PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	1/14/2020	**To:**	1/16/2020
AUDITOR INFORMATION			
Name of auditor:	Mark Stegemoller	**Organization:**	Creative Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-
PROGRAM MANAGER INFORMATION			
Name of PM:		**Organization:**	Creative Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-381-
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:	Acting Field Office Director Albert E. Carter
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)	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Florence Service Processing Center (SPC)		
Physical address:	3250 N. Pinal Parkway, Florence, AZ 85132		
Mailing address: (if different from above)			
Telephone number:	520-868-8377		
Facility type:	SPC		
PREA Incorporation Date:	6/11/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(E)	**Title:**	Acting officer in Charge
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-868-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	SDDO
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-251-

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	10/17/2019
Notes:	

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Florence Service Processing Center (FSPC) was conducted on January 14-16, 2020, by Mark Stegemoller and (b) (6), (b) (7)(C) certified United States (U.S.) Department of Justice (DOJ) and DHS PREA Auditors for Creative Corrections, LLC. The purpose of the audit was to determine compliance with the DHS PREA Standards. The incorporation date for the FSPC was June 11, 2015. The FSPC is operated by U.S. Immigration and Customs Enforcement (ICE) for housing of adult male detainees. On the first day of the audit, the facility held a total of 349 ICE adult male detainees. This is the second DHS PREA audit of the FSPC. The FSPC contains medium and low security detainees and is located in Florence, Arizona. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ and DHS certified PREA Auditor. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE External Review and Analysis Unit (ERAU) section during the audit report review process.

The Team Lead opened the entry briefing at 8:00 A.M. on the first day of the on-site visit. In attendance were:

- (b) (6), (b) (7)(C) Inspections and Compliance Specialist ERAU, Office of Professional Responsibility (OPR), ICE
- (b) (6), (b) (7)(C) Acting Section Chief, ICE/OPR
- (b) (6), (b) (7)(C) Project Manager, Asset Protection and Security Services (Asset)
- (b) (6), (b) (7)(C) Assistant Project Manager, Asset
- (b) (6), (b) (7)(C) Detention Services Manager (DSM), ICE
- (b) (6), (b) (7)(C) Assistant Compliance, Asset
- (b) (6), (b) (7)(C) Chief of Security, Asset
- (b) (6), (b) (7)(C) Assistant Chief of Security, Asset
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) Acting Officer in Charge, ICE
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) Compliance, Asset

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

Prior to the audit, ICE Team Lead (b) (6), (b) (7)(C) provided the Auditor with the facility Pre-Audit Questionnaire (PAQ), facility policies, and other relevant documentation. The PAQ and supporting documentation was very well organized and emphasized, allowing for ease of auditing. The Facility provided the Auditors with the requested documentation for review during the on-site portion of the audit, allowing the Auditors to perform comprehensive reviews of staff PREA training, PREA investigative documentation, detainee education, detainee risk assessments, etc. According to the submitted facility PAQ there were 3 reported incidents of sexual abuse for the previous 12 months. The Auditor reviewed all investigations in their entirety and found them to be very well-organized allowing for ease of auditing. The Auditor determined all investigations to be compliant with the PREA standards in all material ways.

FSPC is located approximately one mile north of Florence and is under the governing authority of the DHS. FSPC was originally built to serve as a World War II confinement camp for prisoners of war. It was utilized in this capacity from 1942 until the end of the war, when it was converted to a detention facility. In 1983, The Immigration and Naturalization Service acquired the facility from the Bureau of Prisons. Over the past two decades, FSPC has undergone expansions and modernization. An administration building was constructed in 2002, which houses staff offices. Since March 2003, it has been under the management of the ICE. FSPC is accredited by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC). ICE Health Service Corps (IHSC) operates medical and mental health care at the facility. Asset Contract staff provide security and food services and maintenance services are provided by Satellite Services, Inc.

Following the entry-briefing, a tour of the facility was conducted. All areas of the facility, accessible to detainees, were toured by the Auditors to include detainee intake processing, medical and mental health services, detainee housing units, library, chapel, recreation, food service, and segregation. The Auditors also visited the facility control center, visitation, and the facility's main lobby. According to the facility PAQ and staff interviews, the total number of staff who may have reoccurring contact with detainees (e.g., security staff, medical staff, kitchen staff, maintenance staff, etc.) is 542. The total number of security staff is 372 and is comprised of ICE employees and contract staff. There is a total of 277 male and 95 female security officers.

The facility is comprised of three buildings and has six housing pods located in the center of facility and each pod has a maximum capacity of 64 detainees. (b) (7)(E) The Auditors noticed excellent lines of sights throughout the housing units and there were no blind spots detected. Medical, food service, laundry, and program services are located in a building to the rear of the housing units. (b) (7)(E) (b) (7)(E) This post is manned by two officers on first and second shifts. There is one officer assigned on third shift.

The Auditors informally spoke with both staff and detainees during the tour. Sightlines were carefully examined during all aspects of the tour, as was the potential for blind spots. (b) (7)(E) The facility is able to store recorded video footage for up to three months, via DVR. (b) (7)(E) Auditors observed cross-gender announcements were being completed upon entry into detainee housing units. PREA related information was

posted in numerous areas throughout the facility to include all housing units. PREA educational and reporting information was strategically located, on bulletin boards and posted on walls so that detainees are made aware of the information available to them; PREA educational information, zero-tolerance policy, methods for reporting sexual misconduct, and victim advocacy contact information were posted in both English & Spanish, languages that are most prevalent. Auditors further observed through the review of staff logbooks that intermediate and high-level staff are making the required unannounced PREA rounds.

Through the review of facility policy and procedures and interviews with detainees, intake staff, Facility Officer in Charge (OIC), and Prevention of Sexual Assault (PSA) Compliance Manager, provisions are made for the limited English proficient (LEP) detainees to receive written translation materials related to sexual abuse or assault in a language they understand for the facility's LEP detainee populations. Oral interpretation or assistance is provided to any detainee who speaks another language in which written material has not been translated or who is illiterate. Detailed information regarding these services is outlined within the corresponding PREA standards noted throughout the report. Notices guaranteeing the privacy of PREA reporting hotlines were present in each housing unit. Detainees have access to phones in their living areas. Notices of the audit were posted throughout the facility, including the facility lobby area. Notices were available in 12 different languages. The Auditor received no written communication from either detainee, staff, or third-party parties.

After the tour, the Auditor was provided with an FSPC staff and detainee roster. The Auditors randomly selected both staff and detainees for formal interviews. The Auditors interviewed 24 total staff that included: the Facility OIC, PSA Compliance Manager/SDDO, who is also assigned as the facility Investigator, human resource staff, medical and mental health staff with IHSC, two Training Supervisors, one for ICE and one for Asset, intake staff, Classification Supervisor, and random security staff, including line-staff and first-line supervisors from all three shifts. The Auditors formally interviewed a total of 21 detainees. Six detainees interviewed were LEP and required the use of interpretive services. The Auditor utilized the interpretive services of Language Services Associates (LSA) provided through contract by Creative Corrections. Twelve detainees interviewed were random samples. The Auditor interviewed two detainees who identified as transgender, one who reported sexual abuse/history, and one who repoted sexual victimization during risk screening. The facility reported that there were no detainees placed in segregated housing (for risk of sexual victimization/following a sexual abuse allegation); detainees who have filed a grievance related to sexual abuse; or detainees with disabilities.

The countries of origin for detainees interviewed were: Mexico, El Salvador, Haiti, Honduras, Romania, Nigeria, and Guatemala.

The PAQ indicated that there were 3 allegations of sexual abuse during the previous 12 months. The Auditor reviewed all 3 investigations and determined they were completed in accordance with the standards. All 3 incidents were detainee on detainee allegations, and all 3 were administratively investigated by the FSPC Investigator and found to be unsubstantiated. Investigative documentation reviewed indicated the Florence Police reviewed the allegations and determined they would not be pursuing criminal charges.

On January 16, 2020, an exit briefing was held in the FSPC staffing conference room. The Team Lead opened the briefing and then turned it over to the Auditor.

In attendance were:

- (b) (6), (b) (7)(C) Management and Program Analyst, ERAU, OPR, ICE
- (b) (6), (b) (7)(C) Acting Section Chief, ICE/OPR
- (b) (6), (b) (7)(C) SDDO, ICE
- (b) (6), (b) (7)(C) Assistant Compliance , Asset
- (b) (6), (b) (7)(C) Assistant Chief of Security, Asset
- (b) (6), (b) (7)(C) Project Manager, Asset
- (b) (6), (b) (7)(C) Assistant Project Manager, Asset
- (b) (6), (b) (7)(C) Acting Officer in Charge (AOIC), ICE
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) SDDO, ICE
- (b) (6), (b) (7)(C) Deportation Officer, ICE
- (b) (6), (b) (7)(C) Assistant Compliance, Asset
- (b) (6), (b) (7)(C) Assistant Health Services Administrator (AHSA)
- (b) (6), (b) (7)(C) Health Services Administrator (HSA)

The Auditor discussed observations made during the on-site portion of the audit and was able to give some preliminary findings, and further explained what would be entailed during the post on-site audit phase. The Auditors informed those in attendance they were appreciative of the hospitality received by facility staff, and for the professionalism provided by all staff during the visit. Both staff and detainees interviewed had a very respectable understanding of PREA and know what mechanisms are in place to report incidents of sexual misconduct, if required.

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: 3
§115.13 Detainee supervision and monitoring
§115.31 Staff training
§115.52 Grievances

Number of Standards Met: 31
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health care
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.53 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
§115.68 Post-allegation protective custody
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§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
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 5
§115.17 Hiring and promotion decisions
§115.32 Other training
§115.67 Agency protection against retaliation
§115.73 Reporting to detainees
§115.86 Sexual abuse incident reviews

Number of Standards Not Applicable: 2
§115.14 Juvenile and family detainees
§115.18 Upgrades to facilities and technologies

PROVISIONS

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

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

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

Notes:

(c) FSPC has a written zero tolerance policy toward all forms of sexual abuse. Florence Detention Center (FDC) Policy 2.11 – Sexual Abuse and Assault Prevention and Intervention outlines the facility's approach to preventing, detecting, and responding to such conduct. Review of policy and interview with the PSA Compliance Manager confirms the policy has been approved by ICE. It was evident to the Auditor through interviews conducted with both staff and detainees that the facility has fostered a culture for zero tolerance of sexual misconduct.

(d) The facility employs a designated PSA Compliance Manager at the supervisory level who oversees the facility's compliance efforts with the implementation of PREA. The Auditor determined compliance through the review of facility policies and procedures; review of the facility organizational chart specifying the facility's PSA Compliance Manager's position. Interview with the PSA Compliance Manager confirmed he has sufficient time and authority to oversee facility efforts to comply with sexual abuse prevention and intervention policies and procedures. He further stated he serves as the point of contact for the agency's PSA Coordinator.

§115.13 - Detainee supervision and monitoring.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) A review of the FSPC PAQ staffing levels indicates there are a total of 542 staff who may have reoccurring contact with detainees. The facility's security staff is composed of ICE employees and Asset contractors. Security staff work (b) (7)(E) The Auditors was able to confirm the facility maintains sufficient supervision of detainees through the review of the facility staffing plan and on-site observations of security staff performing security rounds, to include administrative staff interacting with detainees on a routine basis, and analysis of facility documentation submitted with the PAQ, weekly rosters and staffing patterns for security personnel. The Auditors reviewed daily security shift rosters and provided post assignments for all shifts and determined the facility is ensuring staffing levels are being sustained per the standard. (b) (7)(E) (b) (7)(E) (b) (7)(E) It should be noted, as this is of particular importance to the safety and security of the facility and not just for PREA related matters. (b) (7)(E) This post is manned by (b) (7)(E) Due to staffing requirements and funding issues, this level of detainee observation is rarely seen. Thus, the Auditor considers the facility exceeds the standard's requirement. The facility reported 3 sexual abuse allegations during the previous 12 months. In the review of investigative files, the Auditor determined staff reviewed any available recorded video footage to support the investigative process. (b) (7)(E)

(b) A review of the Florence Pod Housing Officer and Security Facility Supervisors – Specific Post Orders, outlines how the facility documents the comprehensive detainee supervision guidelines, to determine and meet the facility's detainee supervision needs. The facility supervision guidelines delineated staffing housing assignments, security round requirements, physical design, video camera placements, security mirrors placement, etc. Security rounds are required to be completed on all three shifts. Security rounds are typically made (b) (7)(E) Interviews with the OIC, PSA Compliance Manager, and documentation review of the facility's annual PREA staffing plan assessment indicates the facility is meeting the standard and, at least annually, conducts a comprehensive review of the facility's staffing plan and detainee supervision guidelines. The annual review was conducted and approved by the acting OIC on 03/2019. An addendum was made to the Security Facility Supervisors post orders on 12/2019.

(c) A review of policies and procedures and interviews with the OIC and PSA Compliance Manager, indicate all elements outlined in provision (c) of the standard are considered when developing and or updating the supervision guidelines. The facility takes into consideration adequate levels of detainee supervision, the need for additional video monitoring, considers the generally accepted detention and facility correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors.

(d) Policy FDC 2.13 Detainee / Staff Communication indicates, staff, including supervisors and line staff, shall conduct frequent unannounced security inspections rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds is documented in the facility post-log-books. This practice is implemented on all shifts (to include night, as well as day) and in all areas where detainees are permitted. Staff is prohibited from alerting others that security rounds are occurring unless such an announcement is related to the operational functions of the facility. The Auditors were able to verify line staff to include supervisors are conducting frequent unannounced security inspections/rounds both on the day and night shifts through the review of the facility's log-book reports, and through personal observation of staff making rounds while touring the facility, and interviews with line and supervisory staff.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The review of the PAQ and interviews with the OIC and PSA Compliance Manager confirm FSPC does not house juveniles, females, or family detainee units. Therefore, this provision is not applicable.

§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) Policies FDC 2.11.1 Care of LGBTI Detainees and FDC 2.10 Searches of Detainees state cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. During the previous year, there have been reports of opposite gender staff performing cross-gender pat-searches of male detainees. In all seven reported and documented incidents, it was determined after reasonable diligence, staff of the same gender were are not available at the time of the required pat-search. In review of submitted documentation, the Auditor confirmed the facility is conducting and documenting these types of searches in accordance with the standard's requirement. The Auditor has concluded that this does not appear to be a systemic issue within the facility and that the facility has maintained the appropriate documentation when such a pat-search is conducted. Interviews with security staff corroborated same gender staff are required to pat-search same gender detainees unless, after reasonable diligence, staff of the same gender are not available or if an exigent circumstance, such as a facility security emergency it would be properly documented on a facility incident report and/or in facility log-books.

(c) FSPC does not house female detainees; therefore, provision (c) is not applicable.

(e)(f)(i) Policy FDC 2.11.1 states cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. The facility shall not search or physically examine a transgender or intersex detainee for the sole purpose of determining the detainee's genital status. If the detainee's genital status is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. During the audit reporting period, the facility reported no cross-gender strip searches or visual body cavity searches being conducted. Interviews with the OIC, medical, and security staff confirmed staff are aware of facility policy and procedures for conducting strip or body cavity searches, and if performed shall be documented on the facility's "Reasonable Suspicion Visual/Strip Search Form." The facility does not house juvenile detainees.

(g) Policy FDC 4.5 Personal Hygiene outlines how the facility implements policies and procedures that enable detainees to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Policy further indicates all staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing. The facility has taken numerous precautions for eliminating the potential for cross-gender viewing. Shower curtains are fashioned in such a way that prohibits cross-gender viewing but still allows for appropriate security. It should be noted while conducting the facility tour, Auditors observed the potential for cross-gender viewing in Unit-2 housing. There is a clear and direct view into the toiletry area allowing for full view of detainees using the toilet. While onsite the facility quickly remedied the cross-gender viewing concerns with a mobile privacy screen. The Auditor personally verified the correction on the last day of the onsite visit.

(h) This provision is not applicable. FSPC is not a Family Residential Facility.

(j) Policy FDC 2.10 Searches of Detainees, states security staff will be trained in the proper procedures for conducting pat-down searches, including pat-down searches by staff of the opposite gender, and searches of transgender and intersex detainees. While on-site, there were two transgender detainees the Auditor interviewed. Both detainees indicated they have been treated exceptionally well and have not had any issues pertaining to being searched and that pat-down searches are conducted in a professional and respectful manner. Interviews with both the Training Supervisor for ICE and Training Supervisor for Asset Security indicated line staff have received proper training on how to perform pat-down searches in a professional and respectful manner, and in the least intrusive manner. Most security staff were able to articulate to the Auditor proper pat-down search procedures. While on-site, the Auditor reviewed seven staff training records acknowledging such training has been received. Submitted with the facility PAQ was employee signed acknowledgements of completing the training, to include annual refresher training. The Auditor reviewed the submitted facility training curriculum (Detainee Searches) and found the training was compliant with the standard in all material ways.

§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)(c) Policy FDC 2.11, outlines how the facility shall ensure that detainees with disabilities (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. A detainee may request for another detainee to provide interpretation only if the agency determines that such interpretation is appropriate and consistent with DHS policy. Upon intake, detainees are provided with the facility's local detainee orientation handbook in conjunction with the ICE National Detainee Handbook and the ICE Sexual Assault Awareness information pamphlet. During the tour of intake, the Auditor reviewed both the facility local orientation handbook, available both in English and Spanish and the ICE National Detainee handbooks available in 11 different languages, including English and Spanish. Both handbooks provide detainees with information on the agency and facility's zero tolerance policy for sexual abuse and how to report incidents of sexual abuse. Intake staff indicated they could immediately print out additional copies of the detainee handbook which provides information for detainees on the prevention and reporting of sexual abuse and assault, as well as, information on detainee rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS OIG. PREA informational posters were strategically posted in the intake area and throughout the facility so that all detainees would have the opportunity to review. The Classification supervisor advised if a detainee coming through intake spoke a language that was not available in a written format, they will utilize an interpretive service, Language Line Solutions, which is under contract with the facility for providing interpretive services to detainees. In review of completed investigations for the previous 12 months, the Auditor determined the appropriate steps were taken in accordance with the standard to ensure equal opportunities to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. The ICE National Detainee Handbook includes a section (language identification guide) in the very front of the handbook which outlines multiple languages to assist detainees who do not speak English or Spanish. DHS/ICE PREA posters in English and foreign languages, containing the name of the facility PSA Compliance Manager are posted throughout the facility, to include the detainee housing units. Also, posted is contact information for the provided rape crisis center, Southern Arizona Center Against Sexual Assault (SACASA). Interviews with the OIC, Classification Supervisor, and security staff indicate there are multiple staff who speak several languages who are also able to assist detainees with interpretive services, if needed. The Auditors observed this practice through staff and detainee communication throughout the on-site visit. It was evident staff are very familiar with the facility's protocols for utilizing interpretive

services, if required. Detainees who have disabilities, including intellectual, limited reading skills, who may be deaf, blind or hearing impaired are afforded the same level of interpretive services, if required. Detainees who are LEP are provided with interpretative services, either through available staff or an interpretive service. Detainees who are hearing impaired or deaf will receive services through the facility Text Telephone machine (TTY), and written materials, detainees who have a low intellectual or limited reading skills will receive services from mental health personnel. Mental Health will take the appropriate time and care to read the material to them. The Auditor was able to determine this through the observation of actual detainee intake processing, when an LEP detainee was being processed. Further compliance was determined through interviews with the OIC, PSA Compliance Manager, intake and security staff. While onsite there were no detainees to interview who were identified as deaf, blind or hearing impaired. Review of facility policy indicates the provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. The Auditor interviewed 18 detainees who were LEP through the use of telephonic interpretive service, Language Services Associates, provided through Creative Corrections LLC. The Auditor was able to verify the use of interpretive services through a review of detainee classification/intake packets. The documentation noted the language the detainee spoke and if interpretive services was utilized. All detainees interviewed recalled receiving information during the intake/orientation process on the facility's and agency's zero tolerance policy and efforts to prevent, detect, and respond to sexual abuse, and most recall seeing the video "Know Your Rights," educational video playing in the intake area on a large flat screen TV. The video is formatted in English and Spanish languages only and closed captioned for the hearing impaired. The video is played again every morning in the housing units.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) Executive Order 10450 Security Requirements for Government Employment and the Office of Personal Management Section Part 731 and ICE Directives 6-7.0 and 6.8.0 outlines how the facility and agency, to the extent permitted by law, refuse to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor or volunteer who may have contact with detainees, who has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard. All three policies noted above require new hires, staff awaiting promotions, and all staff annually to complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form. The individual will respond directly to questions about previous misconduct as required per the standard and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The form is to be retained in the employee's personnel file. The Auditor was able to confirm the above mentioned through the review of seven randomly selected staff personnel files. Policy further indicates every effort is to be made to contact all prior institutional employers for information on sexual abuse incidents prior to hiring. Interview with Asset Human Resource Personnel while onsite indicated to the Auditor FSPC does not contact prior institutional employers of an applicant for employment to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse.

(c)(d) ICE Directives 6-7.0 and 6.8.0 requires the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees prior to being allowed entrance into the facility. It further requires a background recheck be conducted every five years on all employees and unescorted contractors. The Auditor was advised contractors under staff escort do not have contact with detainees. The Human Resource Manager stated ICE completes all background checks for all staff and contractors. Review of documentation provided by ICE's Personnel Security Unit (PSU) Unit Chief confirmed that the 15 randomly selected employees background checks were performed prior to them reporting to work. Documentation also confirmed the due dates for the five-year background rechecks. There was one staff person where a five-year background check was required, and it was noted as in progress at this time. The Auditor determined the provided background check information was compliant with the standard in all material ways.

(e)(f) This Auditor attended training in Arlington, Virginia in September 2018, where PSU Division Chief (b) (6), (b) (7)(C) presented information on the background investigation process. During this training, he confirmed that any material omissions, intentional false statement, or deception is a factor that would make an applicant, employee, or contractor unsuitable for employment. He further confirmed that the agency would, unless prohibited by law, provide information on a substantiated allegation of sexual abuse involving a former employee or contractor, to any requesting confinement facility. The Auditor further corroborated this process through a telephonic interview with PSU Industrial Security Team Lead (b) (6), (b) (7)(C)

Interview with Asset Human Resource Personnel while onsite indicated to the Auditor FSPC does not contact prior institutional employers of applicants and if an institutional employer requests a reference check about a former employee's history of sexual abuse, they would not disclose the information. The Auditor conducted a post site inspection telephonic interview with facility ICE Human Resource Personnel and was advised they do not contact prior institutional employers of applicants and if an institutional employer requests a reference check about a former employee's history of sexual abuse, they would not disclose the information.

Corrective Action Required: 115.17(b)(f) The facility must make its best efforts to contact all prior institutional employers of an applicant for employment to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. The facility must, unless prohibited by law, provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. The facility will need to develop a process, possibly remedial training/education for ensuring that ICE and Contract Administrative/Human Resources staff are aware of the agency protocols for accomplishing the requirements of standard 115.17, specifically as it relates to subsections (b) & (f).

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) Review of the PAQ and interview with the facility OIC indicated the agency has not acquired a new facility or made a substantial expansion to the existing facility, nor has the facility updated its video monitoring system. This is the FSPC's second DHS PREA audit. Therefore, standard 115.18 is not applicable.

§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) Policy FDC 2.11 outlines to the extent the agency or facility is responsible for investigating allegations of sexual abuse involving detainees and follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal

prosecutions. The investigating entity will offer victims of sexual abuse and assault access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate, and only with the detainee's consent. Examinations will be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), where possible. SAFE/SANE exams are performed at the HonorHealth Scottsdale Osborn Medical Center. If SAFEs or SANEs cannot be made available at the hospital, the examination can be performed by other qualified medical practitioners at the hospital. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable. The Auditor was able to corroborate through the review of FSPC policy and procedures, interviews with the facility's OIC, PSA Compliance Manager, and documentation review, that evidence protocols are developed in coordination with DHS. Security and medical staff stated they are well aware of the facility's evidence protocols and know the necessary steps to take during a report of sexual abuse.

(b)(d) FSPC uses the service of the SACASA and does not require a memorandum of understanding (MOU), as the SACASA is a non-profit organization. The Auditor placed a call and talked with a staff member of SACASA , who confirmed a qualified staff person from the organization will provide emotional support, crisis intervention, information, referrals if needed, and would accompany the victim through any forensics exams and investigative process. The facility reported three sexual abuse investigations during the previous 12 months. In review of the investigative files the Auditor determined the alleged victims were offered victim advocacy services. It should be noted all three detainees declined the services of SACASA.

(c) The interview with the HSA acknowledges victims of sexual abuse would undergo a forensic medical exam at no cost to the detainee and only with the consent of the detainee. Forensic exams are performed by SAFE/SANE at the HonorHealth Scottsdale Osborn Medical Center. The HSA indicated the facility has not needed to send out a detainee for a sexual abuse forensic medical exam within the last 12 months.

(e) Policy FDC 2.11 states to the extent that the agency is not responsible for investigating allegations of sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of paragraph (a) through (d) of this section. The Auditor was provided with a signed MOU between FSPC and the Florence Police Department and the Pinal County Sheriff's Office, that governs the use of local law enforcement and response during an emergency or criminal related matters at the Florence Detention Center. The Florence Police Department is responsible for any and all criminal related matters pertaining to FSPC. In a review of the MOU and interview with the PSA Compliance Manager, the Auditor was satisfied that the investigating agencies have agreed to follow the requirements of 115.21(a) through (d).

§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) Policy FDC 2.11 outlines the facility's protocol for ensuring that all allegations of sexual abuse are investigated by the agency and facility and referred to Florence Police Department, who has the proper investigative authority for conducting all allegations of sexual abuse that are deemed to be criminal. The policy further outlines the roles and responsibilities of the agency, facility, and the Florence Police Department as it relates to coordinating and the sequence of administrative and criminal investigations. Policy further states all reports and referrals of allegations of sexual abuse and any other related documentation are maintained as long as the abuser is detained or employed by the agency or facility, plus five years. Interviews with the facility's OIC and PSA Compliance Manager corroborated the aforementioned. Criminal investigations will be referred to the Florence Police Department, the agency with legal authority to conduct criminal investigations. Qualified investigators must perform all investigations into alleged sexual abuse. Policy states upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon completion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations will include: preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse and assault involving the alleged perpetrator. The PAQ indicated that there were three allegations of sexual abuse during the previous 12 months. The Auditor reviewed all three investigations and determined they were completed in accordance with the standards. All three incidents were detainee on detainee allegations, and all three were administratively investigated by the FSPC Investigator and found to be unsubstantiated. Investigative documentation reviewed indicated the Florence Police reviewed the allegations and determined they would not be pursuing criminal charges. The facility Investigator was interviewed and found to be very knowledgeable concerning his responsibilities in the investigative process.

(c) A review of the ICE website (https://www.ice.gov/prea) confirms the sexual abuse investigation protocols are available to the public. Agency and facility protocols are posted to ensure investigations into allegations of sexual misconduct are explained to the public.

(d)(e)(f) Policy FDC 2.11 outlines the facility's protocol which ensures that all allegations, including when a staff member, contractor, or volunteer are involved, are promptly reported to the agency, Joint Intake Center (JIC); ICE OPR or the DHS Office of Inspector General (OIG); and Appropriate ICE Field Office Director (FOD) and, unless the complaint does not involve potentially criminal behavior, are immediately referred for investigation to an appropriate law enforcement agency with the legal authority to conduct criminal investigations, which is the Florence Police Department. The facility reported that there have been three sexual abuse investigations completed during the past 12 months. In a review of the investigative files the Auditor determined the standard is being met. Interviews with the facility's OIC and PSA Compliance Manager indicated all allegations are promptly reported to the JIC, the ICE OPR, or the DHS OIG, as well as, the appropriate ICE FOD.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) Policy FDC 2.11 outlines how the facility trains all full and part-time employees who may have contact with detainees and for all facility staff to be able to fulfill their responsibilities and the policy includes each element of the standard. Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all new employees. It shall also be included in annual refresher/in-service training after that. Employee training shall ensure the facility staff can fulfill their responsibilities under the DHS PREA standards. Submitted with the facility PAQ was the FSPC PREA training curriculum (ICE- PREA Training for ICE ERO Staff) and supporting documentation demonstrating FSPC staff completion of training. The Auditor determined the curriculum to be compliant with the standard in all material ways. While on-site, the Auditor randomly selected five FSPC employees and reviewed their training documentation for proof of completion and determined the training was compliant per the standard's requirement, to include by the facility's PREA incorporation date. Staff training documentation is maintained both electronically and within employees' training files. Interviews with the PSA Compliance Manager, ICE Training Officer, Asset Training Officer, and random security staff indicated staff had received the required initial PREA training and annual PREA training during in-service. Facility staff receive PREA comprehensive refresher training

annually, exceeding the requirement of the standard, which calls for refresher training every two years. It was clear to the Auditors that staff understand their responsibilities in preventing, detecting, and responding to incidents of sexual misconduct.

§115.32 - Other training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Policy FDC 2.11 outlines how the facility shall train all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard. Submitted with the facility PAQ was the Asset PREA training curriculum utilized for training volunteers and contractors who are required to receive training prior to providing services to the facility. In review of the training curriculum, the Auditor determined all the required elements of standard are covered. The curriculum meets the level and type of training required for volunteers and contractors who may have contact with detainees. Also, submitted with the facility PAQ was supporting documentation of completed training for contractors, i.e., signed acknowledgments of training received and training session sign in sheets. It should be noted the policy further states that the facility must maintain written documentation verifying employee, volunteers, and contractor training. The Auditor interviewed the facility's ICE Training Officer while on-site and was advised contractors receive comprehensive PREA zero tolerance training of the same level that is provided to full-time staff in a classroom setting and volunteers do not. The Auditor reviewed five contractors' files and determined the training provided is in accordance with the standard's requirement. The Auditor reviewed the PREA educational information provided to volunteers and several volunteer files and found it to be lacking in several of the standard's requirements, such as how to report incidents of sexual abuse and if they had been notified of the facility's zero tolerance policy.

Corrective Action Required: 115.32(a)(b) – The facility must ensure that all volunteers who have contact with detainees are trained on their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention, and response policies and procedures. The level and type of training provided to volunteers shall be based on the services they provide and level of contact they have with detainees.

§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)(d)(e)(f) Policy FDC 2.1 – Admission and Release states, upon entrance into FDC, via the Florence Staging Facility (FSF) as part of the intake process, all detainees will view the FDC orientation video. The orientation video covers all the areas that are contained within the FDC Detainee Handbook and provide the detainees with an overview of the facility's operations that affect the detainees. This video, along with the "Know your Rights" video, plays on a continuous loop on one of the televisions in the FSF. The Auditor confirmed the aforementioned through the review of 10 detainee files. It should be noted while on the facility tour, Auditors reviewed the housing unit logbooks and noted where the video is being played as well. In addition to the videos and required documentation, an officer must explain the following to each newly arriving detainee, sexual abuse prevention to include: the facility's zero tolerance policy regarding sexual abuse; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse, including to any staff member other than a point-of-contact line officer and give examples for making reports to medical, OIG, JIC, etc.; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counselling. The Auditors were provided a complete tour of the detainee intake orientation process and observed that all six required elements of provision (a) of the standard are covered in accordance with policy. During the intake process, detainees who are determined to be LEP or who may have a disability, i.e. hearing impaired, deaf, and blind, etc. will receive interpretive services and/or medical and/or mental health assistance throughout the process. The Auditors were provided an opportunity while on-site to observe actual detainee intake proceedings and determined the standard is being met in all aspects. Policy further indicates PREA information will also be provided to detainees through the video "Know Your Rights," DHS posted signage, "ICE Zero Tolerance" to include the ICE Sexual Assault Awareness Information pamphlets and ICE and facility handbooks. The Auditor randomly selected five detainee files and reviewed signed documentation indicating the distribution of both the ICE National Detainee Handbook, local facility handbooks, and DHS-prescribed "Sexual Assault Awareness Information" pamphlet. Any use of interpretive services is documented to include the interpretive service reference number. The Auditors observed numerous PREA related informational signage throughout the facility to include in all detainee housing units: the DHS-prescribed sexual assault awareness notice; the name of the PSA Compliance Manager; and contact information for the local rape crisis center, that can assist detainees who have been victims of sexual abuse.

§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) Policy FDC 2.11 states in addition to the general training provided to all facility staff and employees pursuant to 115.31, the agency or facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training covers interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process.The 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 in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators to document compliance with the standard. Interviews with the OIC, facility Investigator, and Training Supervisor indicated required staff have received specialized training for conducting sexual abuse investigations in accordance with the standard. Both ICE and facility 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. The Auditor determined the curriculum meets the standard requirements in all material ways. According to the facility PAQ there are 22 trained Investigators. Interviews conducted with two investigators verify the completion of training and that investigators are well-informed of the requirements needed to conduct sexual abuse investigations within a confinement setting. The Auditor also confirmed through the review of ICE specialized training documentation the appropriate training was provided to ICE investigative staff. FSPC reported three incidents of sexual abuse during the previous 12 months. In review of all three investigation packets the Auditor determined they were completed by specially trained investigators.

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

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

Notes:

(a)(b) IHSC Directive03-01 Sexual Abuse and Assaut Prevention and Intervention, states 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. IHSC provides medical and mental health services for FSPC. Submitted with the facility PAQ was the agency's specialized training curriculum (IHSC – Sexual Assault and Prevention-PREA) which covers all four elements outlined in subsection (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; how and to whom to report allegations of sexual abuse. FSPC medical staff do not conduct forensic examinations. If a forensic examination would be required, the detainee is sent to the local hospital where a SAFE/SANE will examine the victim. Interviews with medical and mental health staff indicate they are trained in procedures for examining and treating victims of sexual abuse; how to detect and assess signs of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; how and to whom to report allegations or suspicions of sexual abuse; and how to preserve physical evidence of sexual abuse. The Auditor was able to corroborate staff training through the review of medical and mental health specialized training documentation acknowledging the training received and completed test scores.

(c) Interview with the OIC, and PSA Compliance Manager indicated the agency did review and approve the facility's policy and procedures for examining and treating victims of sexual abuse.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d)(e) Policy FDC 2.11 states all detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment should be completed within 12 hours of admission to the facility and considers all 9 elements of subsection 115.41(c). Initial screenings 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. Interviews with detainees confirmed receiving a risk screening upon intake. Reassessments of each detainee's risk of victimization or abusiveness will occur between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. Interview with the Classification Supervisor corroborated the above-mentioned. The ICE electronic Risk Classification Assessment (RCA) screening tool is used for completing the initial and re-assessment. Completed ICE Custody Classification Work Sheets are maintained in the detainee's central file or electronic records, with a copy forwarded to the detainee's medical record and/or, where applicable, the detainee's electronic medical records. During the review of 10 detainee risk assessments, the Auditor confirmed the proper procedures are being followed per the standard in all material ways. Interviews with detainees further confirmed that follow-up risk assessments are occurring in accordance with the standard's requirement.

(f) Interviews with the PSA Compliance Manager, intake staff, and Classification Supervisor indicated detainees are not disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to the standard.

(g) FSPC detainee records include a copy of each detainee's ICE Custody Classification packet. The facility maintains appropriate control on the dissemination of all classification documentation within the facility of responses to questions asked pursuant to standard 115.41. The Auditor confirmed through staff interviews with the PSA Compliance Manager, intake staff, and Classification Supervisor and observation while on-site, detainee records are maintained in a secure location and/or electronically. Staff with a need to know only have access to such documentation. This process was corroborated during interviews with the PSA Compliance Manager, intake staff, and Classification Supervisor.

§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)(b)(c) Policy FDC 2.2 – Classification System, outlines how the facility uses the information from the ICE Custody Classification Screening Tool conducted at initial screening in the consideration of housing, recreation, work program and other activities. In review of 10 completed risk assessments, the Auditor determined the facility is utilizing collected data, such as the detainee's physical characteristics (build and appearance); age; whether the detainee has mental, physical or development disability; previous assignment in specialized housing; alleged offense and criminal history; and whether the detainee is perceived to be lesbian, gay, bisexual, transgender, intersex (LGBTI) or is gender non-conforming to determine housing, recreation, work, and other activity decisions. Interviews with the PSA Compliance Manager, intake staff, and the Classification Supervisor indicated to the Auditor the facility is ensuring the safety of each detainee and are performing all the requirements of the standard. While the Auditor was on-site, the facility had two transgender detainees, and the Auditor interviewed both of them. The transgender interviews and review of their completed risk assessments, indicated to the Auditor that the detainee's gender self-identification is considered when making assessments and housing decisions for a transgender and/or intersex detainee, and that all the elements of subsection (b) of the standard are being conducted. Policy further states in making assessments and housing decisions for transgender or intersex detainees, the facility will consider the detainee's gender and self-identification, and assessment of the effects of placement on the detainee's health and safety. Policy further indicates transgender and intersex detainees shall be reassessed at least twice a year. The two transgender detainees were recent arrivals and a second assessment was not warranted yet. Interviews with intake and medical staff indicated that a medical and mental health professional will be consulted on a case-by-case basis, to determine whether the placement would present management or security concerns. Policy further states, transgender and intersex individuals shall be given an opportunity to shower separately from other individuals. The degree of separation required is dependent on the layout of the facility and may be accomplished either through physical separation (e.g. separate shower stalls) or by time-phasing or scheduling (e.g. allowing a detainee to shower before or after other detainees). Interviews with two transgender detainees, PSA Compliance Manager, intake staff, Classification Supervisor, and security staff all indicated transgender and intersex detainees are given the opportunity to shower separately from other detainees.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c)(d)(e) Policy FDC 2.12 Special Management Units, outlines the facility's use of administrative segregation to protect detainees at high risk for sexual abuse and assault and shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. The facility will consult with the ICE FOD to determine if ICE can provide additional assistance. Detainees may be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. If segregated housing is warranted, the facility will take the following actions: a supervisory staff member will conduct a review within 72 hours of the detainee's placement in segregation to determine whether segregation is still warranted. A supervisory staff member will conduct, at a minimum, an identical review after the detainee has spent 7 days in administrative segregation, and every week thereafter for the first 30 days and every 10 days thereafter. All reviews are required to be documented in the Segregation Review Management System (SRMS). Policy further states, in addition to documenting the reviews in the SRMS, case comments need to be imputed into the ENFORCE Alien Detention Module (EADM) so the information can be referenced during classification reviews. Interviews with the OIC and PSA Compliance Manager indicated detainees placed in segregated housing will have access to programs, privileges, education, and work opportunities to the extent possible. If access to these opportunities is restricted, the facility would document the reasons why. The facility will notify the appropriate ICE FOD no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in segregation based on a vulnerability to sexual abuse or assault. As noted on the PAQ, submitted documentation, and staff interviews, FSPC has not placed a detainee in administrative segregation/protective custody during the previous 12 months due to vulnerability of sexual abuse. In review of Policy FDC 2.12 written procedures were developed in consultation with the ICE FOD who has jurisdiction for the facility. Interviews with the OIC, PSA Compliance Manager, and facility staff who supervise administrative segregation corroborated the above mentioned.

§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)(c) Policy FDC 2.11 outlines the facility's approach to ensure detainees have multiple ways to privately report sexual abuse and retaliation for reporting sexual abuse, and staff neglect or violation of responsibilities that may have contributed to any incidents. Submitted with the facility PAQ were directives on how detainees can contact their consular official, the DHS OIG or, as appropriate, another designated office, to confidentially and, if desired, anonymously report incidents of sexual misconduct. Interviews with random detainees indicated to the Auditor they are aware of the processes in place to report incidents of sexual misconduct, e.g., report to a staff member, file a grievance, place a phone call, contact their consular official, the DHS OIG or, as appropriate, another designated office to anonymously report. During the tour of the facility the Auditor observed the aforementioned signage, for detainees to report incidents of sexual misconduct, to include in all housing areas, posted on bulletin boards, and/or next to detainee phones. During intake/orientation, detainees receive a copy of the ICE National Detainee Handbook and facility local handbook that includes the process for detainees to report allegations of sexual misconduct. It should be noted on day one of the audit, facility staff made the Auditors aware that they were running short on English and Spanish ICE National Detainee Handbooks and had placed an order and were waiting on their arrival. While in one of the detainee housing units the Auditor placed a successful test call to the OIG in which detainees can remain anonymous if they choose too. The Auditor attempted to place a test call to the facility PREA hotline number, and the call would not connect. The facility contacted the company who they contract with for detainee phone services and was able to correct the phone call connecting issues while the Auditors were still onsite. On the last day of the audit, the Auditor placed a successful test call to the hotline number that was not working on the first day. It should also be noted the facility provides detainees with information and directions posted next to detainee phones on how to place anonymous calls to the following: agency's Detention Reporting Information Line (DRIL), OIG, JIC, National Rape Hotline, Rape, Abuse & Incest National Network (RAINN), State Sexual Abuse Hotline, Arizona Coalition Against Domestice Violence and the Facility PREA Hotline. Policy further outlines procedures for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. Interviews with the PSA Compliance Manager, security staff, including line staff and first-line supervisors stated if they were to receive a report of sexual misconduct, they would document it on a facility incident report and forward it on through the appropriate channels for investigation. In review of the three sexual abuse investigations, all allegations were reported to facility staff by the alleged victims. The Auditor determined all cases were completed in accordance with the standard.

§115.52 - Grievances.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c)(d)(f)(e) Policy FDC 6.2 – Grievance Procedures, details the formal grievance process for detainees to utilize involving allegations of an immediate threat to their health, safety, or welfare, and related to sexual abuse. Detainees are permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. A detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives with filing a grievance relating to sexual misconduct. Facility staff are required to bring all medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility does not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Policy further states when the department head or Grievance Officer (GO) receives a formal grievance it shall be maintained and documented through all stages of the review per the following section "'Record-Keeping and File Maintenance." Grievances related to sexual abuse are immediately reported to the facility Investigator for investigation. The grievance will be reviewed, researched, and the detainee will be met with to attempt to resolve the issue, even for sexual abuse investigations. The GO will issue a decision on the grievance within five days of receipt. If the detainee is not satisfied with the decision, he can further appeal to the Grievance Appeal Board (GAB), who in turn will provide the detainee with a decision within five days of receipt, exceeding the standards requirement of providing the detainee a decision within 30 days. If the detainee is not satisfied with the response from the GAB, he may appeal to the OIC, who will respond within five days of receipt. The OIC's decision is final. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE FOD. Interviews with Grievance Coordinator, security staff, and front-line supervisors corroborated the above mentioned.

According the facility PAQ and interview with the Grievance Coordinator, the facility has not received any grievances in the past 12 months regarding allegations of sexual abuse. Interviews with detainees also confirmed they are aware of the facility grievance process and know that they can request assistance from another detainees, housing officers and/or other facility staff, family members, or legal representatives in filing a grievance if needed.

§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) Policy FDC 2.11 outlines the facility's procedures to provide outside confidential support services that will provide services to support in the areas of crisis intervention, counseling, investigation, the prosecution of sexual abuse perpetrators, and to address victim's needs. FSPC has a written agreement with the SACASA. SACASA is a non-profit organization and will not enter into an MOU. The Auditor interviewed a staff representative from SACASA and was advised the aforementioned would take place if there was an incident requiring their service. The staff person further stated she could not recall a time where they were requested to provide services during the previous year. Interview with the PSA Compliance Manager confirmed he has been in contact with SACASA and both parties understand the services to be rendered in the case of reported incidents of sexual abuse. In review of completed sexual abuse investigation packets the facility has not had to utilize the services of SACASA during previous 12 months. The Auditor did confirm through the review of investigative documentation, services were offered to the detainees and the detainees refused.

(c) Upon intake, detainees receive educational information on the facility's zero tolerance policy to include information on how to contact SACASA that can assist detainees who have been victims of sexual abuse, including mailing addresses and hotline telephone numbers. The information is outlined in the facility local handbook. During the tour of the facility, the Auditor observed numerous signage both locally and agency specific, i.e., ICE Zero Tolerance, the SACASA hotline posted in several different languages throughout the facility to include in detainee housing units, on walls, and on bulletin boards. Random detainee interviews confirmed they have received the information at intake and during the facility's orientation and are familiar with the information posted in the housing units.

(d) Information outlined in the detainee local handbook indicates, prior to giving detainees access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Detainees have been advised through the facility local handbook, telephone calls may be recorded and monitored in accordance with the facility's policy governing the monitoring of their communications. Policy FDC 2.11 further indicates detainees are informed to the extent to which such communications are monitored and when reports of sexual abuse will be forwarded to authorities, per mandatory reporting laws. Detainees can either place a call to SACASA or send written communication. The interview with the PSA Compliance Manager further indicated the facility would facilitate reasonable communication between detainees and SACASA, in as confidential a manner as possible, to include detainees who are LEP, utilizing facility staff or interpretive services. Interviews with random detainees also indicated that they are aware that phone calls are or can be monitored and allegations of sexual abuse will be forwarded and investigated in accordance with mandatory reporting laws. The interview with the PSA Compliance Manager stated staff will provide detainees an office to place a confidential phone call if requested.

§115.54 - Third-party reporting.

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

Notes:

Policy FDC 2.11 states third party reports of sexual abuse may be made as follows: DHS OIG toll free hotline number at 1-888-323-8603; JIC toll free hotline number 1-877-256-8253 or e-mail, joint.intake@dhs.gov; and/or call the FSPC directly at 1-866-757-4488.

A review of ICE's websites (www.ice.gov/prea) and DRIL (www.ice.gov/contact/detention-information-line) confirm the public is notified how to report incidents of sexual abuse/harassment on behalf of detainees. These websites list contact numbers for the general public to report allegations of sexual misconduct. Interviews with OIC and PSA Compliance Manager confirm they are aware of the requirement to accept sexual abuse notifications from third parties. It should be noted the FSPC has not received a third-party allegation in the previous 12 months.

§115.61 - Staff and agency reporting duties.

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

Notes:

(a)(b)(c) Policy FDC 2.11 outlines the responsibilities of staff who are required to report, immediately, and any knowledge, suspicion, or information regarding incidents of sexual abuse, retaliation against detainees or staff who have reported incidents of sexual abuse, or staff neglect or violations of responsibilities that may have contributed to an incident or retaliation. According to the PAQ and the interview with the OIC, the agency did review and approve the facility's policy and procedures. Staff members who become aware of alleged sexual abuse will immediately follow the facility reporting requirements. The facility requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Employees are required to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible. Staff are required to promptly document any verbal reports as well. Other than making a report, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to to seek medical treatment, investigation, law enforcement, or other security and management decisions. Interviews with the PSA Compliance Manager, OIC, and random security staff, clearly articulated to the Auditor the protocols in place as it relates to staff reporting duties.

(d) FSPC does not house juvenile detainees. The Auditor received no information the facility houses or has housed potentially vulnerable detainees within the past year. Interviews with the OIC and PSA Compliance Manager indicated if they were to receive a report of sexual abuse from a detainee identified as a vulnerable adult, the incident would be reported to the designated State or local services agency under applicable mandatory reporting laws.

§115.62 - Protection duties.

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

Notes:

Policy FDC 2.11 outlines the facility's approach when staff learns that a detainee is subject to a substantial risk of imminent sexual abuse. Immediate action is taken to protect the detainee. Interviews with the OIC, PSA Compliance Manager, and random security staff revealed if a detainee is determined to be at an imminent risk of sexual abuse, the detainee would be immediately removed from the threat. In review of sexual abuse investigations completed during the previous 12 months, the Auditor determined the facility took the appropriate and immediate action required to protect detainee victims.

§115.63 - Report to other confinement facilities.

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

Notes:

(a)(b)(c)(d) Policy FDC 2.11 outlines the facility's process for reporting to other confinement facilities. Upon receiving an allegation that a detainee currently at the facility was sexually abused while housed at another facility (e.g. state, federal, local, or other private operator) the Facility Administrator of the facility that received the allegation will contact the Facility Administrator or appropriate headquarters office of the facility where the alleged abuse took place as soon as possible, but no later than 72 hours after receiving the allegation. A copy of the statement of the detainee will be forwarded to the appropriate official at the location where the incident was reported to have occurred. The facility will document it has provided such notification. Upon receiving notification from another agency or another facility that a detainee currently at their facility reported an incident/allegation of sexual abuse that occurred while the subject was a detainee at the FSPC, the following actions will take place: the facility will document the name of the agency making the contact, and any information (names, dates, time) that may assist in determining whether an investigation was conducted. If an investigation was not completed, the facility would initiate an investigation. Notification is required to be made to the ICE FOD/designee. It should be noted the facility has reported that there were no recorded claims of sexual allegations occurring at another facility during the previous 12 months. Interviews with the PSA Compliance Manager and OIC corroborated the aforementioned would take place if required. They further indicated they are aware of the proper steps for making such notifications, and for maintaining documentation if a notification is made. The OIC and PSA Compliance Manager indicated documentation of such notifications would be maintained through electronic means, i.e. agency electronic applications, email correspondence, faxes, and facility incident reports.

§115.64 - Responder duties.

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

Notes:

(a)(b) Policy FDC 2.11 states upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or if it is his or her supervisor, shall ensure that the alleged victim and perpetrator are separated and that the alleged victim is kept safe, and has no contact with the alleged perpetrator. The responder shall, to the greatest extent possible, preserve and protect any crime scene until appropriate steps can be taken to collect evidence. Interviews with security staff, policy review, and investigative files review indicates all four elements of the standard is accounted for during the responder duties. According to the facility PAQ and staff interviews with security staff, and security supervisors, there has not been a non-security staff member who acted in the capacity of a first responder. Policy further states and interviews with security staff, and security supervisors, and non-security staff corroborate non-security first responders are required to request that the alleged victim not take any actions that could destroy physical evidence and are required to notify security staff. In a review of a sexual abuse investigations the Auditor determined in all cases; first responder duties were accomplished per the standard's requirement.

§115.65 - Coordinated response.

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

Notes:

(a)(b)(c)(d) Policy FDC 2.11 outlines the facility's coordinated response to incidents of sexual abuse. Staff members who become aware of alleged sexual abuse shall immediately follow the reporting requirements set forth in policy. Policy review and interviews conducted with the OIC and PSA Compliance Manager indicated the facility uses a coordinated, multidisciplinary team approach when responding to incidents of sexual abuse. The facility's written institutional plan delineates the responsibilities for a coordinated response to staff-on-detainee allegations of sexual abuse and detainee-on-detainee sexual abuse allegations. During the past 12 months, FSPC reported three incidents of sexual abuse. Two detainees have been released from ICE custody and one is still at detained at the facility. Interviews with the OIC and PSA Compliance Manager confirmed they are aware of the facility's coordinated response procedures for allegations of sexual abuse and the victim's potential need for medical or social services. Both the OIC and PSA Compliance Manager advised the Auditor, proper notifications per the standard would be made to the receiving facility, to include a DHS immigration detention facility subpart A and B, and if a detainee was to be transferred to a facility not covered by paragraph of subsection C, unless the victim requests otherwise. The Auditor has determined the facility is compliant with the standard in all material ways.

§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:

Policy FDC 2.11 outlines staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. When an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse and/or assault, 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) and reported to the FOD, who shall report it to the OPR, JIC, local government entity or contractor that owns or operates the facility shall also be notified. Employees will be subject to disciplinary sanctions up to and including termination for violating sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse. Contractors or volunteers who have engaged in sexual abuse or assault are prohibited from contact with detainees. The facility will take appropriate remedial measures and considers whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards. Interviews with the OIC and Human Resources staff corroborated that staff, contractors, or volunteers who are being investigated for sexual abuse allegations or any other serious misconduct involving a detainee are prohibited from having contact with detainees. FSPC reported no incidents of sexual abuse involving staff, contractors, or volunteers within the past 12 months.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Policy FDC 2.11 outlines the facility's procedures for protection against retaliation. Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. Policy further indicates, for at least 90 days following a report of sexual abuse, the OIC or designee will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the OIC or designee should monitor include detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff. The OIC or designee shall continue monitoring beyond 90 days, if the initial monitoring indicates a need to. This shall include periodic status checks of detainees in person and review of relevant documentation. Interviews with the OIC and PSA Compliance Manager corroborated the above information noted in policy; however, both confirmed, the required retaliation monitoring for the

three reported incidents of sexual abuse were not completed in accordance with the standard. It was further corroborated through the review of investigative packets that monitoring for retaliation was not conducted.

Corrective Action Required: The facility will need to develop a process for providing and documenting the agency's protection against retaliation per the standards requirement.
Furthermore, the facility will need to provide documentary evidence to support this process is adhered to.

§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) Policy FDC 2.11 indicates the use of administrative segregation to protect detainees at high risk for sexual abuse and assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. The facility shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. Detainee victims shall not be held for longer than five days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a re-assessment taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. According to the facility PAQ, and interviews with the OIC and PSA Compliance Manager, FSPC has not utilized segregation to protect a victim of sexual abuse. In review of sexual abuse investigations, the Auditor saw no indication a detainee was placed in segregation for protective measures.

(d) Interviews with the OIC and PSA Compliance Manager indicated the facility will notify the appropriate ICE FOD whenever a detainee victim has been placed in administrative segregation as soon as possible but would not exceed 72 hours in accordance with the standard.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b)(c) Policy FDC 2.11 outlines procedures for criminal and administrative investigations. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The ICE OPR will typically be the appropriate investigative office within DHS, as well as the DHS OIG in cases where the DHS OIG consents conducting the investigation. Administrative investigations shall be prompt, thorough, objective, and conducted by specially trained, qualified investigators, and a referral is initiated for a criminal investigation, if potentially criminal behavior is involved, are completed for all allegations of sexual abuse or assault. According to the facility PAQ there are 22 trained Investigators. Interviews conducted with two investigators, and review of training certificates verify the completion of training and that investigators are well-informed of the requirements needed to conduct sexual abuse investigations within a confinement setting. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. All investigations into alleged sexual abuse must be conducted by qualified investigators. FSPC has an MOU with the Florence Police Department who will conduct criminal investigations into allegations of sexual abuse. The Auditor was able to corroborate this through the review of completed sexual abuse investigations. Upon the conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within ICE/DHS, and the assigned criminal investigative entity. Policy further delineates written procedures for administrative investigations to be performed. In review of policy, procedures, and sexual abuse investigations, the Auditor determined all elements of the standard were completed as required. Interviews conducted with the OIC, PSA Compliance Manager, and Investigator corroborated the above stated.

(e)(f) Interviews with the OIC and PSA Compliance Manager revealed an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. When the outside law enforcement agency, Florence Police Department, investigates sexual abuse, the facility investigator cooperates to the fullest with outside investigators and remains informed through verbal or written communication, i.e., email correspondence, about the progress of the investigation. The aforementioned was corroborated through the review of sexual abuse reports and facility investigative documentation, the facility remains informed through verbal or written communication.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Policy FDC 2.11 states the facility will impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated. Upon review of investigative documentation, the Auditor determined investigations are completed in accordance with the standard. Interviews with the facility investigator and PSA Compliance Manager verified the facility will not impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. Compliance with the standard was further determined through the review of investigative files.

§115.73 - Reporting to detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Policy FDC 2.11 outlines the procedures the facility will take for reporting to detainees. Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken. If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee. All detainee notifications or attempted notifications shall be documented on a DHS ICE Investigative Findings and Responsive Actions Notifications form. The detainee shall sign the allegation status notification verifying that such outcome notification has been received. The signed detainee allegation status notification shall be filed in the detainee's file. While on-site, the Auditor reviewed three completed sexual abuse investigation packets completed during the past 12 months and concluded all three detainees were not notified by the facility of the facility's investigative outcome per policy and the standard requirements. Interviews with the OIC and PSA Compliance Manager confirmed they didn't have a process in place for reporting to detainees.

Corrective Actioned Required: When detainees who have reported allegations of sexual abuse are still in custody or where it is otherwise feasible, the facility must notify them about the outcome results of the investigation and any responsive action taken.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d) Policy FDC 2.11 states staff are subject to discipline to include termination for violation of the department's sexual abuse and sexual harassment policies. According to the PAQ and interviews with the OIC and PSA Compliance Manager confirmed the facility's policies and procedures regarding disciplinary or adverse actions for staff were provided to the agency for review and approval. Removal from their position and from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer, paragraphs (1)–(4) and (7)–(8). All terminations for violations of sexual abuse policies or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, to the extent known. The facility will also report all such incidents of substantiated abuse, removals, or resignations in lieu of removal to the ICE 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. During the past 12 months, the facility has not had an allegation involving staff sexual misconduct. Therefore, files demonstrating termination, resignation, or other disciplinary actions were not available for review. Interview with the OIC confirmed staff are subject to discipline for violations of the department's sexual abuse policies and termination is the presumptive disciplinary sanction for a staff member who has engaged in sexual abuse. Interview with the OIC indicated removals or resignations for violations of agency or facility sexual abuse policies would be appropriately handled. Reports of removals or resignations for violations of agency or facility sexual abuse policies would be forwarded to any relevant licensing bodies by the facility to the extent known.

§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) Policy FDC 2.11 states contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies, unless the activity was clearly not criminal. The facility shall report such incidents to the ICE FOD/designee regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known. During the past 12 months, the facility has not had an allegation where a contractor or volunteer was involved in sexual misconduct. Therefore, files demonstrating termination, or removal from contact with detainees were not available for review. Interview with the OIC confirmed volunteers and contractors are subject to termination and/or prohibited contact from detainees for violations of the department's sexual abuse policies. The facility will take appropriate measures when considering whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within the standard.

§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) Policies FDC 2.11 and FDC 3.1 (Detainee Discipline System) outlines if a detainee engages in sexual abuse, sanctions shall be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar histories. If a detainee is determined mentally disabled or mentally ill, but competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. This process would be completed by mental health staff. A detainee may be disciplined for sexual conduct with an employee only upon a finding that the employee did not consent to such contact. Detainees who deliberately allege false claims of sexual abuse can be disciplined. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Policy FDC 3.1 outlines the facility's disciplinary system which incorporates progressive levels of reviews, appeals, procedures, and documentation procedure. While on-site the Auditor reviewed three completed cases of sexual misconduct reported during the previous 12 months and determined they were handled in accordance with the standard in all material ways. Interview with the OIC confirmed all elements of the standard are followed regarding disciplinary sanctions of detainees.

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

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

Notes:

(a)(b)(c) IHSC Directive 03-01 states if the assessment pursuant to 115.41 indicates the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral. Interviews with medical and mental health care staff confirmed, if a referral for medical follow-up is initiated, the detainee will receive a health care evaluation no later than 2 working days from the initial assessment and if a referral for mental health follow-up is initiated, the detainee will receive a mental health evaluation no later than 72 hours. While on-site the Auditor interviewed one detainee who reported a prior sexual victimization and the detainee confirmed to the Auditor he was seen by both medical and mental health in accordance with the requirements of the standard. Also, while on-site the Auditor was provided with investigative documentation demonstrating the detainee was seen both by medical and mental health staff in accordance with the requirements of the standard.

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

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

Notes:

(a)(b) IHSC Directive 03-01 states detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally

accepted standards of care. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Policy further states the facility shall provide such victims with medical and mental health services consistent with the community level of care. The facility reported three incidents of sexual abuse during the previous year, and while on-site the Auditors were advised the alleged victims were no longer at FSPC. Therefore, the Auditor was not able to interview a detainee who reported sexual abuse while at FSPC. According to the PAQ, the facility has not had to send a detainee out to the HonorHealth Scottsdale Osborn Medical Center to receive emergency medical assistance for PREA/sexual assault related injuries or treatment in the past 12 months. Interview with the HSA confirmed detainees will receive timely emergency access to medical and mental treatment without financial cost to the detainee and will have unimpeded access to emergency medical and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. Medical staff acknowledge that victims of sexual abuse would undergo a forensic medical exam at no cost to the detainee and only with consent of the detainee.

§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) Policy FDC 2.11 states the facility will offer a medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse or assault while in immigration detention. The policy also requires the evaluation and treatment of the victim; including follow-up services, treatment plans, and, when necessary, referrals for continued care consistent with the community level of care. Both the medical and mental health staff interviews confirmed that detainee treatment is immediate, based on their professional opinion, and consistent with community level of care, including additional follow-up if necessary. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

(d) Policy FDC 2.11 states detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. It should be noted, FSPC does not house female detainees. Interview with the HSA confirmed the aforementioned. Therefore, this provision is non-applicable.

(e) Policy FDC 2.11 states detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. Interview with the HSA confirmed detainee victims of sexual abuse are offered tests for sexually transmitted infections at the local hospital and follow-up services at the facility and as medically appropriate. It should be noted there were no detainees who required the above-mentioned treatments during the previous 12 months.

(f) Policy FDC 2.11 states treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall provide such victims with medical and mental health services consistent with the community level of care. In review of completed sexual abuse investigations during the past 12 months, and interview with the HSA the Auditor determined detainees receive appropriate treatment, if needed and free of financial cost per the standards requirement.

(g) Policy FDC 2.11 states 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. Interview with the Mental Health Coordinator confirmed an attempt would be made to conduct a mental health evaluation of a known detainee abuser within 60 calendar days and would happen much sooner of learning of such abuse history and offer treatment deemed as appropriate. This practice was corroborated through the review of the three completed investigations and detainee file review. Furthermore, all refusals for medical and mental health services will be documented.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Policy FDC 2.11 outlines the facility's process of conducting sexual abuse incident reviews. Staff shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. An unfounded allegation means an allegation that was investigated and determined not to have occurred. Staff shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the FOD or his or her designee, for transmission to the ICE PSA Coordinator. Staff shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. Policy further states the facility shall 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 the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the OIC, FOD or his or her designee, for transmission to the ICE PSA Coordinator. The Auditor was advised by both the OIC and PSA Compliance Manager the facility did not complete annual report in accordance with the standards requirement. It should also be noted in review of completed investigations during the previous 12 months none contained a sexual abuse incident review at the conclusion of every investigation of sexual abuse.

Corrective Action Required: 115.86(a)(c) - The facility must complete and document a sexual abuse incident review at the conclusion of every investigation of sexual abuse per the standard's requirement. The facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts, including preparation of a negative report if the facility does not have any reports of sexual abuse during the reporting year.

§115.87 - Data collection.

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

Notes:

(a) Policy FDC 2.11 states, the facility shall maintain in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be maintained in appropriate files. The retention of such reports are for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. The age, confidentiality, and release of case records will follow the requirements of policy set forth in regard to the Privacy Act of 1974. Because of the sensitive nature of information about victims and their medical condition, including infectious disease testing, staff must be vigilant about maintaining confidentiality and releasing information only for legitimate need-to-know reasons. Policy further indicates and the OIC confirmed files are chronologically maintained in a secure location. The OIC shall maintain a listing of the names of sexual assault victims and assailants along with the dates and locations of all sexual assault incidents occurring within the facility. Such information shall be maintained on a need-to-know basis in accordance with FDC policies "4.3 Medical Care" and "7.1 Detention Files," which includes protection of electronic files from unauthorized access. At no time may law enforcement sensitive documents or evidence be stored at the facility. Access to this designation shall be limited to those staff involved in the treatment of the victim or the investigation of the incident. The authorized designation shall allow appropriate staff to track the detainee victim or assailant of sexual assault across the system. On an ongoing basis, the facility's PSA Compliance Manager and OIC must work with the field office and ICE PSA Coordinator to share data regarding sexual abuse incidents and response.

§115.201 - Scope of audits.

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

Notes:

(d)(e)(i)(j) During the PREA audit of the FSPC, the Auditors were able review all policies, memos, and other documents required to make assessments on PREA compliance. All areas of the facility were observed during the on-site portion of the audit, to include several areas that were revisited by an Auditor. Interviews with staff and detainees were accommodated in private areas, and the Auditor was able to interview staff from all shifts. The Auditor observed numerous notices of DHS PREA Audit posted throughout the facility to include in all detainee housing areas, both in English and Spanish. The Auditor received no detainee or staff correspondence prior to the on-site audit.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	3
Number of standards met:	31
Number of standards not met:	5
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Mark Stegemoller 5/4/2020

Auditor's Signature & Date

(b) (6), (b) (7)(C) 5/4/2020

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Mark Stegemoller	**Organization:**	Creative Corrections, LLC
Email (b) (6), (b) (7)(C)	[redacted]	**Telephone number:**	270 625-(b) (6), (b)

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:	Acting Field Office Director Albert E. Carter
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)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Florence Service Processing Center (SPC)		
Physical address:	3250 N. Pinal Parkway, Florence, AZ 85132		
Mailing address: *(if different from above)*			
Telephone number:	520-868-8377		
Facility type:	SPC		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Acting Officer in Charge
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-868-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	SDDO
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-251-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) on-site audit of the Florence Service Processing Center (FSPC) in Florence, Arizona was conducted on January 14-16, 2020 by Mark Stegemoller and (b) (6), (b) (7)(C) certified Department of Justice (DOJ) and Department of Homeland Security (DHS) PREA Auditors, contracted through Creative Corrections, LLC of Beaumont, Texas. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ and DHS certified PREA Auditor. The Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process.

This was the second DHS PREA audit for FSPC under the DHS PREA Standards. FSPC is operated by ICE for housing of adult male detainees. FSPC has a designed capacity for 392 detainees. The purpose of the audit was to determine compliance with the DHS PREA standards. The audit period was from 01/14/2018 through 01/16/2019.

The Auditor found FSPC met 31 standards, had 3 standards (115.13, 115.31, and 115.52) that exceeded, had 2 standards (115.14, 115.18) that were non-applicable, and 5 standards that were non-compliant (115.17, 115.32, 115.67, 115.73, and 115.86).

On May 21, 2020, the Auditor, received the ICE PREA Corrective Action Plan (CAP) from the ERAU Team Lead, (b) (6), (b) (7)(C) for FSPC. The Enforcement and Removal Operations (ERO) developed the CAP with the facility, and the plan addressed the five standards that did not meet compliance during the PREA audit site visit and documentation review. The Auditor reviewed the CAP and concurred with the corrective action taken for achieving compliance with the deficient standards.

PROVISIONS

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

§115. 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) Executive Order 10450 Security Requirements for Government Employment and the Office of Personal Management Section Part 731 and ICE Directives 6-7.0 and 6.8.0 outlines how the facility and agency, to the extent permitted by law, refuse to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor or volunteer who may have contact with detainees, who has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard. All three policies noted above require new hires, staff awaiting promotions, and all staff annually to complete and submit a Self-Declaration of Sexual Abuse/Sexual Harassment form. The individual will respond directly to questions about previous misconduct as required per the standard and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The form is to be retained in the employee's personnel file. The Auditor was able to confirm the above mentioned through the review of seven randomly selected staff personnel files. Policy further indicates every effort is to be made to contact all prior institutional employers for information on sexual abuse incidents prior to hiring. An interview with the Asset Human Resource personnel while onsite indicated to the Auditor FSPC does not contact prior institutional employers of an applicant for employment to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse.

(e)(f) This Auditor attended training in Arlington, Virginia in September 2018, where PSU Division Chief (b) (6), (b) (7)(C) presented information on the background investigation process. During this training, he confirmed that any material omissions, intentional false statements, or deception is a factor that would make an applicant, employee, or contractor unsuitable for employment. He further confirmed that the agency would, unless prohibited by law, provide information on a substantiated allegation of sexual abuse involving a former employee or contractor, to any requesting confinement facility. The Auditor further corroborated this process through a telephonic interview with PSU Industrial Security Team Lead (b) (6), (b) (7)(C)

Interview with Asset Human Resource Personnel while onsite indicated to the Auditor FSPC does not contact prior institutional employers of applicants and if an institutional employer requests a reference check about a former employee's history of sexual abuse, they would not disclose the information. The Auditor conducted a post site inspection follow-up phone call with facility ICE Human Resource Personnel and was advised they do not contact prior institutional employers of applicants and if an institutional employer requests a reference check about a former employee's history of sexual abuse, they would not disclose the information.

Corrective Action Required: 115.17(b)(f) The facility must make its best efforts to contact all prior institutional employers of an applicant for employment to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. The facility must, unless prohibited by law, provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. The facility will need to develop a process for ensuring that ICE and Contract Administrative/Human Resources staff are aware of the agency protocols for accomplishing the requirements of standard 115.17, specifically as it relates to subparts (b) & (f).

Corrective Action Taken: The Auditor determined compliance with standard 115.17 (b)(f) through submitted documentation, Asset's PREA policy and email correspondence from Asset Headquarters Human Resources delineating the process that covers all the elements required in subparts (b) and (f). The Asset Human Resource personnel onsite at the FSPC does not hire new employees; the hiring process is completed by the Asset Corporate Office (ACO) located in Corpus Christi, Texas. The ACO was contacted, and they stated that they follow all DHS PREA Standards when hiring employees and provided a copy of the regulations stating they do indeed contact prior institutional employers regarding previous sustained allegations of sexual abuse. ACO also stated that when another institutional employer requests information on a former employee regarding sexual abuse, they require a Release and Disclosure Authorization (RDA) form with the former employee's signature. Once the signed RDA is received, they provide the requesting information.

The ICE Human Resource Personal officer at the FSPC also does not hire new employees and therefore, would not contact prior institutional employers of applicants regarding sexual abuse. The Office of Human Capital completes the ICE hiring process. No personnel records are kept at the FSPC for former employees. If an institutional employer requests information on a former employee regarding sexual abuse, they would be referred to the ICE Human Capital Office.

§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). The Auditor interviewed the facility's ICE Training Officer while on-site and was advised contractors receive comprehensive PREA zero-tolerance training of the same level that is provided to full-time staff in a classroom setting, and volunteers do not. The Auditor reviewed five contractors' files and determined the training provided is in accordance with the standard's requirement. The Auditor reviewed the PREA educational information provided to volunteers and several volunteer files and found it to be lacking in several of the standard's requirements, such as how to report incidents of sexual abuse and if they had been notified of the facility's zero-tolerance policy.

Corrective Action Required: 115.32(a)(b) – The facility must ensure that all volunteers who have contact with detainees are trained on their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention, and response policies and procedures. The level and type of training provided to volunteers shall be based on the services they provide and the level of contact they have with detainees.

Corrective Action Taken: The Auditor was provided with the following documentation, an approved facility volunteer roster, a facility memorandum, titled "Required PREA training for Religious Service Providers/Visitors," PREA education training PowerPoint, and volunteer training certificates of completion for demonstrating compliance with standard 115.32 (a)(b). On January 17, 2020, the memorandum directive was given to the facility ICE training department to incorporate PREA educational information/material training to volunteers. The PowerPoint training was disseminated to the volunteer staff and signed training certificates were turned in to the training department upon completion. The Auditor reviewed the PREA education PowerPoint training and determined that it meets the standard in all material ways.

§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) Policy FDC 2.11 outlines the facility's procedures for protection against retaliation. Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. The policy further indicates, for at least 90 days following a report of sexual abuse, the OIC or designee will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the OIC or designee should monitor include detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff. The OIC or designee shall continue monitoring beyond 90 days if the initial monitoring indicates a need too. This shall include periodic status checks of detainees in person and review of relevant documentation. Interviews with the OIC and PSA Compliance Manager corroborated the above information noted in the policy; however, both confirmed, the required retaliation monitoring for the three reported incidents of sexual abuse were not completed in accordance with the standard. It was further corroborated through the review of investigative packets that monitoring for retaliation was not conducted.

Corrective Action Required: The facility will need to develop a process for providing and documenting the agency's protection against retaliation per the requirements of the standard. Furthermore, the facility will need to provide documentation demonstrating the monitoring of retaliation.

Corrective Action Taken: The Auditor was provided with documentation for demonstrating full compliance with standard 115.67. On January 20, 2020, a PREA Retaliation Monitoring Report was created to be included with every PREA investigation packet. The monitoring report will be completed every 30 days for the victim following a PREA incident for at least 90 days or beyond 90 days if the initial monitoring indicates a need. Initially, to demonstrate compliance, the Auditor requested completed monitoring for retaliation documentation; however, during the corrective action period, the facility had no incidents of sexual abuse requiring the monitoring of retaliation.

§115. 73 - Reporting to detainees

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

Notes:

Policy FDC 2.11 outlines the procedures the facility will take for reporting to detainees. Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation and any responsive action taken. If the facility did not conduct the investigation, the relevant information shall be requested from the outside investigating agency or entity in order to inform the detainee. All detainee notifications or attempted notifications shall be documented on a DHS ICE Investigative Findings and Responsive Actions Notifications form. The detainee shall sign the allegation status notification verifying that such outcome notification has been received. The signed detainee allegation status notification shall be filed in the detainee's file. While on-site, the Auditor reviewed three completed sexual abuse investigation packets completed during the past 12 months and concluded the facility did not notify all three detainees of the facility's investigative outcome per policy and the standard requirements. Interviews with the OIC and PSA Compliance Manager confirmed they didn't have a process in place for reporting to detainees.

Corrective Actioned Required: When detainees who have reported allegations of sexual abuse are still in custody or where it is otherwise feasible, the facility must notify them about the outcome results of the investigation and any responsive action taken.

Corrective Action Taken: The Auditor was provided with documentation for demonstrating full compliance with standard 115.73. On January 22, 2020, an investigative findings notification was prepared for all three PREA cases and mailed to the detainee's most current address recorded in the (b) (7)(E) .

§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)(c) Policy FDC 2.11 outlines the facility's process of conducting sexual abuse incident reviews. Staff shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. An unfounded allegation means an allegation that was investigated and determined not to have occurred. Staff shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the FOD or his or her

designee, for transmission to the ICE PSA Coordinator. Staff shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. Policy further states the facility shall 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 the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the OIC, FOD, or his or her designee, for transmission to the ICE PSA Coordinator. The Auditor was advised by both the OIC and PSA Compliance Manager; the facility did not complete the annual report in accordance with the standards requirement. It should also be noted in a review of completed investigations during the previous 12 months none contained a sexual abuse incident review at the conclusion of every investigation of sexual abuse.

Corrective Action Required: 115.86(a)(c) - The facility must complete and document a sexual abuse incident review at the conclusion of every investigation of sexual abuse per the standard's requirement. The facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts, including preparation of a negative report if the facility does not have any reports of sexual abuse during the reporting year.

Corrective Action Taken: The Auditor was provided with documentation for demonstrating full compliance with standard 115.86. On February 5, 2020, a 30-day review was conducted for the three PREA cases. On May 8, 2020, the facility conducted an internal annual PREA review. The Auditor determined the annual PREA review was completed in accordance with the requirements of the standard, to include providing the results and findings of the annual review to the facility administrator, Field Office Director or his or her designee, and the agency PSA Coordinator.

§115. Choose an item.

Outcome: Choose an item.

Notes:

AUDITOR CERTIFICATION:

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

Mark Stegemoller August 20, 2020

Auditor's Signature & Date

(b) (6), (b) (7)(C) August 21, 2020

Program Manager's Signature & Date