detainee searches and cross-gender, transgender, and intersex search techniques professionally. The training curriculum was reviewed and found to address this subpart's requirements. The Auditor reviewed six security staff training files and found completed search training documentation in each file. At the time of the audit, there were no transgender or intersex detainees present at the facility to interview. Interviews with the 20 detainees confirmed that searches were conducted professionally and respectfully.

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

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

Notes:

(a)(b) The Auditor determined compliance with these standard subparts based on policies FDC 2.11, FDC 2.13 Staff Detainee Communication, and FDC 4.8, Disability Accommodations, which collectively require the facility to take appropriate steps to ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. Such steps shall include, when necessary, effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision. FSPC must provide, where required, access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary and provide access to written materials related to sexual abuse in formats or methods that ensure effective communication. The facility must also take steps to ensure meaningful access to all aspects of the facility's efforts to

prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. The AGS Intake staff (Detention Officer) informed the Auditor that detainees arriving at FSPC are provided and sign for the FSPC Facility Handbook, available in Spanish and English, the DHS-prescribed ICE Sexual Abuse and Assault Awareness (SAA) information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed ICE SAA information pamphlet is available in 15 languages (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian). The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). This Detention Officer also detailed how FSPC handles detainees with disabilities. He stated that staff would determine the detainee's reading ability when the facility encounters a detainee who is hearing impaired or deaf. If the detainee could read English or Spanish, he would be provided with the standard written intake information. He also informed the Auditor that the facility has a contract with an agency to sign for certain languages if that were needed. He stated that a detainee arriving with any hearing limitations would be provided information in writing through the text telephone (TTY) or an interpreter. The Auditor was also informed that if the facility was to encounter a detainee with low intellect, mental health concerns, or limited reading skills, the detainee would be assessed to determine their specific limitations and needs but would be provided information orally or in written format in a manner that ensures their understanding of the material, and if necessary, a referral to a supervisor, medical, or mental health staff based on the detainee's limitation. He also indicated that if they encounter an LEP detainee, they will utilize their contracted interpretive language service to assist them with interviews if a staff interpreter is unavailable. The Auditor was also informed that when providing information on the efforts to prevent, detect, and respond to sexual abuse in a language not covered by ICE National Detainee Handbook, they utilize the facility's Language Line Solutions contract for accessing interpreting services to provide the detainee with meaningful access to all aspects of the agency's SAAPI program. The Auditor was informed that the ICE intake staff read information from the SAA information pamphlet to the detainee through the interpreter. According to the intake staff, the information provided to these detainees includes topics regarding the zero-tolerance policy, reporting information to the DHS/Office of the Inspector General (OIG) Hotline, Rape Crisis Center, ICE SAAPI, and Detainee Phone Pin Instructions. The Auditor interviewed 20 random detainees during the site visit. Seven of them claimed not to have been provided the above-noted orientation information. The Auditor reviewed their detention files and found the signatures of these seven detainees receiving the orientation information. The files did not mention what language the orientation information was provided or if an interpreter was used to provide the information for any of the files.

Recommendation (b): The Auditor recommends when the facility utilizes the contracted interpreter to provide this orientation information it notes the language utilized and the interpreter ID number.

(c) The Auditor determined compliance with these standard subparts based on policy FDC 2.11, which requires FSPC, in matters relating to allegations of sexual abuse, staff employs effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities following professionally accepted standards of care. The facility must provide detainees with disabilities and limited English Proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, receptively and expressively, using any necessary specialized vocabulary. Interpretation services shall be provided by someone other than another detainee unless the detainee expresses a preference for another to give an interpretation and the OIC determines that such arrangement is appropriate and consistent with OHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is inappropriate in matters relating to allegations of sexual abuse. The 12 random detention staff interviewed were aware of the restrictions on interpreters outlined in the standard and policy. The Auditor's review of the one allegation of sexual abuse reported at FSPC for the audit period found that the detainee was provided a staff interpreter during the investigative process.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(e)(f) The Auditor determined compliance with these subparts of the standard based on review of Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive that collectively require, to the extent permitted by law, to decline to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity as outlined above. The Unit Chief of O.P.R. Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that candidate suitability for all applicants includes their obligation to disclose: any misconduct where they engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in a sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where they have been civilly or administratively adjudicated to have engaged in such activity. The AGS HRM described their hiring process. She indicated that candidates are scheduled for an interview once their qualifications are checked and verified. During this interview, the individual is asked directly about any misconduct outlined in subpart (a) of the standard. If they respond affirmatively to those questions, the person does not go any further in the hiring process. The HRM also confirmed that the facility

would provide information on substantiated allegations of sexual abuse involving former employees upon any request from an institutional employer for which the employee has sought new employment. She indicated that this information is provided through Work Force, an agency that AGS contracts with to maintain records. She also stated that the facility would request information from prior institutions where the prospective candidate was previously employed. She confirmed that the candidate goes through the ICE hiring and approval process and is not hired until FSPC receives the approval from ICE. She also confirmed that during the thorough ICE background investigation, the person's entire employment record would be scrutinized. Material omissions of subpart (a) incidents or providing false information would be a basis for termination or withdrawal of any offer of employment. She also stated that as a condition of employment, the employee has an affirmative duty to disclose any misconduct outlined in subpart (a). The Auditor also reviewed 10 employee files and found ICE approvals to hire the staff member and a signed self-declaration that the employee had not engaged in behavior outlined in subpart (a) of the standard and as required by policy. One of the 10 files reviewed was a current promotion. The Auditor noted that a current disclosure form was also present in this individual's file.

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

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on the interviews with the AFOD and the PSA Compliance Manager. (b) (7)(E) [redacted] According to them, detainee sexual safety was considered during the design of this building and the placement of the additional cameras.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a) The Auditor determined compliance on this standard subpart after a review of policy 11062.2, which requires uniform evidence protocols and local evidence protocols be followed to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The facility AGS and ICE investigators confirmed that their training and procedures in sexual abuse investigations maximize the potential for obtaining usable physical evidence. This policy also requires when OPR accepts a case, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel by OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred to or accepted by the OIG, OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted. As noted earlier, one allegation of sexual abuse was reported at FSPC during the audit period. It was a detainee-on-detainee allegation determined to be unsubstantiated after the investigation. The Auditor reviewed the investigative file and determined that uniform evidence procedures, including ensuring detainees do not destroy useable evidence, were followed during the administrative investigation. FSPC is an adult male facility with no juveniles.

(b)(d) The Auditor determined compliance with these standard subparts based on the review of the email from the Southern Arizona Center Against Sexual Assault (SACASA) to FSPC. SACASA stated that they would provide crisis services, advocacy, support, therapy, and education for individuals and families through telephone and zoom but could not provide in-person support. The Auditor spoke with the Honor Health (HH) Emergency Room Supervisor, who confirmed the hospital would provide an advocate for the victim if requested. The facility AGS and ICE investigators confirmed that upon notification of every allegation, the detainee is first taken to medical, then they are provided this victim advocate information by both the investigator and medical staff. The investigative file, reviewed for the one allegation of sexual abuse for the audit period, documented that the alleged victim was provided the victim advocate information. During the site visit, there were no detainees at the facility who alleged sexual assault to interview.

(c) The Auditor based compliance with this standard subpart on the review of policy FDC 2.11 that requires where evidentiary or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the OIC shall arrange for an alleged victim to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified healthcare personnel. The FSPC's medical department is managed and operated by IHSC staff, who are prohibited from participating in sexual assault forensic medical examinations or evidence gathering. The HSA confirmed that forensic examinations are conducted by HH in Scottsdale. He also confirmed that all treatment of sexual assault victims is without cost. With no sunset date, the 2018 Memorandum of Understanding (MOU) with HH agrees to provide an examiner (SANE) for comprehensive care, prophylaxis treatment for any sexually transmitted disease, a timely collection of forensic evidence, forensic photography, and

testimony. The Auditor spoke with the HH Emergency Room Supervisor, who confirmed that a SANE practitioner would be provided for the forensic examination. She also confirmed that HH would provide an advocate for the victim if requested. The facility had no forensic examinations conducted during the audit period based on interviews with the PSA Compliance Manager, the HSA, and a review of the facility's PAQ.

(e) The Auditor determined compliance with these standard subparts based on the interview with the PSA Compliance Manager, ICE Investigator, and the AGS Investigator, who confirmed all allegations of sexual assault are immediately reported to the Florence Police Department (FPD). The Auditor interviewed the FPD Detective, who confirmed that his department would comply with the (a) through (d) of the standard requirements.

Recommendation (e): The Auditor recommends the FSPC enter into an MOU with FPD requesting the FPD put into writing their agreement to comply with the standard subparts. During the audit period, the one allegation of sexual assault at FSPC was determined not to be criminal.

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

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

Notes:

(a)(b) The Auditor determined compliance with these standard subparts based on the review of the FDC 2.11 policy and interviews with the PSA Compliance Manager, ICE Investigator, and the AGS Investigator that all allegations of sexual assault are immediately reported to the FPD for criminal investigation. The AFOD and PSA Compliance Manager confirmed that criminal investigations are referred to the FPD, the agency with legal authority to conduct a criminal investigation and must follow the (a)(b) subparts of this standard. The FDC 2.11 policy further requires that an administrative investigation be conducted upon the conclusion of a criminal investigation where the allegation was substantiated. Upon completion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations will include preserving direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse and assault involving the alleged perpetrator. This policy also requires FSPC retain investigative reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. The PAQ indicated one allegation of sexual abuse during the audit period. This was a detainee-on-detainee allegation determined to be unsubstantiated after the completed investigation. That investigative file review appeared to be completed by the standards. It included direct and circumstantial evidence, including any available physical and DNA evidence and electronic monitoring data, interviewing alleged victims, suspected perpetrators, and witnesses. The AGS and ICE Investigators were interviewed and found to be very knowledgeable concerning their responsibilities in the investigative process. The November 2021 Auditor training confirmed all allegations, once reported to the JIC, are assessed to determine if it falls within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and in coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for action, and the agency would assign an administrative investigation to be completed.

(c) FSPC is an ICE facility, and the agency's investigative protocols can be found on the agency website https://www.ice.gov/detain/prea. A website review confirms that the sexual abuse investigation protocols are available to the public. These protocols are posted to ensure the public is informed about the investigative process.

(d)(e)(f) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 that requires when a staff member, contractor, or volunteer is involved in a sexual abuse allegation, it be promptly reported to the agency: Joint Intake Center (JIC); ICE OPR or the DHS OIG; and appropriate ICE FOD, and local law enforcement entity unless the complaint does not involve potentially criminal behavior. The policy further requires that when a detainee is alleged to be the perpetrator, it is the OIC's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal), reported to the FOD, who shall report it to the OPR, JIC, and is promptly reported to ICE through the SEN (Significant Event Notification) system. The interview with the AFOD and the SDDO confirmed that they are notified of every allegation of sexual abuse made at the FSPC and make all the required ICE notifications. There was no allegation at FSPC during the audit period involving a staff member, contractor, or volunteer; however, there was one allegation involving a detainee which was reported in accordance with the requirements of provision (e).

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11, which requires training on the facility's SAAPI program to be included in initial and annual refresher training for all employees. The review of the staff training curriculum includes instruction on: the facility's zero-tolerance policies for all forms of sexual abuse; definitions and examples

of prohibited and illegal sexual behavior; the right of detainees and staff to be free from sexual abuse and from retaliation from reporting sexual abuse; instruction that sexual abuse and/or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences; the requirement to limit reporting of sexual abuse and assault to personnel with a need to know in order to make decisions concerning the detainee-victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex or gender nonconforming detainees; instruction on reporting knowledge or suspicion of sexual abuse and/assault and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault. All employees must sign and date the "Acknowledgement of PREA Training Certification" form to document pre-service and annual in-service training after the training. The Auditor reviewed 10 random training files (five ICE staff and five AGS staff) and found each contained a signed acknowledgment form. The 12 random AGS staff and two ICE staff interviewed by the Auditor confirmed that each had received PREA pre-service and annual refresher training. Those interviewed also confirmed that their instruction included the requirements outlined in subpart (a) of the standard. The interview with the AGS Training Administrator and review of the training curriculum confirmed that subpart (a) requirements are part of the information provided. The ICE curriculum was also reviewed and met the requirements of subpart (a). The Training Administrator also confirmed that all staff assigned at FSPC received their annual refresher training in 2021 except for those out on long-term absence due to military leave. The Auditor indicated the facility exceeds the requirements of the standard as refresher training is provided annually and is only required every two years by the standard.

§115.32 - Other training.

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

Notes:

(a)(b)(c) The Auditor determined compliance with this subpart of the standard based on the review of the FDC 2.11 policy that requires FSPC to ensure that all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the facility's zero-tolerance policy and informed how to report such incidents. The FDC 2.11 policy also requires FSPC to maintain documentation confirming that temporary contractors, regular contractors, and volunteers understand the training they have received. According to the PSA Compliance Manager, the facility had no contractors meeting the subpart (d) definition or volunteers access the facility during the audit period. The Training Administrator confirmed that all volunteers and those contractors meeting the subpart (d) definition would receive the US Customs and Immigration Enforcement PREA Implementation Training.

§115.33 - Detainee education.

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

Notes:

(a)(b)(c) The Auditor determined compliance with this subpart of the standard based on the review of the FDC 2.1 policy, Admission and Release, that requires all detainees arriving at FSPC will be notified of the facility's zero-tolerance policy for all forms of sexual abuse. Each detainee will be provided with information about the facility's SAAPI program. This information, at a minimum, will include: the facility's zero-tolerance policy for all forms of sexual abuse or assault; the name of the facility's PSA Compliance Manager and information about how to contact them; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point of contact line officer, the DHS/OIG and the ICE/OPR investigation processes; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The FDC 2.1 policy further requires FSPC to provide the detainee notification, orientation, or instruction in formats accessible to all detainees, including those who are LEP, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. As noted in standard 115.16, detainees arriving at FSPC are provided and sign for the FSPC Facility Handbook, available in Spanish and English, the DHS-prescribed ICE SAA information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed ICE SAA information pamphlet is available in 15 languages (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian). The ICE National Detainee Handbook is available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese). The intake Detention Officer detailed how FSPC handles detainees with disabilities. He stated that staff would determine the detainee's reading ability when the facility encounters a detainee who is hearing impaired or deaf. If the detainee could read English or Spanish, he would be provided with the standard written intake information. He also informed the Auditor that the facility has a contract with an agency to sign for certain languages if that were needed. He stated that a detainee arriving with any hearing limitations would be provided information in writing through the text telephone (TTY) or an interpreter. The Auditor was also informed that if the facility was to encounter a detainee with low intellect, mental health concerns, or limited reading skills, the detainee would be assessed to determine their specific limitations and needs but would be provided information orally or in written format in a manner that ensures their understanding of the material, and if necessary, a referral to a supervisor, medical, or mental health staff based on the detainee's limitation. He also indicated that if they

encounter an LEP detainee, they will utilize their contracted interpretive language service to assist them with interviews if a staff interpreter is unavailable. The Auditor was also informed that when providing information on the efforts to prevent, detect, and respond to sexual abuse in a language not covered by ICE National Detainee Handbook, they utilize the facility's Language Line Solutions contract for accessing interpreting services to provide the detainee with meaningful access to all aspects of the agency's SAAPI program. The Auditor was informed that the ICE intake staff read information from the SAA information pamphlet to the detainee through the interpreter. According to the intake staff, the information provided to these detainees includes topics regarding the zero-tolerance policy, reporting information to the (OIG) Hotline, Rape Crisis Center, ICE SAAPI, and Detainee Phone Pin Instructions. The Auditor interviewed 20 random detainees during the site visit. Seven of them claimed not to have been provided the above-noted orientation information. The Auditor reviewed their detention files and found the signatures of these seven detainees documenting they received the orientation information.

Recommendation (b): The Auditor recommends when the facility utilizes the contracted interpreter to provide this orientation information, it notes the language utilized and the interpreter ID number.

(d) The Auditor determined compliance with this subpart of the standard after the review of policy FDC 2.11, which requires the facility post the DHS prescribed sexual assault awareness notice; the name of the PSA Compliance Manager; and the name of local organizations that can assist detainees who have been victims of sexual abuse on all housing unit bulletin boards. During the site visit, the Auditor observed the DHS-prescribed notice, the name of the PSA Compliance Manager and the name of the victim advocate, SACASA, in each of the detainee living areas. The random detainee interviews confirmed their knowledge of these postings in the living areas.

(e)(f) The Auditor determined compliance with these subparts of the standard after the interview with the intake Detention Officer who confirmed each detainee upon arrival receives the DHS-prescribed SAA information pamphlet and a copy of the ICE National Detainee Handbook. The Auditor interviewed 20 detainees. Seven of these stated that they had not received copies of these documents. A review of their detention files confirmed a signed receipt of them. The files did not mention what language was provided or which interpreter was used to provide the information for any of the files.

§115.34 - Specialized training: Investigations.

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

Notes:

(a)(b) The Auditor determined compliance with this subpart of the standard based on the review of the 11062.2 policy that requires in addition to the general training, all facility staff responsible for conducting sexual abuse or assault investigations shall receive specialized training that covers at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross agency coordination in the investigation process. The facility must maintain written documentation verifying specialized training is provided to investigators pursuant to the requirement. Agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault that covers investigative techniques, evidence collections, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency offers another level of training, Fact Finders Training that provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process.

The agency provided training records of agency investigator to review for compliance with subpart (b) of the standard. Interviews with the AFOD, the Facility Investigator, ICE Investigator and Training Administrator indicated the Investigator has received specialized training for conducting sexual abuse investigations in accordance with the standard. Both ICE and AGS investigators have received the ICE OPR-Investigating Incidents of Sexual Abuse and Assault training. The Auditor was provided with certificates of completion for staff completing the specialized training. It was also determined the curriculum meets the standard requirements. The interviews conducted with the ICE and AGS investigators verified the completion of the training and indicated the training included interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information. The one investigative file for the only allegation for the audit period confirmed the investigation was completed by a trained investigator.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after a review of IHSC Directive 03-01, Sexual Abuse and Assault Prevention and Intervention, which requires, in addition to the general training provided to all employees, the agency shall provide specialized training to DHS or agency employees who serve as full and part-time medical practitioners or full and part-time mental health practitioners in immigration detention facilities where medical and mental health care is provided. The interview with the HSA detailed the specialized training IHSC medical and mental health practitioners provided. He stated the IHSC staff and the contracted mental health practitioners both receive this training annually and this training covers each of the four elements outlined and required in subpart (b) of the standard; how to detect and assess signs of sexual abuse; how to preserve physical evidence of

sexual abuse; how to respond effectively and professionally to victims of sexual abuse; and how and to whom to report allegations of sexual abuse. His interview also confirmed that medical staff at FSPC are prohibited from conducting forensic examinations, and the facility has an MOU for these services at HH. The Mental Health practitioner also confirmed this training during her interview. The Auditor randomly chose two medical training files and verified that this training was received. The Auditor determined the facility exceeds the specialized training requirement as the standard only indicates the training is a one-time event and the facility requires it annually.

(c) The Auditor determined compliance with this standard subpart based on policies 11062.2 and Directive 03-01 that prohibits FSPC medical staff from examining victims of sexual assault and requiring referral to a hospital emergency department, or to a designated specialized facility, for evaluation and forensic examination, to include testing for sexually transmitted diseases. The interviews with the AFOD and PSA Compliance Manager, indicated the agency reviewed and approved these policies.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor reviewed policy FDC 2.2 that requires special consideration be given to any factor that would place the detainee at risk of victimization or assault. Reasons for a detainee being given special consideration would include, but not be limited to, detainees with disabilities, detainees who are transgender, elderly, pregnant, suffering from a serious medical or mental illness, and victims of torture, trafficking, abuse, or any other crime of violence. Policy FDC 2.11 requires that detainees be screened upon arrival at FSPC within 24 hours to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. Staff shall also use the information to inform assignment of detainees to recreation and other activities, and voluntary work. This policy further requires that in determining either abusiveness or victimization the staff consider, to the extent that the information is available: (1) Whether the detainee has a mental, physical, or developmental disability; (2) The age of the detainee; (3) The physical build and appearance of the detainee; (4) Whether the detainee has previously been incarcerated or detained; (5) The nature of the detainee's criminal history; (6) Whether the detainee has any convictions for sex offenses against an adult or child; (7) Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the detainee has self-identified as having previously experienced sexual victimization; (9) The detainee's own concerns about his or her physical safety; and (10) The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive. Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked during the initial screening. According to the Classification staff person interviewed, FSPC is utilizing the Risk Classification Assessment (RCA) including the "Special Vulnerabilities" section to evaluate the detainee's potential as a victim or abuser to the extent that the information is available assessing the 1-10 elements. The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. He also indicated that the classification process at FSPC typically is conducted within the first two hours of the detainee arrival but never beyond 12 hours. He also stated the detainee remains in the holding area until the entire classification process is completed. He confirmed he is also responsible for conducting reassessments for detainees' risk of victimization or abusiveness between 60 and 90 days from the date of their initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The Auditor was provided and reviewed a reassessment, utilizing the RCA, completed before the detainee's' 90th day at FSPC. The detainee alleging sexual abuse did not have a reassessment conducted as he left the facility prior to one being completed. The Classification Detention Officer further stated that no detainee is ever disciplined for refusal to answer any of the questions asked of them during the classification process.

Recommendation (b): The Auditor recommends policy FDC 2.11 be updated to align with the DHS provision (b) and facility practice of completing within 12 hours.

(g) The Auditor determined compliance with this subpart of the standard after the interview with the Classification Detention Officer who confirmed, because of the sensitive nature of information about the detainee obtained during intake, his staff is vigilant about maintaining confidentiality about securing this information and releasing the information only for legitimate need-to-know reasons. He confirmed appropriate controls are placed on all detainee records, and information including reassessments are maintained in the detainee's detention file and secured in the records room file cabinet, which is under double lock and key.

§115.42 - Use of assessment information.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.2 that requires that FSPC detainees are assigned detainee housing, offered recreational activities, assigned work, and provided food service according to their classification levels after review of the RCA and special vulnerabilities. The Auditor was informed by the Classification Detention Officer that detainee assignments are made for work and housing based on each individual detainee's risk assessment and classification. The instructions for completion of the vulnerability assessment informs the staff member conducting it, that it is important that any information indicating the potential for being at risk of victimization or the potential of being sexual abusive be noted, to provide the correct initial housing for placement and recreation. FSPC has very limited voluntary work opportunities for detainees, but the facility utilizes information from the risk assessment and classification process for making work assignments. The Auditor reviewed 10

detainee detention files in which the initial assessment and reassessment files are maintained. The file review demonstrated individualized determinations being conducted on each detainee and consideration of the information from the risk assessment for placement decisions to ensure his/her safety.

(b) The Auditor determined compliance with this standard subpart based on the FDC 2.11 policy that requires classification and housing decisions for a transgender or intersex detainee must be found on the detainee's gender self-identification and an assessment of the effect of placement on the detainee's health and safety. A medical or mental health professional will be consulted as soon as practicable on this assessment. Placement decisions of transgender or intersex detainees should not be based solely on the detainee's identity documents or physical anatomy. A detainee's self-identification of their gender and self-assessment of safety needs shall always be taken into consideration as well. The placement will be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee. The PSA Compliance Manager and Classification Detention Officer confirmed the policy requirements of this subpart. According to both, FSPC has not had a transgender or intersex detainee housed at the facility during the audit period. They indicated if they were to ever receive one, the 2.11 policy for this subpart would be followed.

(c) The Auditor determined compliance with this subpart of the standard based on the interviews conducted with the PSA Compliance Manager, Classification Detention Officer, and the 12 security staff, whom all confirmed transgender and intersex detainees would be allowed to shower separate from the other detainees, and they would make times available when others were not present. FSPC has not had a transgender or intersex detainee housed at the facility during the audit period.

§115.43 – Protective custody.

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

Notes:

(a)(b)(c)(e) The Auditor determined compliance with this subpart of the standard based on the review of policy FDC 2.12, Special Management Units, and policy 2.11, which require the use of administrative segregation to protect detainees with special vulnerabilities, including detainees vulnerable to sexual abuse or assault, be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, and as a last resort with such an assignment not ordinarily to exceed a period of 30 days. This policy further requires detainees placed in administrative segregation for protective custody to have access to programs, services, visitation, counsel, and other services available to the general population to the maximum extent possible. The Auditor interviewed the AGS shift Captain, who indicated that segregation is not customarily used to house victims or potential victims of sexual assault unless the detainee requests it. The AFOD indicated segregation would not be used to protect a vulnerable detainee and that alternative housing would be utilized, including another housing unit or movement from the facility. He also stated that segregation was not utilized within the audit period to house any victim or vulnerable detainee and if it were to be used the FOD would be notified within 72 hours of the detainee's placement. The OIC approved all policies used at FSPC.

(d) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.12, which requires the facility to determine whether Administrative Segregation or protective custody is still warranted, a supervisory review must be completed within 72 hours of initial placement and an identical review be completed after 7 days and every week after that for the first 30 days, and a review at least every 10 days after that. As noted above, the AFOD indicated segregation would not be used to protect a vulnerable detainee. He also indicted if it were to be used, the review process outlined in policy 2.12 would be utilized. He also stated that segregation has not been utilized within the audit period to house any victim or vulnerable detainee. There were no detainees present at the facility who alleged sexual abuse to interview.

§115.51 - Detainee reporting.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 and the FSPC Detainee Handbook, which require that detainees have multiple ways to privately and, if desired, anonymously report incidents of sexual abuse and assault, retaliation for reporting sexual abuse or staff neglect or violations of responsibilities that may have contributed to such incidents. Detainees are informed of reporting options to any staff, during sick call, through the grievance office, to FSPC administrators, calling the facility's 24-hour toll-free notification telephone numbers, through their family members, and the contact information; each detainee is provided upon arrival and posted throughout the facility. The ICE National Detainee Handbook and FSPC Detainee Handbook have reporting information for the DHS OIG, the JIC, Detainee Reporting Information Line (DRIL), and the detainee Consular. The Auditor checked the reporting line (DHS OIG) in three different housing locations and found them operational with no need for a detainee PIN to make the call. Reporting information, including contact information for the detainees' Consular, was posted in the housing unit areas and the holding area during the site visit. As noted earlier in the report, the Auditor interviewed 20 random detainees during the site visit. Seven claimed not to have been provided the orientation information, including reporting information. The Auditor reviewed their detention files and found the signatures of all seven receiving the orientation information.

(c) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.11, which requires staff to accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports. The Auditor interviewed 12 random staff who confirmed the facility policy requirement that they are to accept and immediately report all

allegations of sexual abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors. The one investigative file review demonstrated written allegation of sexual abuse was made to an AGS staff verbally.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 and the FSPC Detainee Handbook. Both these documents outline the procedure to file a formal grievance related to sexual abuse and sexual assault that informs detainees about filing formal grievances related to sexual abuse and assault at any time during, after, or instead of lodging an informal grievance or complaint with no time limit imposed on when this grievance may be submitted. These documents also inform detainees that they may obtain assistance from another detainee, housing officer, or other facility staff in preparing a grievance. The policy also requires FSPC staff to make all efforts to accommodate the special assistance needs of detainees in preparing and pursuing a grievance, including detainees who are disabled, illiterate, or LEP. It also requires outside sources, such as family members or legal representatives, be permitted to provide assistance. Decisions on grievances shall be issued within five days of receipt, and appeals shall be responded to within 30 days. The policy also requires training for all staff to respond appropriately and in an expeditious manner to emergency grievances. An emergency grievance involves an immediate threat to a detainee's health, safety, or welfare. Medical emergencies shall be brought to the immediate attention of medical staff for further assistance. The Auditor interviewed the Grievance Officer, who confirmed that the PSA Compliance Manager and OIC are immediately notified of all allegations of sexual abuse made through the grievance office. He also stated that allegations of sexual abuse are treated as an "emergency" grievance and that all medical emergencies are brought immediately to the proper medical personnel for assessment. All findings on this type of grievance are responded to within 5 days of receipt, and responses to an appeal of the grievance decision are responded to within 30 days. The interview with the PSA Compliance Manager confirmed that once notified of the grievance, he would notify the OIC of the allegation as required. The one allegation within the audit period was not made through the grievance process. Random staff interviews confirmed their knowledge of the permitted assistance requirements noted in policy and the FSPC Detainee Handbook.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 and the FSPC Detainee Handbook. The policy requires FSPC to utilize available community resources and services to provide valuable expertise and support in crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to appropriately address victims' needs. The policy further requires the OIC to establish procedures to make available outside victim services following incidents of sexual abuse. The facility is also required to attempt to make available such victim services for any individuals identified as having experienced sexual victimization before entering DHS custody. As noted in standard 115.21, FSPC attempted to enter into an MOU with SACASA. The victim advocacy stated, through email, that they would provide crisis services, advocacy, support, therapy, and education for individuals and families through telephone and zoom but were unable to deliver in person support. The investigative file documented that the alleged victim was provided with this victim advocate information. During the site visit, there were no detainees at the facility who alleged sexual assault to interview. The PSA Compliance Manager confirmed that all contact with SACASA is confidential and unmonitored at FSPC. Telephone contact is made to this advocate without the detainee providing their PIN to make contact. The review of the one investigative case file documented that victim advocate services were offered to the detainee. The extent to which the telephones are monitored is found in the FSPC Detainee Handbook and noted on the housing unit bulletin boards. The majority of the random detainee interviews confirmed their knowledge of this victim advocate. The Auditor observed the contact information for SACASA posted in each of the FSPC housing units.

§115.54 - Third-party reporting.

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

Notes:

The Auditor determined compliance with the standard after a review of policy FDC 2.11, which requires FSPC have a method to receive third-party reports of sexual abuse in its facility, with the information made available to the public regarding how to report sexual abuse on behalf of a detainee. The Auditor observed posted writing information in the public lobby of the facility. The lobby has SAAPI posters in plain view of visitors with information on how to report sexual abuse on behalf of a detainee. The ICE National Detainee Handbook and the FSPC Detainee Handbook provide information for reporting sexual abuse by third parties. The ICE website, https://www.ice.gov/prea, also has information to report on behalf of a detainee. These resources are available to the public. The PSA Compliance Manager confirmed that the facility had no allegations reported through a third party during the audit period.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11, which requires staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The policy further requires that apart from such reporting, staff shall not reveal any information related to 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. The policy further requires ICE employees follow the chain of command by reporting to their first line SDDO who will, in turn, report directly to the OIC/AOIC. All AGS staff are required to report directly to their supervisors, who will report to the SDDO, who notifies the OIC. The AFOD interview confirmed that the OIC and AFOD have an open-door policy on reporting incidents of a serious nature that do not require the standard chain of command to be followed. Staff may also utilize any of the methods of reporting available to the detainees including DHS OIG, which is outside of their chain of command. As previously noted, this policy was reviewed and approved by the OIC. The 12 random staff interviews confirmed their knowledge of the reporting obligations outlined by the policy and reinforced in their annual PREA training. The staff interviews also confirmed their understanding of reporting sexual abuse outside their chain of command directly to the OIC if needed. The Auditor also reviewed the pre-service and annual refresher training curriculum and found the reporting information and requirements detailed in the curriculum as required by the standard. The investigative file review for the one allegation made during the reporting period was reported to an AGS staff member verbally and documented in writing.

(d) The Auditor determined compliance with this subpart of the standard after a review of policy 11062.2 that requires if the alleged victim is under the age of 18 or determined, after consultation with the relevant OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under a State or local vulnerable persons statute, the facility would report the allegation to the designated State or local services agency as necessary under applicable mandatory reporting laws. FSPC is an adult facility. The AFOD and the PSA Compliance Manager confirmed that if any vulnerable adult were ever the victim of a sexual assault at FSPC, the facility would notify the FPD and OPLA OCC for proper notifications to be made. The one incident reported during the audit period did not involve a vulnerable adult.

§115.62 - Protection duties.

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

Notes:

The Auditor determined compliance with the standard after a review of policy FDC 2.11 that requires if a staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, they shall take immediate action to protect the detainee. The Auditors questioned 12 AGS security staff, 2 ICE staff, the PSA Compliance Manager, and the AFOD about their response to the substantial risk of imminent sexual abuse. Each of them responded that the detainee's safety and well-being would be their primary concern in any situation where they would be at substantial risk of sexual abuse. Each of their responses indicated that their immediate reaction would be to immediately locate the detainee, remove him from danger, and then make appropriate notifications. The AFOD and PSA Compliance Manager interviews confirmed the facility had no known detainees at substantial risk of imminent sexual abuse during the audit period.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 that requires FSPC, upon receiving an allegation that a detainee was sexually abused while confined at another facility, that they notify the FOD and the appropriate administrator of the facility where the alleged abuse occurred. The notification is required to be made as soon as possible but no later than 72 hours after receiving the allegation. The facility shall document that it has provided such notification. The facility where the alleged abuse occurred shall then ensure the allegation is referred for investigation and reported to the appropriate FOD by this standard. The AFOD and PSA Compliance Manager interviews confirmed that FSPC has had no allegations either reported to them from another facility or reported allegations occurring at other facilities. Both were aware that if they received such a complaint that they would contact the other facility and document the notifications in accordance with the policy requirements. They were also aware of their obligation to investigate the allegation if it occurred at FSPC.

§115.64 - Responder duties.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.11, which requires the first security staff member to respond to a report of sexual abuse, or their supervisor, shall preserve and protect the greatest extent possible any crime scene until appropriate steps can be taken to collect any evidence. Suppose the abuse occurred within a period that still allows for collecting physical evidence. In that case, the responder shall request the alleged victim not to take any actions and shall ensure that the alleged abuser does not accept any steps that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The interviews with the 12 security staff confirmed their responsibilities as responders to incidents of sexual abuse. Each of them detailed their handling of any sexual abuse allegation. All indicated they would separate the victim and abuser and then follow the protocols provided in training and outlined in the policy. The review of the only reported allegation investigative file for the audit period confirmed that the staff member followed the procedure and training protocols.

(b) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.11, which requires if the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff. Interviews with two non-security staff confirmed that if an allegation of sexual abuse were made to them, they would secure the detainee, not let him destroy evidence, and notify the closest security staff person. The AFOD and FSPC Investigator reported no incidents of sexual abuse to a non-security member during the audit period.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The Auditor determined compliance on these subparts of the standard after the interview with the AFOD and the PSA Manager. Both confirmed that policy 2.11 is the facility's coordinated plan for response to incidents of sexual abuse. The multidisciplinary approach and responsibilities are addressed. The policy outlines the responsibilities for security staff, non-security staff, medical staff, and mental health practitioners when responding to incidents of sexual abuse. The interviews conducted with these specific staff outlined how they would respond to allegations of sexual abuse referencing this policy. There was one allegation of sexual abuse reported during the audit period. The review of this investigative file demonstrated the multi-disciplinary approach by the FSPC staff.

(c)(d) The Auditor determined compliance on these subparts of the standard after the review of policy FDC 2.11 that requires if a victim is transferred between ICE subpart A or B detention facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services (unless, in the case of transfer to a non-ICE facility, the victim requests otherwise). If the receiving facility is unknown to the sending facility, the sending facility shall notify the FOD, so that he or she can notify the receiving facility. The AFOD, PSA Compliance Manager, and the PAQ confirmed that FSPC had no detainee make an allegation of sexual abuse prior to being transferred to another facility by ICE that would have required this notification. If they had, the OIC and PSA Compliance Manager both stated the policy and notification process would have been followed as required in subparts (c)(d).

Recommendation (d): The Auditor recommends the policy language to be changed to a facility not covered by the DHS PREA Standards instead of a non-ICE facility.

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

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

Notes:

The Auditor determined compliance with the standard after a review of policy FDC 2.11, which require FSPC staff, contractors, and volunteers suspected of perpetrating sexual abuse or assault be removed from all duties requiring detainee contact pending the outcome of an investigation. The contractor's company will also be notified when a contractor is alleged to be the perpetrator. The PSA Compliance Manager and AFOD indicated that if staff (ICE, AGS, contractor, or volunteer) were the subject of a sexual abuse allegation, they would be removed from all detainee contact until the investigation was completed. FSPC had no allegations of sexual abuse made against staff during the audit period.

§115.67 - Agency protection against retaliation.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11, that requires staff, contractors, volunteers, and detainees not to retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. The policy further requires the OIC to employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. FSPC is also required by this policy to monitor for retaliation for at least 90 days following a report of sexual abuse to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. The PSA Compliance Manager has been designated as the staff and detainee retaliation monitor. He confirmed during his interview, that he monitors detainees for at least 90 days, during which time he meets with the detainee and monitors any detainee disciplinary reports, housing changes, or requests and questions them on issues they may be experiencing or concerned about. He also stated his staff monitoring for retaliation continues for at least 90 days and may be extended longer, if needed. His staff retaliation monitoring includes his investigation into negative performance reviews, time off refusals, and change of duties or reassignment requests. As part of his review with both staff and detainee he offers emotional support to those he is monitoring. The Auditor observed documentation in the one investigative file for the audit period that demonstrated monitoring until the detainee was released.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 that requires care shall be taken to place the detainee victims in a supportive environment that represents the least restrictive housing option possible (e.g., in a different housing unit, transfer to another facility, medical housing, or protective custody), and that takes into account any ongoing medical and mental health needs of the alleged victim. The policy further requires that victims of sexual abuse shall not be held for longer than five days in any administrative segregation except in highly unusual circumstances or at the detainee's request. A detainee victim in protective custody after having been subjected to sexual abuse shall not be returned to the general population until a proper re-assessment is completed, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. The Auditor interviewed the Shift Supervisor that monitors segregation. He stated that the SMU is never used for victims or potential victims of sexual assault unless the detainee requests it. The PSA Compliance Manager indicated segregation would not be used to protect a vulnerable detainee or victim and that alternative housing would be utilized, including another housing unit or movement from the facility. He also stated that if segregation were ever used for that purpose, he would notify the FOD within

72 hours and comply with the provision of the policy. The OIC approved all policies used at FSPC. A review of the one case file confirmed that the victim was not placed in protective custody.

Recommendation (a): The Auditor recommends the words medical housing be removed from policy FDC 2.11 as FSPC has no medical beds.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 that requires if a detainee alleges sexual abuse or assault, a sensitive and coordinated response is necessary. The facility shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse. The investigation into the alleged sexual assault will be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators. FSPC is also required by this policy to conduct an administrative investigation upon the conclusion of a criminal investigation where the allegation was substantiated or in instances where no criminal investigation has been completed. Upon the conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. The ICE Investigator confirmed his investigations are always prompt thorough and objective. The AGS Investigator confirmed he conducts the facility's administrative investigations after OIG, OPR, and local law enforcement have concluded their investigation or declined it. He also confirmed that administrative investigations are conducted on every allegation regardless of the criminal investigative finding. As previously noted, the Auditor reviewed one investigative file. A trained investigator performed the investigation and it appeared to be prompt, thorough, and objective.

(c)(e)(f) The Auditor determined compliance with these standard subparts after reviewing policy 2.11, which requires an administrative investigation to be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity. The policy further requires the investigative procedures for the administrative investigation to include: the preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse or assault involving the suspected perpetrator; assessment of the credibility of an alleged victim, suspect or witness without regard to the individuals status as detainee, staff or employee; without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph; and an effort to determine whether actions or failures to act at the facility contributed to the abuse. FSPC is also required by this policy to document each investigation by a written report to include a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings, and the departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating any investigation. The AGS Investigator and the PSA Compliance Manager confirmed that documentation of such reports is maintained for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. Each stated that when outside agencies investigate allegations of sexual abuse the facility cooperates and remains in contact with the agency. They also confirmed that an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. One allegation of sexual abuse was reported at FSPC for the audit period. The Auditor reviewed this investigative file and found that the file contents demonstrated compliance with the subpart (c) and policy protocol requirements.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with the standard after a review of policy 11062.2, which requires administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse or assault. The AGS Investigator and ICE Investigator interviews confirmed the evidence standard they utilize when determining the outcome of a sexual abuse case is preponderance of the evidence. The review of the one investigative file appeared to demonstrate preponderance of evidence was used to make the outcome determination.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with the standard after a review of policy FDC 2.11, which requires detainees still in ICE immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation of sexual abuse or assault, to be notified of the investigation outcome. The investigative file for the only allegation at FSPC during the audit period noted that the detainee was released before the investigation's conclusion. According to the PSA Compliance Manager, ICE would make the notification if the detainee were still in detention and when otherwise feasible; this detainee was removed from the country with no known address. Both the ICE and AGS Investigator and the PSA Compliance Manager confirmed detainees would be provided with investigative outcomes for allegations of sexual abuse.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 requires FSPC staff be subject to disciplinary or adverse action, up to and including removal from their position for substantiated allegations of sexual abuse

or for violating ICE or facility sexual abuse rules, policies, or standards. The policy further requires removal from their position as the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in those acts of sexual abuse as defined in this policy. Interviews with the AFOD and HRM confirmed that removal from employment and Federal Service would be the presumptive discipline for any staff member who has engaged in, attempted, or threatened to engage in sexual abuse or failed to follow the zero-tolerance policy. As noted throughout the report, the OIC reviewed this policy. FSPC had no allegations of sexual abuse involving a staff member during the audit period.

(c)(d) The Auditor determined compliance with these subparts of the standard after a review of policy 2.11, which requires the facility to report all incidents of substantiated sexual abuse by staff and all removal of staff or resignations in lieu of removal for violations of sexual abuse policies, to appropriate law enforcement agencies unless the activity was clearly not criminal. This policy further requires FSPC to report all such incidents of substantiated abuse, removals, or resignations in lieu of removal to the FOD, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies to the extent known. The AFOD interview confirmed that staff is subject to discipline for violations of the department's sexual abuse policies, and termination is the presumptive disciplinary sanction for a staff member who has engaged in sexual abuse. He also indicated that removals or resignations for violations of agency or facility sexual abuse policies would be appropriately handled with notification to the FOD and any relevant licensing bodies by the facility to the extent known. He also stated that no staff had been terminated or disciplined within the audit period for violating the zero-tolerance policy. There were no staff-on-detainee allegations made during the audit period.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.1.1 that requires any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility shall also report such incidents to the FOD regardless of whether the action was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies to the extent known. The AFOD stated that any contractor or volunteer who violated any part of their zero-tolerance policy would face immediate removal from the facility, be prohibited from future contact with any detainee, and reported to the FOD and any relevant licensing bodies. He also confirmed there were no allegations made during the audit period involving a contractor or volunteer.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 and policy FDC 3.1, Detainee Discipline, that require detainees to be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault consistent with the FDC 3.1 policy. The 3.1 policy requires the sanctions to be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories. This policy further requires the disciplinary process to maintain reviews, appeals, procedures, documentation procedures and consider whether a detainee's mental disabilities or mental illness contributed to their behavior when determining what type of sanction. The facility is also prohibited by this policy to discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. FSPC is required to accept a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred and not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The AFOD and PSA Compliance Manager confirmed that FSPC follows both policies when dealing with detainee misconduct to encourage the detainee to conform to rules and regulations in the future. Disciplinary hearings are conducted by the shift AGS Captain and are reviewed and signed off by the OIC. In the one case reported during the audit period, the allegations were found to be unsubstantiated; therefore, no discipline hearing was warranted.

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

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard after interviews conducted with the PSA Compliance Manager, Classification Detention Officer conducting the RCA on arrival, HSA, and Mental Health. During the interview with the Classification Detention Officer, he confirmed that for any detainee answering in the affirmative to the particular vulnerabilities question about prior victimization of sexual abuse or abusive sexual abusive behavior, the detainee is referred to medical and mental health. The HSA and Mental Health interviews confirmed that their directive 03-01, requires the detainee be seen within 48 hours for medical referrals and 72 hours for mental health referrals. If the detainee answers in the affirmative, they would be referred to mental health for follow-up. The Mental Health practitioner indicated she would normally see any referral made with 48 hours. According to the PSA Compliance Manager, no detainees were received at FSPC disclosing prior victimization or sexual abusive behavior during the audit period.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11 and Directive 03-01. The FDC 2.11 policy requires detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. Directive 03-01 requires all treatment services, both emergency and ongoing, be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility provided the Auditor with the medical record and investigative files for the one alleged victim of sexual abuse reported during the audit period. The review of the files confirmed that the alleged victim was immediately brought to the medical unit and evaluated by medical staff. The HSA indicated that victims would have access to medical examinations and crisis services consistent with community standards and at no cost to the detainee, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The detainee who alleged sexual assault was no longer at the facility and the allegation did not require a forensic medical exam.

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

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

Notes:

(a)(b)(c)(f) The Auditor determined compliance with these subparts of the standard after a review of policy 2.11, which requires the facility to offer medical and mental health evaluation and, as appropriate, treatment to all detainees who, have been victimized by sexual abuse while in immigration detention and shall provide such victims with medical and mental health services consistent with the community level of care. The policy further requires, the evaluation and treatment of such victims shall include follow up service; treatment plans; and when necessary, referrals for continued care following their transfer to, or placement in other facilities, or their release from custody. The HSA confirmed that the medical and mental health services are consistent with the community level of care and that all treatment would be provided without cost to the detainee victims regardless of if he names the abuser or cooperates with any investigation arising out of the incident. The Auditor reviewed the only investigative file for the audit period, documenting that the detainee was seen by medical and mental health staff. The detainee who alleged sexual assault was no longer at the facility to interview.

(d) This subpart is not applicable at FSPC as it is a male facility.

(e) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.11 that requires detainee victims of sexual abuse, while detained, be offered tests for sexually transmitted infections as medically appropriate. The HSA confirmed that the facility follows the FDC 2.11 policy requirements and indicated that the medical and mental health departments at FSPC can provide on-site crisis intervention services and testing for sexually transmitted infections and other infectious diseases. If necessary, they could give prophylactic treatment to detainees if needed.

(g) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.11, which requires the facility shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. As noted earlier, FSPC had no substantiated allegations of sexual abuse during the audit period. The mental health practitioner and HSA confirmed that the facility would see any abusive detainee and offer services.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard after a review of policy FDC 2.11, that requires the facility to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation and, where the allegation was not determined to be unfounded, prepare a written report within thirty (30) days of the conclusion of the investigation. The facility shall implement the recommendations for improvement from this review or shall document its reasons, in writing, for not doing so. The report and response shall be forwarded to the FOD or his or her designee for transmission to the ICE PSA Coordinator. The PSA Compliance Manager stated that FSPC has a review team comprised of ICE administrators, the PSA Compliance Manager, AGS administrators, an investigator, and a medical or mental health staff person. The team completes an incident review in writing on all sexual abuse allegations regardless of the finding. During the site visit, the PSA Compliance Manager was interviewed regarding his role as Chairperson of the incident review team. He informed the Auditor that an incident review is conducted on every allegation of sexual abuse. He indicated that their review includes the policy requirements and the subpart (b) requirements, and once completed, he provides copies to all parties required by policy and standard, including the agency PSA Coordinator. The Auditor reviewed the one investigative file for the audit period and observed a completed incident review conducted within 30 days of the conclusion of the investigation and documentation of the appropriate notifications. There were no recommendations made by the committee due to the review.

(c) The Auditor determined compliance with this subpart of the standard after a review of policy FDC 2.11, that requires FSPC conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If there are no reports of sexual abuse during the annual reporting period, then the facility shall

prepare a negative report. The results and findings of the annual review shall be provided to the OIC and ICE FOD, or his or her designee, for transmission to the ICE PSA Coordinator. The Auditor was provided the facility annual review of sexual abuse allegations and subsequent incident reviews, dated January 2022. The PSA Compliance Manager confirmed a copy of this review is provided to the ICE ERO FOD and the agency PSA Compliance Manager.

§115.87 - Data collection.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) The Auditor determined compliance with this standard after a review of policy FDC 2.11 which requires the facility maintain in a secure area all case records associated with claims of sexual abuse or assault, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment if necessary. The PSA Compliance Manager confirmed that all investigative files and related abuse data are securely maintained in his office under double lock and key, with access restricted to only staff needing review. He indicated that the records are retained for at least five years after the release of the staff or detainee from FSPC unless federal, state, or local law requires otherwise.

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

(d) The Auditor was allowed access to FSPC and able to revisit areas of the facility as needed during the site visit.
(e) The Auditor was provided with and allowed to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and detainees were conducted in a private confidential setting.
(j) The Auditor observed audit notices posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian, Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor received no staff, detainee, or other party correspondence.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	38
Number of standards not met:	0
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 11/7/2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) 11/7/2022
Program Manager's Signature & Date

(b) (6), (b) (7)(C) 11/7/2022
Assistant Program Manager's Signature & Date