PREA Audit: Subpart B
DHS Holding and Staging Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	1/25/2022	**To:**	1/26/2022
AUDITOR INFORMATION			
Name of auditor:	Mark McCorkle	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

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

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Florence Staging Facility		
Physical address:	3520 N. Pinal Parkway, Florence, AZ 85132		
Mailing address: (if different from above)			
Telephone number:	520-868-8377		
Facility type:	Staging Facility		
PREA Incorporation Date:	Click or tap to enter a date.		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	520-868-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	SDDO
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	520-868-(b) (6), (b)

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	12/14/2021
Notes:	Click or tap here to enter text.

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Florence Staging Facility (FSF) was conducted from January 25, 2022, to January 26, 2022. The audit was performed by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Mark McCorkle, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by Immigration & Customs Enforcement (ICE) Assistant Program Manager (APM) [redacted] and Program Manager (PM) [redacted] both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The audit period is March 23, 2017, through January 26, 2022, and was extended because there were no allegations reported in the 12 months prior to the audit to review. FSF is a Staging Facility operated by ICE, Office of Enforcement and Removal Operations (ERO). Security services for the facility are provided by Akima Global Services (AGS), a private contractor.

The facility is located in Florence, Arizona, approximately 64 miles southeast of Phoenix. FSF is situated on the far west portion of a custodial campus of the Florence Detention Center (FDC), also operated by ICE ERO but not included in this audit for assessment. The staging facility is separated from the detention facility by security fencing, topped with concertina wire. The onsite ICE ERO administrative staff and AGS are responsible for managing both the detention and staging facility operations.

The last PREA audit conducted at the staging facility occurred in 2017. Team Lead [redacted] ICE OPR ERAU Inspections and Compliance Specialist (ICS), provided the completed Pre-Audit Questionnaire (PAQ), along with supporting documents and policies for FSF on the secure ERAU SharePoint website approximately four weeks prior to the onsite phase of the audit. The information provided included agency policies, memorandums of understanding (MOUs), training records and curricula, facility schematics, exhibits and other documentation needed for the Auditor to determine compliance with the DHS PREA standards.

The Auditor completed the review of the documentation provided by the Team Lead and FSF in the FY22 Facility Document folder found on the SharePoint platform. The intent of the documentation is to support how a facility establishes a baseline for its actual practice for zero tolerance for sexual abuse and sexual harassment.

During the pre-audit review of documentation, the Auditor identified questions and requested clarification from the Team Lead and facility prior to the site visit. Those areas were detailed in a formal Issue Log, presented to the parties, and all issues were resolved to the satisfaction of the Auditor prior to the onsite portion of the audit.

On January 25, 2022, at approximately 7:45 a.m., the Auditor and APM arrived at the facility and established their work area in a secure conference room in the administration building of the facility. At approximately 8:15 a.m., the audit team met with facility administration and staff in the conference room where the entry briefing was moderated by Team Lead [redacted] via teleconference. In attendance at the briefing, either in person, or via teleconference were the following:

- [redacted] Assistant Officer in Charge (AOIC), ERO
- [redacted] Supervisory Detention & Deportation Officer (SDDO), ICE/ERO
- [redacted] Deportation Officer (DO), ICE/ERO
- [redacted] Detention Officer, AGS
- [redacted] Detention Officer, AGS
- [redacted] Quality Assurance Manager, AGS
- [redacted] SDDO, ICE/ERO, PSA Compliance Manager
- [redacted] Assistant Health Service Administrator (AHSA), ICE Health Service Corp (IHSC)
- [redacted] Psychologist, SIG International
- [redacted] Detention Service Manager (DSM), ICE/ERO
- [redacted] DO, ICE/ERO
- [redacted] DO, ICE/ERO
- [redacted] DO, ICE/ERO
- [redacted] Assistant Project Manager, AGS
- [redacted] Project Manager, AGS
- [redacted] ICE/OPR/ERAU, ICS
- Mark McCorkle, Auditor, Creative Corrections, LLC
- [redacted] APM, Creative Corrections, LLC

The entry briefing provided an opportunity for all parties to establish a positive working relationship and outline the proposed schedule for the two onsite days.

At the completion of the entry briefing, the audit team conducted a tour of the staging facility.

The staging facility is a two-story building, containing three dormitories, with 100 bunks each. The main building also contains a Special Management Unit (SMU) with five cells. FSF also has two satellite housing areas, which are portable trailers placed on the north side of the building. These satellite housing areas are used to house female detainees or detainees that need to be isolated. Each trailer has a maximum capacity of ten detainees. A medical screening trailer, psychologist office, property storage, and the Criminal Alien Program (CAP) building are also located in the staging facility compound.

The second floor of the building is dedicated to the Compliance Unit and Flight Operations. There is no detainee housing on the second floor and detainees are not allowed access to this area.

A control booth, staffed by two AGS officers, sits at the approximate center of the staging facility building. Housing Unit #1 sits in the southwest corner of the structure, while housing units #2 and #3 comprise the north side of the building. The SMU cells are located directly across from the officer control booth and run west to east. When detainees are present, the facility utilizes a direct supervision model, with one officer assigned to each of the housing units. The officer's station is in the dayroom, just inside the entry/exit door of the dormitory. The housing units are divided into three distinct areas: a dayroom, a bunk/housing area, and the restroom and shower facilities. Each of the three housing units are identical, except for their geographic orientation.

(b) (7)(E) [redacted] There are no cameras in the restroom areas, and none of the cameras have visibility into those areas which would violate the privacy of detainees as defined by 115.15. The Auditor confirmed those sight lines by viewing camera angles in the control booth.

(b) (7)(E) [redacted]

The audit team found that PREA and Zero Tolerance posters were in prominent viewing areas in each of the dormitory day rooms, and the PREA audit announcement was clearly visible on a bulletin board in each of the housing areas. The audit announcement was printed in English and Spanish.

At each bank of telephones in all dayrooms were clear instructions on how to reach the PREA hotline, DHS Office of Inspector General (OIG), Consular, support services and other detainee resources. The Auditor placed a phone call to the OIG hotline and spoke to a representative who was knowledgeable about PREA and was prepared to receive any information provided by detainees.

The Auditor also called the PREA Hotline and left a brief voicemail test message. Within approximately 30 seconds of the call, the accompanying AOIC, SDDO and other relevant staff received an email notification that there was a PREA incident in a specific dormitory. A supervising AGS security staff member was one of those responding and arrived in the dormitory within approximately one minute of the test call being made (additional information provided in the relevant standards below).

The facility houses male and female detainees for up to 72 hours but does not house juveniles or families. Facility staff stated that females are not common at the staging facility; however, one was processed during the two-day onsite audit.

Although the audit team was not able to observe the processing of detainees during the tour in person, they were able to watch a live processing via video surveillance on day two due to a positive COVID exposure among the detainees. During the video processing, the processing officer could be seen explaining all documents to the detainee, including the PREA screening form. The detainee was provided with a detainee handbook and pamphlet containing PREA resources. The processing of the detainee began at 10:41 am and was completed at 11:01 am (additional screening information provided in the relevant standards below).

The audit team also toured the facility's main control room located in the detention center. The main control room is staffed by two AGS security officers and has access to all facility cameras, including those located in the staging facility.

There was one allegation reported during the audit period which was a detainee-on-detainee sexual abuse. This case was investigated by OPR and closed as unsubstantiated.

A total of 31 staff members were interviewed during the onsite portion of the audit. The following facility designee staff were interviewed: The AOIC, the SDDO, PSA Compliance Manager, Human Resources Manager, Training Manager, Classification Manager, Grievance Coordinator, Intake Staff (2), Investigative Staff (2), Medical and Mental Health Care Staff (3), Sample of Non-Security First Responders (1), Sample of Non-Security Contractors (1), First Line Supervisors (2).

In addition to the 17 staff designee interviews, 14 random staff were also interviewed. The random staff members were selected by the Auditor from a roster of personnel provided by the facility. The Auditor selected a wide selection of job classifications and interviewed personnel from all shifts. Additionally, the Auditor randomly selected contract maintenance staff at the facility from a list provided. There are currently no volunteers assigned to the facility.

There were no detainees present on day one of the onsite audit. On day two, there were 11 detainees present at the staging facility; however, again due to a positive COVID exposure, none of the detainees were interviewed by the audit team.

All interviews were conducted privately in a secure conference room.

On Wednesday, January 26, 2022, an exit briefing was held at 3:00 p.m. in the administration building conference room. Team Lead (b) (6), (b) (7)(C) moderated the exit briefing via teleconference conducted by the Auditor. Present during the exit briefing, either in person, or via teleconference were the following:

- (b) (6), (b) (7)(C) Officer in Charge (OIC), ICE/ERO
- (b) (6), (b) (7)(C) AOIC, ICE/ERO
- (b) (6), (b) (7)(C), SDDO, ICE/ERO
- (b) (6), (b) (7)(C) Quality Assurance Manager, AGS
- (b) (6), (b) (7)(C) DO, ICE/ERO
- (b) (6), (b) (7)(C) Detention Officer, AGS
- (b) (6), (b) (7)(C) Detention Officer, AGS
- (b) (6), (b) (7)(C) DO, ICE/ERO
- (b) (6), (b) (7)(C) SDDO, ICE/ERO, PSA Compliance Manager
- (b) (6), (b) (7)(C) DSM, ICE/ERO
- (b) (6), (b) (7)(C) HSA, IHSC
- (b) (6), (b) (7)(C) AHSA, IHSC
- (b) (6), (b) (7)(C) Project Manager, AGS
- (b) (6), (b) (7)(C) Facility Manager, Office of Asset Facility Management
- (b) (6), (b) (7)(C) DO, ICE/ERO
- Mark McCorkle, Auditor, Creative Corrections, LLC
- (b) (6), (b) (7)(C) APM, Creative Corrections, LLC

The Auditor informed the group that he was pleased with the organization of audit documents and at the timeliness in which additional required exhibits were provided. He expressed his thanks to AGS staff for facilitating interviews and assuring that the audit team had all necessary materials to complete the audit.

The Auditor informed the staff that he did not foresee any significant obstacles in achieving full compliance and that there were two standards not immediately in compliance at the time of the exit briefing. The Auditor requested specific documentation related to the hiring process, and those documents were provided to the Team Lead. Those documents were received by the Auditor prior to the preparation of this audit report and satisfied the requirements of the standards in question.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 4

§115.111 Zero-tolerance of sexual abuse
§115.131 Employee, contractor, and volunteer training
§115.134 Specialized training: Investigations
§115.151 Detainee reporting

Number of Standards Met: 24

§115.113 Detainee supervision and monitoring
§115.115 Limits to cross-gender viewing and searches
§115.116 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.117 Hiring and promotion decisions
§115.118 Upgrades to facilities and technologies
§115.121 Evidence protocol and forensic medical examinations
§115.122 Policies to ensure investigation of allegations and appropriate agency oversight
§115.132 Notification to detainees of the agency's zero-tolerance policy
§115.141 Assessment for risk of victimization and abusiveness
§115.154 Third-party reporting
§115.161 Staff reporting duties
§115.162 Protection duties
§115.163 Reporting to other confinement facilities
§115.164 Responder duties
§115.165 Coordinated response
§115.166 Protection of detainees from contact with alleged abusers
§115.167 Agency protection against retaliation
§115.171 Criminal and administrative investigations.
§115.172 Evidentiary standard for administrative investigations
§115.176 Disciplinary sanctions for staff
§115.177 Corrective action for contractors and volunteers
§115.182 Access to emergency medical services
§115.187 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 1
§115.186 Sexual abuse incident reviews

Number of Standards Not Applicable: 1
§115.114 Juveniles and family detainees

§115.193 Audits of standards – Not Low Risk

PROVISIONS

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

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) FSF provided a written directive, Policy Number FSF 2.11, Sexual Abuse and Assault Prevention and Intervention (SAAPI), which states, "The Prison Rape Elimination Act of 2003 (PREA) sets a zero-tolerance threshold regarding rape and sexual assault in 'any confinement facility of a Federal, state, or local government, whether administered by such government or by a private organization.' Staff shall maintain an atmosphere that promotes a zero-tolerance stance." Interviews with the AOIC, other designees and AGS security staff revealed an overwhelming commitment to provide a zero-tolerance environment for detainees at the FSF.

Following the tour of the facility, which included informal conversations with staff, coupled with signage, posters and other PREA materials, the auditor's initial impression was staff that truly understand the tenets of the PREA Standards. However, after formal interviews with staff at every rank structure and position, it was apparent that FSF has not only embraced the PREA Standards, but it is engrained in their culture. The facility has made a significant commitment to the sexual safety of everyone at FSF.

In addition, the PREA Compliance Team includes staff members from AGS, in addition to the ICE PSA Compliance Manager. In their interviews with the audit team, the AGS compliance team members demonstrated a thorough knowledge of PREA policies and are clearly integral in implementing the zero-tolerance protocols that have become so engrained in the facility's culture.

§115.113 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) Policy FSF 2.4, Facility Security Control/Inspections, outlines protocols that are to be followed related to detainee supervision. Procedural Section B of the policy specifically discusses video monitoring of the facility from Building 648, and Section D, General Population Housing Unit says, "FDC will employ direct supervision and a high-degree of facility staff-detainee interaction to address detainee grievances, housing issues and facility concerns. Cameras and video surveillance may be used to supplement this supervision but will never be used instead of it."

Section F of the same policy (Security Inspections) goes on to state, "Frequent unannounced security inspections are an integral part of the security program at FDC and help ensure its integrity. Security inspection shall be conducted on day and night shifts to control the introduction of contraband, identify and deter sexual abuse of detainees; ensure facility security and good order…"

In Section I, Housing Unit, of the policy, it states that "the facility will conduct detainee welfare and security inspections every 15 minutes (at a minimum) between the hours of 2200-0600."

During the onsite audit, the Auditor inspected the logbook of each of the three housing areas. In each of the books, hand-written, detailed observations were noted by officers and supervisory staff conducting unannounced visits to each of the three dormitories on each shift. The supervisory rounds were documented in red ink. The Auditor observed that rounds were documented at specific times during the day (e.g., 2312 hours, as opposed to regular five or 10-minute intervals), lending greater credibility to the entries.

In their interviews, the AOIC and SDDO stated that staff members are required to conduct rounds and that SMU cells are monitored to an even greater degree. When detainees are present in the housing units, assigned dorm staff are required to conduct regular checks of the dayroom, bunk area and restroom/shower facilities. The AOIC stated that in the event a detainee placed is on suicide watch, constant monitoring protocols are put into place.

The facility provided its staffing plan and roster of employees along with a memorandum from the AOIC detailing what factors were considered during the 2021 annual review of the plan, such as the physical layout of the facility, composition of the detainee population, prevalence of substantiated and unsubstantiated incidents of sexual abuse, the frequency of allegations, recommendations from sexual abuse incident reviews, suggestions from staff, and number of facility code violations. The Auditor read the final review and determined it contained the elements necessary to fulfill the requirement.

After conversations with the AOIC and the SDDO, along with the tour of the facility at which time the Auditor was able to observe staffing levels, it was clear that the staffing plan put in place was not only appropriate but provided the operation with its best opportunity for success in providing the safest environment possible for detainees and staff.

§115.114 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) FSF Policy 2.1.2, Juvenile Aliens states that, "Juvenile aliens will NOT be detained at the Florence Detention Center." The policy goes on to state that if a detainee is determined to be a juvenile, they will be separated from general population until supporting documentation is acquired. Once that has been established the juvenile will be transferred from the facility to the jurisdiction of the Phoenix Field Office.

A memorandum from the AOIC states that FSF is an adult-only facility, which also confirmed in interviews by the Auditor with the AOIC and SDDO.

§115.115 - 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)(c)(d)(e)(f) FSF policy 2.10, B, Pat/Frisk Search, says that "Security staff shall be trained in proper procedures for conducting pat searches, including cross-gender pat searches and pat searches of transgender and intersex detainees."

The policy also states, "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. Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances. All cross-gender pat-down searches shall be documented."

As it relates to strip-searches, Section C, Strip Search, specifically says that all strip searches shall be documented. Under item 1., it says in summary that reasonable suspicion that a detainee may be concealing a weapon or other contraband must exist prior to conducting a strip-search and that supervisory approval is required. The section goes on to say, "This shall include the documentation of the reasons justifying the search on a Form G-1025, Record of Search, and the approving supervisor's signature shall be obtained prior to conducting the search. Strip searches will be performed by an officer of the same gender as the detainee." Any strip search performed must be conducted by a member of the same gender as the detainee, unless a staff member of the same gender is not present at the facility at the time that the strip search is required, and the strip search is an emergency. If a strip search must be conducted by an officer not of the same gender as the detainee, an additional staff member must be present who is of the same gender as the detainee. The Auditor asked the SDDO during his interview to explain why a second person of the same gender would be present during the search. The SDDO stated that in the event no "officers" of the same gender were available, and the circumstances of the strip search were exigent, the purpose of having another staff member – who is not an officer - of the same gender as the detainee present, is to help mitigate any false claims made by the detainee of some type of untoward activity. The SDDO reiterated that it would need to be a true emergency for this to occur.

The policy also says "detainees shall not be observed while changing into facility clothing, and that officers may be immediately outside of the room with door ajar to hear what may transpire inside. Staff are also prohibited from searching or physically examining a detainee for the sole purpose of determining a detainee's genital characteristics. If a detainee's gender is unknown, it may be determined during conversations with the detainee, reviewing medical records, or learning the information as part of a standard medical examination that all detainees must undergo."

Policy 4.5, Personal Hygiene Limits to Cross-Gender Viewing says "staff shall ensure that detainees are permitted to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances, or when viewing is incidental to routine hold room checks. The policy also specifically states that all staff of the opposite gender of the detainee must announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothes."

During the onsite inspection, the Auditor toured the restroom and shower facilities in each of the dormitories. In each case, each toilet and shower area are protected by a partial wall (approximately 40 inches in height), which prohibits the casual observer the opportunity to see a detainee's genetalia. The walls are constructed in a manner that allows security staff to see if the area is occupied, yet provides the detainee with adequate privacy.

All staff members interviewed stated that announcements are made when female staff members enter a male housing area, and males will do the same when female detainees are present. The facility has placed yellow placards on the entrance door to each dormitory which read, "Staff of Opposite Gender Must Announce their Presence upon Entering." During the first day of the audit, there were no detainees present at the facility during the facility tour, so the audit team was not able to personally observed staff making announcements, or to interview detainees regarding staff announcements. On Day two of the audit, there were 11 detainees present, and the auditor observed opposite gender staff making the required opposite gender announcements to detainees upon entering the area.

During interviews with randomly selected staff, 100% stated that cross-gender searches are never performed at the facility. The only instance cited as an exeption, is when a self-identified transgender detainee requests that a pat search be conducted by an officer of a specific gender. All staff interviewed stated that strip and body cavity searches are not conducted at the facility. Nine of 14 security staff members interviewed stated that the only time a strip search would be conducted, would be in the event of a detainee being placed on suicide watch, and that the determination would be made by medical staff.

All 14 randomly selected staff members said that the gender of a detainee would never be determined through a search by facility security staff and if necessary, that determination would be made through informal conversations with the detainee, or through the medical staff and medical records.

The facility provided access to training curricula and certification for all security staff indicating that each had successfully completed training in pat down search techniques .

The SDDO stated that no strip searches had been conducted in the past year, and had there been, it would have been documented.

The facility provided a blank Reasonable Suspicion Visual/Strip Search form G-1025 for the Auditor's review.

§115.116 - 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) In the Procedural Guidelines, under Section "A," Staff and Detainee Contact, Policy 2.13 states, "ICE detainees have the opportunity to have frequent unrestricted informal access to and interaction with key ICE staff and key facility staff members, in a language they can understand."

Section D, Request to Staff from ICE Detainees of the same policy, says, "Upon request, the shift SDDO shall ensure that detainees with special assistance needs based on, for example, disability, illiteracy, or limited English proficiency are accommodated and receive the needed assistance. When language services are needed, the use of a bilingual staff member or qualified interpretation and translation services to communicate with limited English proficient detainees shall be obtained. The facility will provide detainees with disabilities auxiliary aids and services when such aids and services are needed to ensure effective communication with a detainee with a disability."

During interviews with the Auditor, and informal conversations during the tour, intake staff stated they are prepared to assist any detainee in understanding information provided during that process, up to, and including, hearing impaired, visually impaired, detainees with a cognitive disability, and those who are LEP. The intake staff interviewed by the Auditor said that nearly 100% of the detainees who need assistance are due to language. In those cases, intake staff will utilize the ERO Language Line Services (which were demonstrated for the Auditor) to accomplish the intake and interview process. To access the language lines, the intake officer will dial a toll-free number, provide a digital code, then provide the facility name. The operator then asks what language is needed and the intake officer waits for the appropriate interpreter to come on the line.

In the event of an allegation of sexual abuse, telephonic interpreter services are available to staff in order to conduct an interview of involved detainees. The interpreter services are not directly associated with the facility and are the most effective, accurate and impartial means to accomplish interviews when there is a language barrier with staff.

Policy 4.8, Section F, Reasonable Accommodation Process, says that the facility's process to appropriately accommodate a detainee with a disability will differ depending on the nature of the impairment or disability being addressed. However, in certain cases the facility administrator, or his/her designee, shall automatically convene a multidisciplinary team.

In the same section of policy 4.8, it states that the facility will make necessary accommodations in an expeditious manner; detainees will have access to appropriate medical and mental health programs; detainees with cognitive, intellectual, or developmental disabilities may be referred to the multidisciplinary team to determine appropriate programs and accommodations.

The aforementioned multidisciplinary team will include a healthcare professional and any additional staff with requisite knowledge of and/or responsibility for compliance with disability policies and procedures and address requests or referrals from (1) detainees with mobility impairments; (2) detainees with communication impairments; (3) detainees whose initial requests for accommodations or assistance have been denied; (4) detainees who have filed grievances about the accommodations of their disabilities or impairments; (5) detainees whose requests are complex or best addressed by staff from more than one discipline (e.g., security, programming, medical, or mental health); (6) detainees whose cases are otherwise determined by facility staff to be appropriate for referral to a team.

In their interviews with the Auditor, the SDDO and AHSA (members of the multidisciplinary team) said independent of one another, that the multidisciplinary team would consider all factors in determining appropriate housing of a detainee with a disability. In his interview with the Auditor, the SDDO stated that the multidisciplinary team was not convened in the past 12 months and no detainees have required an accommodation for a disability within the audit period.

The Auditor observed during the onsite audit posters and materials in multiple languages available to detainees. Additionally, telephonic interpreter services are available, and the Auditor successfully tested those services. In addition, the Auditor was able to easily locate consulate contact information in each of the housing areas. Even if the detainee could not identify the consulate based on the verbiage used on the flyer, the flag of the respective nations was adjacent to the phone number as a guide.

During his interview, the SDDO said that PREA pamphlets and the detainee handbook are available in multiple languages and the Auditor observed handbooks in English, Spanish, Haitian, Portuguese, and Punjabi in the processing area. He also stated that if they do not have the materials on hand, they have access to PDF files in a multitude of languages that staff can print for detainees. The languages include English, Spanish, Arabic, Bengali, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Simplified Chinese, Turkish, and Vietnamese.

Each of the random staff members interviewed was able to detail the language services available to detainees, and 10 of the 14 said there were posters and pamphlets in each of the housing areas for detainees to reference. Additionally, staff referenced the one-page language identification guide, which can be used if staff can not immediately determine what language a detainee may speak.

FSF provided the ERO Language Services flyer as a resource to be used for communicating effectively with detainees. These resources include Language Access Resource Center, 24-Hour Language Line telephone number and the United States Citizenship and Immigration Services (USCIS) language Line.

§115.117 - Hiring and promotion decisions.

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

Notes:

(a)(b)(c)(e)(f) 5 CFR 731, Executive Order 10450, ICE Directive 6-7.0, and ICE Directive 6-8.0 require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, financial check, residence and neighbor checks, and prior employment checks."

The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors who attended virtual training in November 2021 that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity.

Based on information provided in an email by the OPR PSO (A) Division Chief, information on substantiated allegations of sexual abuse involving a former employee would be provided to prospective employers upon request, unless prohibited by law.

5 CFR 731, and ICE Directive 6-8.0 requires the agency to conduct a background investigation on everyone to determine access into government employment or into a facility. 5 CFR 731 requires investigations every five years for agency employees.

5 CFR 731 also states that "unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." The Human Resources Manager confirmed this in her interview with the Auditor.

The Auditor created a list of 10 random AGS and 5 ICE employees working at FSF and submitted them to the OPR PSO. The Auditor received a response regarding up-to-date background checks on all 15 employees.

The Auditor was informed by the HR Manager during her interview that any applicant must successfully complete all background checks as stated in policy prior to that person being submitted to ICE for hire. Any failure to meet the requirements as stipulated above would result in an automatic disqualification. The HR Manager stated that no promotions have occurred since AGS has been the contract security provider.

Based on the Auditor's interview with the Human Resources Manager and Facility Administrator, any material omissions by candidates will be grounds for termination, or withdrawal of an employment offer.

(d) The Auditor requested the Department of Homeland Security 6 Code of Federal Regulations Part 115 form for randomly selected contractors and was provided documentation and determined the procedures are in line with the above referenced ICE hiring and promotional policies. Documentation reviewed by the Auditor enabled him to make the assessment that background checks of contractors are being performed.

§115.118 - Upgrades to facilities and technologies.

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

Notes:

(a)(b) FSF Policy 2.11, provides the following requirements: "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility shall consider the effect of the design, acquisition, expansion, or modification upon its ability to protect detainees from sexual abuse."

As it pertains specifically to updating or installing a video monitoring system, the policy shall consider, "how such technology may enhance its ability to protect detainees from sexual abuse."

The facility provided the Auditor with an ICE OPR Security Division Physical Security Operations Unit Scope of Work, which detailed upgrades made to the video surveillance system. (b) (7)(E) Additionally, the video surveillance system was upgraded to be entirely digital and has an archived recording capacity of approximately 90 days.

The Auditor inspected the system located in the FSF officer control booth, and the facility's main control booth located in the detention center and found all cameras to be operational and the system appeared to function properly.

In interviews with the AOIC and SDDO, the decision to make the upgrades was to enhance facility security and provide the facility with a better means to protect the sexual safety of the detainee population. They additionally stated that to date they have been pleased with the system and that any issues that have occurred have been immediately addressed by the vendor.

(b) (7)(E) This coupled with the fact that, as demonstrated by the facility, all cameras were operational and recording, is a significant statement of the facility's commitment to not only providing an excellent level of staff coverage but providing a quality overlay of technology to compliment those efforts.

§115.121 - 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) FSF Policy 2.11, M, Investigation, Discipline and Incident Reviews, Section 1., Preservation of Evidence, it states, "The first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the responder shall request the alleged victim not to take any actions and shall ensure that the alleged abuser does not take any actions, that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urination, defecating, smoking, drinking, or eating. If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." These evidence protocols are found to be consistent with the DHS ICE protocols found in Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention.

At the FSF, AGS is responsible for conducting all administrative investigations at the facility. In his interview with the Auditor, the Facility Investigator stated that he would stay in constant communication with the SDDO and AOIC, and that upon completion, the investigation would be presented to them for a finding.

ICE Policy 11062.2, Section 5.9. Investigation of Allegations, directs that the OPR shall, "Coordinate with the FOD or SAC and facility staff to ensure evidence is appropriately secured and preserved pending an investigation by federal, state, or local law enforcement, DHS OIG, and/or OPR." They are also directed to coordinate with DHS OIG to affect a timely acceptance of the case by DHS OIG or referral to OPR. This same policy requires an assessment of the allegation to determine the investigative response and assignment in accordance with ICE policies and procedures; to coordinate investigative efforts with federal, state, or local law enforcement, or facility incident review personnel, in accordance with OPR policies and procedures; coordinate with appropriate ICE entities and federal, state, or local law enforcement to facilitate necessary immigration processes that ensure availability of victims, witnesses, and alleged abusers for investigative interviews and administrative or criminal procedures and provide federal, state, or local law enforcement with information about U nonimmigrant visa certification. The policy also prescribes specific steps related to criminal cases, providing telephone numbers, access to U nonimmigrant status information, compiling and maintaining in the Joint Integrity Case Management System all documentation, submit briefings to ICE senior management, notifying the detainee, if still in detention. The policy sets forth requirements for the FOD to ensure the facility complies with investigative mandates, secures crime scenes and preserves evidence; conducts prompt, thorough investigations by qualified investigators; arranges for forensic examinations when appropriate; ensures that the victim's internal or external victim advocate is allowed for support; pursues internal administrative investigations and disciplinary sanctions in coordination with the criminal investigation; cooperates with any outside investigators; and ensures the SAAPI Program Coordinator reviews the results of the investigation and that the facility implements any resultant recommendations.

Following a review of the policies, and interviews with the SDDO and AOIC, it was clear to the Auditor that they had a thorough understanding of their responsibilities and steps taken in the event of a PREA criminal and administrative investigation.

(b)(c)(d) Policy 11087.1, states in part that; "the FOD shall coordinate with the ERO HQ and the ICE PSA Coordinator in utilizing, to the extent available and appropriate, community resources and services that provide expertise and support in areas of crisis intervention and counseling to address victims' needs." The policy also states that; "where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the FOD shall arrange or refer an alleged victim detainee to a medical facility to undergo a forensic medical examination, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFE's or SANE's cannot be made available, the examination can be performed by other qualified health care personnel. If in connection with an allegation of sexual abuse, the detainee is transported for a forensic examination to an outside hospital that offers victim advocacy services, the detainee shall be permitted to use such services to the extent available consistent with security needs." The Auditor conducted an interview with the AHSA, who informed him that a clinician

at the facility was responsible for treating only traumatic injuries that may have been caused during a physical assault and this individual would not collect evidence related to a sexual assault. The AHSA stated that a party involved in a sexual assault would be transported to the Scottsdale Osborn Medical Center for medical forensic exams, upon detainee consent, to be performed by a Forensic Nurse Examiner. The facility provided an MOU with the HonorHealth Scottsdale Osborn Medical Center to provide forensic medical exams administered by SAFE/SANE nurses at the facility. Following the onsite audit, the Auditor contacted the medical center, spoke to an administrator, and confirmed the facility's responsibilities under the MOU. The facility also provided a memorandum and email confirming that the Southern Arizona Center Against Sexual Assault (SACASA) would provide resources including victim services, crisis hotline, on site group therapy as well as telephonic therapy. Since SACASA is a nonprofit organization, they stated they were unable to enter a formal (MOU) with the facility.

(e) The facility provided an MOU with the Florence Police Department (FPD), which outlines the police department's responsibility when a criminal investigation of a PREA allegation is required. After examining the MOU, the Auditor determined that the police department has agreed to follow the provisions as stated in this policy in regarding its investigative practices. In a letter dated January 9, 2020, a FPD detective stated that his agency is responsible for conducting all criminal investigations at the staging facility and the detention center, specifically including PREA allegations, and filing criminal charges where appropriate. Following the onsite audit, the Auditor contacted the FPD and spoke to an investigative supervisor. He confirmed the MOU with the facility and that his agency was responsible for conducting criminal investigations only. He said an administrative investigation would be conducted by the facility and that it would run parallel to the criminal investigation. The Facility Investigator was interviewed, and he stated he would monitor the criminal investigation by staying in communication with the lead detective and he would ensure he would take no actions that would interfere or somehow compromise the criminal investigation. He also said that the administrative investigation would be conducted after the criminal investigation was complete.

§115.122 - 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)(c)(d)(e) ICE Policy 11062.2, Section 5.9, Investigation of Allegations provides detailed direction to "ensure the thorough investigation (both criminal and administrative) and follow-up regarding any sexual abuse allegation." The policy articulates the communication between staff, supervisory personnel, internal and external entities, and assurances that the "victims of sexual abuse have access to medical services (including forensic examinations when appropriate), advocates and services." Policy 11062.2 establishes that the ICE OPR shall "coordinate with the FOD or SAC and facility staff to ensure evidence is appropriately secured and preserved pending an investigation by federal, state, or local law enforcement, DHS OIG, and or OPR." It also requires that OPR shall "coordinate with DHS OIG to effect timely acceptance of the case by DHS OIG, or referral to OPR."

Policy 11062.2 goes into explicit detail on roles and responsibilities when an allegation is made, along with the necessary coordinated response by the OPR, DHS OIG, the FOD, SAC, and local law enforcement, when applicable. The policy further explains that the agency protocol is developed in coordination with DHS investigative entities and includes a description of responsibilities of both the agency and investigative entities; The policy requires "all sexual abuse and assault data collected pursuant to [11062.2] shall be maintained for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise."

Policy 11062.2 and FSF Policy 2.11 also set forth that "facility staff incorporate any recommendations made following the investigation(s), which may improve or enhance sexual safety at the facility."

There was one allegation, detainee-on-detainee, within the audit period which was investigated by OPR. The Auditor reviewed the investigation, which resulted in a finding of unsubstantiated. The allegation was made by a detainee after he had been transferred to another facility. That facility is unaffiliated with FSF and is managed by CoreCivic. The allegation was referred to the Florence Police Department for criminal investigation, and they determination that there was no evidence of a crime. The administrative investigation was conducted by a specially trained OPR Investigator.

Based on a review of all information related to that allegation, all notification protocols were followed and executed within the required time frames prescribed by policy.

In their interviews with the Auditor, the SDDO demonstrated a thorough understanding of his responsibility in promptly notifying the Joint Intake Center (JIC) on all allegations. He said in any PREA allegation, the Florence Police Department would respond to take a first report and determine if criminal behavior had occurred. He said the JIC would be notified immediately.

FSF provided an MOU with the Florence Police Department, which identifies the law enforcement agency as the authority to investigate sexual abuse/assault crimes at the facility. OPR is the designated administrative investigative entity for this facility.

During their interviews, the AOIC, SDDO and facility investigator clearly articulated the role of facility investigators and those of the Florence Police Department. The facility investigator was extremely knowledgeable regarding his duties and described in detail to the Auditor his procedures while conducting the fact-finding investigation to present to the agency investigator for administrative investigations. He demonstrated superior knowledge of the subject matter and was able to convey a clear plan of action when allegations arise.

§115.131 - Staff training.

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

(a)(b)(c) Section 5.2, Training, of ICE Policy 11062.2 establishes the training requirements for employees, contractors, and volunteers. The policy section requires that "all employees, contractors, and volunteers receive training on current sexual abuse and assault policies and procedures, and that training shall take place within one year of their entrance on duty. Employees shall also receive biennial refresher training after that." Additionally, 11062.2 requires that, "The agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed the training." FSF Policy 2.1 states, "The facility must maintain written documentation verifying employee, volunteer and contractor training."

The training shall include ICE's "zero tolerance policy for all forms of sexual abuse and assault; the right of detainees and staff to be free from sexual abuse and assault; definitions and examples of prohibited and illegal behavior; dynamics of sexual abuse and assault in confinement; prohibitions on retaliation; recognition of physical, behavioral, and emotional signs of sexual abuse or assault; how to avoid inappropriate relationships; accommodating limited English proficient individuals and individuals with mental or physical disabilities; communicating effectively and professionally with lesbian, gay, bisexual, transgender, intersex, or gender nonconforming individuals; procedures for fulfilling notification and reporting requirements; and the investigative process."

The facility provided the Auditor with the curriculum presented to staff and contractors and determined all eight required elements were covered in the training.

FSF Policy 2.1 states that "officers must explain to each newly arriving detainee the facility's zero-tolerance to sexual abuse; prevention and intervention strategies; definitions of sexual abuse; methods for reporting; information about self-protection; prohibition against retaliation; and the right of a detainee to treatment and counseling."

FSF provided the training records for all AGS, ICE, Medical and contract personnel, demonstrating that all have received PREA training, including refresher training. The Auditor inspected 20 randomly selected training records of ICE and AGS personnel, which included Sexual Abuse/Misconduct, Assault Prevention & Reporting/PREA course. Each of the records was signed by the training manager. The auditor confirmed through the same records that the training had occurred immediately upon the staff member's assignment to the facility.

The Auditor also randomly selected and inspected another 20 training records for ICE and AGS staff members who had completed a 40-hour refresher course training, with blocks of instruction on sexual harassment, supervision of transgender inmates and appropriate conduct with detainees. Again, each of the training documents was signed by the training manager.

Additionally, the facility provided training documentation for personnel completing the ICE Performance Based National Detention Standards 2021 Annual Refresher Training, which included a specific block of training titled PREA/SAAPI. The Auditor inspected 20 of these records and each contained a certificate of training record and an acknowledgement of training record, which contained the name of the employee, their signature, and the date of the training. All 20 records inspected contained signatures that were clearly authentic.

The Auditor interviewed the facility Training Manager who demonstrated a clear understanding of the curriculum provided to ICE employees, AGS security personnel and contractors. He said the courses are typically generated in person, but COVID restrictions required some of the training to be delivered virtually. The facility providing annual PREA training to employees is above and beyond the every other year requirement of this standard.

§115.132 - Notification to detainees of the agency's zero-tolerance policy.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

FSF Policy 2.11 states, "The Prison Rape Elimination Act of 2003 (PREA) sets a zero-tolerance threshold regarding rape and sexual assault in 'any confinement facility of a Federal, state, or local government, whether administered by such government or by a private organization.' Staff shall maintain an atmosphere that promotes a zero-tolerance stance."

Detainees also receive information on the Zero Tolerance policy during an orientation video, and the information is also contained in the detainee handbook distributed to each detainee.

The Auditor observed each dormitory at the staging facility contained the "Ice Has a Zero Tolerance for Sexual Abuse & Assault" color posters, which have been prominently placed in the dayrooms. Each of the posters identifies the facility contact as an SDDO and includes toll free telephone numbers for detainees to use, if necessary. All staff members (14) and contractors (2) interviewed by the Auditor were keenly aware of ICE's zero-tolerance policy.

§115.134 - Specialized training: Investigations.
Outcome: Exceeds Standard (substantially exceeds requirement of standard)
Notes:

(a)(b) FSF Policy 2.11, Section E, Staff Training, provides the requirement that, "…the facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. The training must include interviewing victims, sexual abuse and assault evidence collection

in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral and effective cross-agency coordination in the investigative process." ICE Policy Section 11062.2 prescribes the same training be provided to OPR investigators. The policy 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. This policy requires that the training include, at a minimum, "interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process." The auditor reviewed the curriculum for this specialized training, and it contained the elements prescribed in this policy. The Auditor reviewed the one investigative case file from the audit period and confirmed through the training files available on ICE SharePoint that the OPR Investigator who conducted the investigation had received the required specialized investigations training.

The AGS officer responsible for conducting administrative investigations at the facility demonstrated superior knowledge of investigative responsibilities, including effectively coordinating across multiple agencies, both federal and local. The investigator provided certifications from the DOJ National Institute of Corrections (NIC) PREA: Investigating Sexual Abuse in a Confinement Setting; NIC Investigating Sexual Abuse in a Confinement Setting: Advanced Course; and DHS Investigation Incidents of Sexual Abuse and Assault course through the Performance and Learning Management System (PALMS).

The facility investigator demonstrated his commitment to PREA related investigations by seeking out training on his own, above and beyond what is required by the standard and articulated precisely how that training would be implemented in his investigative tactics. The SDDO stated in his interview that the investigator was a true professional and is committed to doing the best job possible.

§115.141 - 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) FSF Policy 2.1, Procedural Guidelines, Admission, establishes that, "New arrivals shall be separated from the general population during the admission process. Detainees shall be assigned to initial holding settings according to their immediate security needs, physical and mental condition, and other considerations. Detainees will never be transferred into a housing unit until they have been fully processed. This includes being medically and mentally screened and cleared, properly classified, and have received all the required orientation materials."

FSF Policy 2.1, Procedural Guidelines, Admission, under Risk Classification, Assessment Detailed Summary, it states that Risk Classification Assessment form (RCA) is completed if the detainee is in custody 12 hours or more. The form is utilized to record special vulnerabilities, determine mandatory detection, and assess risk to public safety and risk of flight. During interviews with the SDDO, AHSA and a facility intake officer, it was learned that when detainees arrive at the staging facility they are first evaluated at the medical trailer. During this initial screening, the medical officer/nurse utilizes an electronic form ENFORCE Application Suite RCA Special Vulnerabilities), which enables the interviewer to ascertain information from the detainee to determine if they may be vulnerable or be an abuser/predator.

(c) In the Classification section of the FSF Policy 2.1, it states that every new arrival will be scored and classified in accordance with the Custody Classification System (the nine risk of sexual victimization factors). Detainees identified and confirmed as being "at risk" or "high risk" shall be placed in the least restrictive housing that is available and appropriate. Detainees are classified utilizing a scoring system in accordance with the Custody Classification System. The detainee's criminal and institutional history are utilized to determine a score, which will determine each detainee's risk category.

In the first section of the policy, titled Special Vulnerabilities, "an assessment is made on whether the detainee has a serious physical illness, a serious mental health illness, is disabled, or elderly."

(d) A subsequent section of FSF Policy 2.1 addresses the detainee's sexual orientation, and asks questions such as, "do you fear being harmed in detention based on your sexual orientation?" Additionally, they are asked if they have been a victim of sexual abuse, or violent crime. Fourteen random staff members were interviewed, and all had knowledge regarding the separation of "at risk" or "high risk" detainees. Of the 14, 12 stated that there are Special Management Unit cells in the staging facility, and those would be utilized if a detainee needed to be segregated from the general population. Two of the 14 said the 2 satellite trailers would likely be used to separate at risk detainees. When asked if the designation of "at risk" or "high risk" would trigger any other actions, 10 of the 14 said there would be a referral to mental health. Two said they were not clear on subsequent protocols, and two said, "it depends," but were not 100% clear on what other actions would be taken. The Auditor asked follow-up questions to each of the four who were not 100% clear on those protocols, asking each what facility resources were available to detainees. All four stated after further questioning that a referral to mental health would be appropriate. None of the four responses were from staff assigned to intake; however, greater emphasis on the importance of "at risk" and "high risk" protocols during refresher training with staff would likely be helpful. The SDDO, AOIC and AHSA all articulated the need to provide additional services to anyone deemed "at risk" or "high risk." Each said that separation was the key for any detainee who was "at risk" and that a mental health referral would be automatic.

Recommendation (d): The Auditor recommends that the facility emphasize the importance of "at risk" and "high risk" protocols with staff during the next refresher training.

(e) FSF Policy 2.11 under Staff Training provides the requirement that staff be instructed to, "…limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee-victim's welfare, and for law enforcement/investigative purposes." This same policy requires that staff be trained on how to communicate effectively and professionally with detainees who may be lesbian, gay, bisexual, transgender, intersex, or gender non-conforming. Thirteen of the 14 random staff interviewed were able to identify the "need to know" policy regarding the dissemination of sexual abuse or assault information. One of the 14 was not clear and stated that he would only tell a supervisor.

§115.151 - Detainee reporting.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) FSF Policy 2.11, Section F, Detainee Notification and Orientation, #4 requires an "explanation of the ways of reporting sexual abuse, or assault, including one or more staff members other than an immediate point-of-contact officer, the [D]etention and Reporting Information Line (DRIL), and the investigation process." Other mechanisms available to detainees for reporting are the DHS OIG, a PREA hotline, and the JIC. The policy also states that detainees will receive written information which includes the same information as described in the policy (which is available in 14 languages as stated previously in this report). This information is disseminated during the intake process. During the onsite audit, the Auditor observed the contact numbers for each of these resources posted above each of the phone banks in every housing area. During the onsite facility tour, the Auditor observed postings in the dayrooms providing telephone numbers for a wide array of outside contacts, including the American Civil Liberties Union, the OIG, DRIL line, and contacts for consulate offices. Another separate posting provides website, phone, fax, and a mailing address for the OIG. Additionally, above each phone bank is a clearly marked document which provides toll free telephone access to numerous agencies in which a report can be made.

Included in section L, Reporting, Notifications and Confidentiality, is the requirement that "staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." In interviews conducted with the 14 randomly selected staff members, all said they were responsible for accepting any reports from detainees. Twelve of the 14 indicated they were required to document those reports and two said their responsibility was to notify an immediate supervisor.

As stated earlier in this report, the Auditor was able to successfully make phone calls from each of the three housing areas, including calling the OIG, DRIL lines, and the PREA hotline. In the case of the OIG and DRIL line, representatives from each entity confirmed that they would accept anonymous reports. The Auditor was provided a PIN number and called the PREA hot line and left a voicemail test message. Within 30 seconds of disconnecting the call, the SDDO received an automated text message stating there was a PREA incident in the dorm from which the Auditor placed the call. There was no identifying information on the caller, and since there was no detail in my message, it merely said there was a PREA incident. The SDDO showed the Auditor the message and he stated it would go to certain members of facility leadership and on duty supervisors. Within a minute of placing the call, an on-duty supervisor responded and showed the Auditor the same message. The SDDO said the messaging system was a feature of the phone system.

In her interview with the Auditor, the PSA Compliance Manager detailed all the mechanisms in place for detainees to make reports, including those made verbally to staff, requiring documentation and immediate reporting.

In addition to the written and verbal notification processes described above, detainees also can file a request/grievance. Forms were readily available in the dormitories or can be requested from an officer. Once completed by the detainee, the form can either be given to an officer, or placed in a clearly marked, locked box in each housing area. In his interview with the Auditor, the Grievance Manager stated that the forms are picked up daily and are responded to immediately. The Auditor asked how the Grievance Manager communicates with detainees who are LEP, and he stated that he either uses the language line services available at the facility, or he uses Google Translate on his mobile phone. He recounted a recent interaction with a detainee (non-PREA issue), in which he used his phone to conduct an informal interview with a Russian speaking detainee.

The facility provided the Auditor with a copy of the consulate phone list and the DHS OIG contact information flyer.

The use of the PREA notification messaging system is an outstanding tool and provides the facility real-time opportunities to respond to PREA events that may occur at FSF. This tool is above and beyond any of the standard requirements and demonstrates the facility's commitment to sexual safety.

§115.154 - Third-party reporting.

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

Notes:

Section 2, Procedural Guidelines of FSF Policy 2.11, item 2., e. says, "Procedures for immediate reporting of sexual abuse allegations, including: A method to receive third-party reports of sexual abuse in the facility, with information made available to the public regarding how to report sexual abuse on behalf of a detainee." Section L of policy 2.11 also says, "Staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports."

The Auditor searched the ice.gov website and was easily able to locate information on PREA, and the various methods a member of the public can make a report, which included the DHS OIG and DRIL hotlines, and to ICE OPR.

In each of the staging facility dayrooms were yellow placards that provided telephone contact information for the same resources. The Auditor conducted a test of the phones in each of the dormitories and was able to contact the external agencies from each of the dorms.

In interviews with staff, all 14 randomly selected staff members and one of the two contractors were able to describe the methods in which detainees, or their families, could make third-party reports of sexual abuse in the facility. One of the contractors was aware of toll-free numbers but could not provide any other specific information.

§115.161 - Staff reporting duties.

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

Notes:

(a)(b)(c) FSF provided a memorandum, dated November 10, 2010, from the Deputy Director of ICE, stating "employees are directed to report allegations of substantive misconduct or serious mismanagement to the JIC, OPR, or OIG, and to report less serious misconduct to local management. As examples, the memo identified physical, or sexual abuse of a detainee or anyone else, as circumstances that must be reported to the JIC, OPR, or OIG."

In FSF Policy 2.11, Section L, Reporting, Notifications and Confidentiality, "staff are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." Additionally, that policy says 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."

The PSA Compliance Manager and facility Training Manager both stated that a duty to immediately report is a significant aspect of the facility's PREA policy and is emphasized during training sessions. The AOIC and SDDO echoed those sentiments in their interviews.

All 14 randomly selected staff stated they understood their duty to immediately report. Eleven of the 14 specifically cited the OIG as a potential source for staff to utilize outside of the facility's chain of command, while the other three identified the "PREA hotline," as an outside, third-party mechanism.

When asked about their responsibility in sharing information regarding an allegation of sexual abuse, 13 of the 14 staff members said the safety of the victim was the primary concern, and that only information necessary to help protect the victim would be shared. One of the 14 was not able to articulate the importance of keeping details to what was only necessary to protect the victim.

Two contractors were interviewed, with one stating he would only share what information was pertinent, while the other said he would only provide the information for which he was asked by an investigator, security staff member, or a supervisor.

(d) Under ICE Policy 11062.2, Reporting, it states that "if the alleged victim is under the age of 18, or determined, after consultation with the relevant OPLA Office of the Chief Council (OCC), to be a vulnerable adult under a State or local vulnerable persons statute, report the allegation to the designated State or local services agency as necessary under applicable mandatory reporting laws…and document…efforts taken under this section." In his interview with the Auditor, the AOIC confirmed his reporting responsibility.

§115.162 - Protection duties.

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

Notes:

FSF Policy 2.11, Section I, Prevention states, "if a staff member has a reasonable belief that a detainee is subject to substantial risk of imminent sexual abuse, staff shall take immediate action to protect the detainee."

ICE Policy 11062.2, 5.4, Protection of Individuals at Risk provides the identical language to that of the FSF policy.

All 14 randomly selected staff members, and both contractors were aware of their responsibility in protecting detainees at risk.

The SDDO and PSA Compliance Manager confirmed their responsibility to protect detainees. Both acknowledged that housing changes, work assignment changes, and monitoring detainee discipline were methods which could be employed to protect detainees.

§115.163 – 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) ICE Policy 11062.2, 5.7, Notification and Reporting Following an Allegation, requires that, "if the alleged assault occurred at a different facility from the one where it was reported, ensure that the administrator at the facility where the assault is alleged to have occurred is notified as soon as possible, but no later than 72 hours after receiving the allegation, and document such notification."

FSF Policy 2.11, Section 2, Notification and Reporting Procedures, says that "Upon receiving an allegation that a detainee was sexually abused while confined in another facility, the facility whose staff received the allegation shall notify the FOD and the appropriate

administrator of the facility where the alleged abuse occurred. The notification provided in this section shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. The facility shall document that it has provided such notification." In his interview, the SDDO said that if a detainee reported being sexually abused at another facility, that he would be required to report the allegation within 72 hours to the facility at which the alleged abuse occurred.

Although no allegations had been received in the previous year, the Auditor reviewed the allegation which occurred in May 2017, shortly after the last audit. The incident allegedly occurred at FSF but was reported to another facility two days later. The notifications were made to FSF within 24 hours of being reported, and FSF launched an immediate investigation into the incident. Based on the Auditor's review of the case, all required notifications were made well within the required time frames.

The facility provided a memorandum from the AOIC, which was confirmed through interviews, that stated there had been no incidents in the past 12 months, but accurately stated what actions and notifications would be made, along with their associated time frames. In his interview with the auditor, the AOIC confirmed that although there were no allegations reported to have occurred at another facility within the reporting period .

§115.164 - Responder duties.

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

Notes:

(a) FSF Policy 2.11, J, Prompt and Effective Intervention, says that "Staff shall take seriously all statements from detainees claiming to be victims of sexual assaults and respond supportively and non-judgmentally. Any Detainee who alleges that they have been sexually assaulted shall be offered immediate protection and separation from the assailant and referred for a medical examination and/or a clinical assessment of the potential for negative symptoms. Staff becoming aware of an alleged assault shall immediately follow the reporting requirements set forth in this policy." Section I, Preservation of Evidence, of the same policy says that "…first security staff members to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any physical evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the responder shall request the alleged victim not to take any actions and shall ensure that the alleged abuser does not take any actions, that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating."

All 14 randomly selected staff stated that separating the victim and the abuser were two of the initial steps they would take. Each also said that notifying a supervisor and obtaining potential assistance from other officers was paramount. Furthermore, of the 14, 11 were able to clearly state their duty to preserve the crime scene. Two said they needed to protect the scene but could not articulate that evidence preservation was a key component. One staff member did not discuss protecting the scene in their response.

(b) FSF Policy 2.11, J, Prompt and Effective Intervention, says that "If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and notify security staff." A total of four non-security staff members were interviewed (two facility staff members and two contractors), each stated that they would separate the victim, give them instructions to not destroy evidence, then contact a security staff member. Both contractors interviewed were able to say that they knew it was important not to allow the detainees to leave, and to do what they could at the moment to separate victims and abusers.

§115.165 - Coordinated response.

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

Notes:

(a) FSF Policy 2.11, Section M, Investigation, Discipline, and Incident Reviews, #2, Forensic Examinations says that "…the OIC shall arrange for an alleged victim to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) when practicable."

Subsequently, the policy states, "As requested by the victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews."

ICE Policy 11062.2, Section 5.8, Response: Intervention and Health Care Services Following an Allegation, the FOD shall use a "…coordinated, multidisciplinary team approach to respond to the allegation."

The SDDO, AOIC and AHSA all articulated this requirement in their individual interviews. The AOIC specifically indicated that if a detainee who was the victim of sexual abuse is transferred to another facility, they will provide what information is permitted by law to ensure the victim receives proper medical care and Services. The AHSA said that they would provide the pertinent and lawful information in the transfer medical records for the victim detainee.

(b) In a memorandum, prepared by the AOIC, it states that if a victim of sexual assault were transferred from FSF to another facility, medical personnel would notate on the victim's record, as permitted by law, that they had been the victim in a PREA incident at the facility. This was also confirmed during the AOIC interview.

(c) FSF and ICE policy state that if a victim is transferred to a facility other than a Subpart A or B facility, as permitted by law, the agency shall inform the receiving facility. In his interview, the SDDO stated that the notification would first be accomplished with a phone call to the facility, followed by an email confirming the conversation.

§115.166 - 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:

ICE Policy 11062.2, Response: Intervention and Health Care Services Following an Allegation, subsection f says, "Ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring detainee contact pending the outcome of an investigation."
The one investigation reviewed by the Auditor for this report did not include an allegation against a staff member, contractor, or volunteer.

The AOIC and the administrative investigator said that the alleged perpetrator would be reassigned to duties that did not require detainee contact until the outcome of the investigation.

§115.167 - Agency protection against retaliation.

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

Notes:

FSF Policy 2.11, Section K, Protection Against Retaliation says, "Staff, contractors, volunteers and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats or fear of force."

ICE Policy 11062.2, Section 5.3, Obligation to Report Information and Prohibition of Retaliation, states the same essential language, but is specific to ICE employees.

The AOIC, SDDO, PSA Compliance Manager, and 14 randomly selected staff members were all asked specifically about the facility's policy regarding retaliation. All parties interviewed stated the need to ensure that no retaliation of any kind should take place. The AOIC, SDDO and PSA Compliance Manager all added that anyone who has the potential to be a victim of retaliation should be monitored for at least 90 days following the incident. Based on her interview with the Auditor, The PSA Compliance Manager would monitor retaliation.

Of the 14 staff members interviewed, all acknowledged the need to ensure no retaliation occurs, and 10 of the 14 were able to independently state that there needs to be some follow-up to ensure the safety of the detainee.

The one investigation reviewed by the Auditor contained an allegation made by a detainee after leaving the FSF and being assigned to the Florence Correctional Center (managed by CoreCivic and not part of the FDC/FSF complex).

The AOIC authored a memorandum stating that there were no reports of retaliation related to a sexual abuse investigation in the past year.

§115.171 - Criminal and administrative investigations.

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

Notes:

(a) ICE Policy 11062.2, Section 5.9, Investigation of Allegations, subsection #2, "says that the FOD shall, [Conduct] a prompt, thorough, and objective investigation by qualified investigators." The Auditor reviewed training records and conducted an interview with the Facility Investigator and confirmed he has received substantial specialized training for conducting sexual assault and abuse training in a confinement setting. He also demonstrated a clear command of the investigative process and how he would apply the tenets of that training at the facility.

The PSA Compliance Manager, SDDO, AOIC, and Facility Investigator were all interviewed by the Auditor, and all demonstrated a clear understanding of not only the investigative process, but notification protocols as well. Independent of one another, each detailed the investigative steps to be taken in the event of a PREA allegation and the notifications which need to be made per ICE policy.
The one allegation reported during the audit period was investigated by OPR. The Auditor's review of this case file found the investigation to be prompt, thorough, objective, and conducted by a specially trained investigator.

(b)(c) In accordance with policy 11062.2, section 5.9, page 17, "the FOD shall ensure that the facility complies with the investigation mandates established by the Performance-Based National Detention Standards (PBNDS) 2011 2.11, as well as other relevant detention standards."

PBNDS 2011 2.1 pages 143-144, states in part that; "upon conclusion of a criminal investigation where the allegation was substantiated, or in instances where no criminal investigation has been completed, 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. Substantiated allegation means an allegation that was investigated and determined to have occurred. Unsubstantiated allegation means an allegation

that was investigated, and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity. The ICE Office of Professional Responsibility will typically be the appropriate investigative office within DHS, as well as the DHS OIG in cases where the DHS OIG is investigating."

ICE Policy 11062.2 states "The facility shall develop written procedures for administrative investigations, including provisions requiring; preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviewing alleged victims, suspected perpetrators, and witnesses, reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator, assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph, an effort to determine whether actions or failures to act at the facility contributed to the abuse, documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings, and retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." The policy also requires that the OPR coordinate with the FOD or SAC and facility staff to, "…ensure evidence is appropriately secured and preserved pending an investigation by federal, state, or local law enforcement, DHS, OIG, and/or OPR."

ICE Policy 11062.2 also says "such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation.

The Auditor discussed the notification hierarchy for investigations with the PSA Compliance Manager, AOIC and Facility Investigator. In each case (including the AGS facility investigator), they were fluent in the notification and investigative protocols and the role of the FPD in investigating criminal allegations.

(d) ICE Policy 11062.2, Section 5.9 Investigation of Allegation, subsection #1, e, says an investigation "… may not be terminated solely due to the departure of the alleged abuser or victim from the employment or control of ICE." This was confirmed through interviews with the AOIC and Facility Investigator.

(e) PBNDS 2011 states in part that; "When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation."

During his interview with the Auditor, the Facility Investigator articulated the importance of coordinating and cooperating with the FPD. During a phone conversation with an investigative supervisor at the FPD, he indicated that it was critical for the facility and his agency to have a cooperative relationship.

The Auditor reviewed the one sexual abuse investigation which was investigated by OPR. The allegation was referred to the Florence Police Department for a criminal investigation but declined. The administrative investigation was conducted by OPR. Based on the Auditor's review, all notifications were made as per ICE policy.

§115.172 - Evidentiary standard for administrative investigations.

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

Notes:

Security operations at the FSF are contracted with AGS, which would not make determinations on administrative investigations. Based on interviews with the AOIC and SDDO, the Facility Investigator would conduct a fact-finding review and make a recommendation to the assigned agency Investigator. Findings on an administrative investigation would be the responsibility of ICE and not solely by the AGS investigator.

ICE Policy 11062.2, Section 5.9 Investigation of Allegation, subsection #1, e, says, "Administrative Investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse or assault, and may not be terminated solely due to the departure of the alleged abuser or victim from the employment or control of ICE."

The Auditor's review of the one investigation found that the Investigator used a preponderance of the evidence in concluding the disposition as unsubstantiated.

§115.176 - Disciplinary sanctions for staff.

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

Notes:

(a) FSF Policy 2.1 states that "staff shall be subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiate allegations of sexual abuse or violating agency sexual abuse policies."

(c)(d) ICE Policy 11062.2, 5.9 says "Upon receiving notification from a FOD or SAC of the removal or resignation in lieu of removal of staff for violating agency or facility sexual abuse and assault policies…make reasonable efforts to report that information to any relevant licensing bodies."

FSF Policy 2.11 also requires that the OIC shall report such violations to local law enforcement, unless clearly not criminal. The AOIC and PSA Compliance Manager reiterated what is stated in ICE and FSF policy as it relates to their responsibilities.

In her interview with the Auditor, the human resources manager stated that every effort would be made to notify any licensing agencies in the event of a removal due to a violation of sexual abuse and assault policies. The SDDO also confirmed that anyone in violation of these policies would be removed and that any licensing entities or relevant law enforcement bodies would be notified as soon as practical.

A memorandum from the AOIC confirmed there had been no instances of a removal of staff in the past 12 months, and there had been no notifications to licensing bodies.

§115.177 - 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) ICE Policy 11062.2, 5.8, Response: Intervention and Health Care Services Following an Allegation, says, "Ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring detainee contact pending the outcome of an investigation."

Under Section 4, Discipline of FDC Policy 2.11, it states that, "Any contractor or volunteer who has engaged in sexual abuse 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 but have violated other provisions within this policy." The policy goes on to say, "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 OIC shall also report such incidents to the Field Office Director regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known."

The HR Manager stated in her interview with the Auditor that any contractor or volunteer who had engaged in any of these violations, substantiated by an investigation would be immediately terminated. The AOIC, SDDO and PSA Compliance Manager also affirmed this through their interviews.

A memorandum from the AOIC indicated there have been no such incidents in the past 12 months. The facility also provided a blank letter of termination as it relates to this standard.

§115.182 - 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) ICE Health Service Corps Directive 03-01, Section 4.2, states that ICE shall, "Provide emergency medical and mental health services to detainees who are victims of sexual abuse. Services include: Initial evaluation; ongoing mental health care; examination; and referrals; Emergency medical treatment; Crisis intervention services including emergency contraception, sexually transmitted infections testing, and prophylaxis. (National Commission on Correctional Health Care (NCCHC) 2018 Standards)."

The AHSA was interviewed and said that any victim of sexual abuse at the facility would be seen immediately by medical staff. She said in the event of a sexual assault, the facility would treat any life-threatening conditions, but would not attempt to collect evidence. She said the victim would be transported to Honor Health Scottsdale, the local hospital for a SAFE/SANE exam, if necessary, and provided any advocacy services requested by the victim. She also said these services would be provided at no cost to the victim.

Two randomly selected medical staff were also interviewed for this standard. Both said that they would not collect evidence and that it would be the responsibility of a SANE nurse to conduct a forensic medical exam. Each stated they would be responsible for treating any traumatic injuries and that a mental health referral would be made for any allegation of sexual assault or abuse

The AOIC provided a memorandum, which stated there had been no instances of a detainee victim requiring emergency medical services following a sexual abuse or assault in the past 12 months. The SDDO and AOIC confirmed this with their interviews with the Auditor. The one incident that occurred within the audit period was reported at another facility after the detainee left FSF, and the investigation clearly documented that the detainee received medical and mental health services at the facility where the allegation was reported.

§115.186 – Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) FSF Policy 2.11, Section M, subsection #5, Sexual Abuse Incident Reviews states that staff shall conduct reviews at the conclusion of every sexual abuse investigation. When not determined to be unfounded, a written report shall be prepared within 30 days of the conclusion of the investigation recommending whether a change in policy, or practice would better prevent, detect, or respond to sexual abuse. This same policy requires staff "to implement the recommendations for improvement or document its reasons for not in

a written response… The report and response shall be forwarded to the FOD, or his designee for transmission to the ICE PSA Coordinator.'

The policy also requires that the "facility conduct an annual review of all sexual abuse investigations and their accompanying incident reviews to assess any improvements that can be made to improve sexual safety at the facility. The results of the annual review shall be provided to the OIC, FOD, or his designee, for transmission to the ICE PSA Coordinator."

In their interviews with the Auditor, both the AOIC and SDDO stated they were clear on their responsibilities regarding sexual abuse incident reviews.

The facility was unable to provide an incident review for the one case that occurred within the audit period.

Does Not Meet (a): The agency/facility was unable to provide the Auditor with evidence that a sexual abuse incident review had been completed at the conclusion of the one investigation that occurred within the audit period. Additionally, as this case was unsubstantiated, a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse should have been prepared, but was not. Corrective action requires an incident review be completed on the incident, along with a written report responding to the requirements of this standard prepared, and evidence that both reports have been forwarded to the agency PSA Coordinator.

§115.187 – Data collection.

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

Notes:

(a) Policy 11062.2, Section 512, Data Storage, says, "All sexual abuse and assault data collected pursuant to this Directive shall be maintained for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise."

Under the Procedures for Administrative Investigations section of FSF Policy 2.11, it says, "Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years."

Under the Data Collection section of the same policy it states, "The facility shall maintain in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be maintained in an appropriate file. The age, confidentiality, and release of records will follow the requirements set forth in regard to the Privacy Act of 1974. Because of the sensitive nature of information about victims and their medical condition, including infections disease testing, staff must be vigilant about maintaining confidentiality and releasing information only for legitimate need-to-know reasons."

In his interview with the Auditor, the Facility Investigator and SDDO said that when an investigation is conducted and completed, those files are maintained in a locked filing cabinet, within a secured office in the administration building of the facility. The Auditor confirmed the secure location of the files during the onsite audit during his interview with the SDDO.

§115.193–Audits of standards.

Outcome: Not low risk

Notes:

Choose an item.

The physical layout of the facility, coupled with its staffing plan and use of upgraded digital video surveillance technology provide for a safe environment for detainees and staff. The use of a direct supervision model in the three primary housing areas, and two satellite trailers help enhance the security of detainees at the facility. The facility has also had no reports of sexual abuse during this audit period.

However, after a careful review, it was determined that the facility is not in compliance with one standard; and therefore, not in full compliance with the DHS PREA Standards. Based upon the Auditor's interviews with the PSA Compliance Manager, SDDO, the facility tour and the fact that the even though the facility only holds detainees up to 72 hours, the Auditor must take into consideration the one area of non-compliance (115.186); therefore, the Auditor has determined that the facility is not low risk. This determination is validated by the fact there have been no reports of sexual abuse or sexual assault during this audit period.

§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) The Auditor was provided full access to the entire facility without restriction. Necessary documentation, including while onsite, was provided in a timely manner.

The Auditor was able to conduct all interviews in a private setting, without interruption. Although no detainee interviews were conducted, space had been identified which would have allowed for private interviews and access to a phone for interpretive services, if necessary.

Postings in each of the dayrooms provided detainees the opportunity to correspond with the Auditor if needed. The Auditor received no correspondence from detainees or staff regarding this 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:	4
Number of standards met:	25
Number of standards not met:	1
Number of standards N/A:	1
Number of standard outcomes not selected (out of 31):	0
Facility Risk Level:	Low Risk

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 A. McCorkle 2/23/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 3/31/2022

PREA Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) 4/14/2022

PREA Program Manager's Signature & Date

PREA Audit: Subpart B
DHS Holding Facilities
Corrective Action Plan Final Determination

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Mark McCorkle	**Organization:**	Creative Corrections, LLC
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	(661) 618-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b)(6), (b)(7)(C)	**Telephone number:**	(772) 579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Phoenix		
ICE Field Office Director:	John E. Cantu		
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 FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Florence Staging Facility		
Physical address:	3520 N. Pinal Parkway, Florence, AZ 85132		
Mailing address: *(if different from above)*			
Telephone number:	(520) 868-8377		
Facility type:	ICE Staging Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	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) 868-(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 U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Florence Staging Facility (FSF) was conducted from January 25, 2022, to January 26, 2022. The audit was performed by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Mark McCorkle, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by Immigration & Customs Enforcement (ICE) Assistant Program Manager (APM) (b) (6), (b) (7)(C) and Program Manager (PM) (b) (6), (b) (7)(C) both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The audit period is March 23, 2017 through January 26, 2022, and was extended because there were no allegations reported in the 12 months prior to the audit to review. FSF is a Staging Facility operated by ICE, Office of Enforcement and Removal Operations (ERO). Security services for the facility are provided by Akima Global Services (AGS), a private contractor.

During the audit, the Auditor found the FSF met 25 standards, exceeded in four standards (115.111, 115.131, 115.134, and 115.151), one standard that was non-applicable (115.114), and one non-compliant standard (115.186). As a result, the facility was placed under a Corrective Action Plan to address the non-compliant standard. On Monday, May 2, 2022, the Auditor was provided the ICE PREA Corrective Action Plan (CAP) from the External Reviews and Analysis Unit (ERAU), which was reviewed and approved by the Auditor to determine compliance with the non-compliant standard. The final supplied documentation was reviewed by the Auditor on May 2, 2022, and it was determined that the standard was compliant in all material ways.

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.

§115. 186 - Sexual abuse incident reviews

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

Notes:

(a) FSF Policy 2.11, Section M, subsection #5, Sexual Abuse Incident Reviews states that staff shall conduct reviews at the conclusion of every sexual abuse investigation. When not determined to be unfounded, a written report shall be prepared within 30 days of the conclusion of the investigation recommending whether a change in policy, or practice would better prevent, detect, or respond to sexual abuse. This same policy requires staff "to implement the recommendations for improvement or document its reasons for not in a written response… The report and response shall be forwarded to the FOD, or his designee for transmission to the ICE PSA Coordinator."

The policy also requires that the "facility conduct an annual review of all sexual abuse investigations and their accompanying incident reviews to assess any improvements that can be made to improve sexual safety at the facility. The results of the annual review shall be provided to the OIC, FOD, or his designee, for transmission to the ICE PSA Coordinator." In their interviews with the Auditor, both the AOIC and SDDO stated they were clear on their responsibilities regarding sexual abuse incident reviews.

The facility was unable to provide an incident review for the one case that occurred within the audit period.

Does Not Meet (a): The agency/facility was unable to provide the Auditor with evidence that a sexual abuse incident review had been completed at the conclusion of the one investigation that occurred within the audit period. Additionally, as this case was unsubstantiated, a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse should have been prepared, but was not. Corrective action requires an incident review be completed on the incident, along with a written report responding to the requirements of this standard prepared, and evidence that both reports have been forwarded to the agency PSA Coordinator.

Corrective Action Taken: On May 2, 2022, the Auditor was provided the CAP for this standard and reviewed the supporting documentation on the same day. The Auditor thoroughly reviewed the Sexual Abuse and Assault Incident Review Form, dated April 12, 2022, provided by the facility. The Auditor found that the Sexual Abuse and Assault Incident Review form contained a detailed summary of the incident in question. There were no recommendations for improvements made by the incident review team. The Incident Review form was signed by the Chief of Security, the Assistant Health Services Administrator, the (A)AFOD, the AGS Security Captain, and the Officer in Charge.

The completed ICE Sexual Abuse and Assault Incident Review Report of Findings and Recommendations report dated April 12, 2022, for this incident was also provided to the Auditor for review. The report confirmed there were no recommendations made for improvement based on the findings of the Incident Review. A copy of the email dated April 29, 2022, from the facility's PSA Compliance Manager to the agency's PSA Coordinator and the SDDO providing them with the ICE Sexual Abuse and Assault Incident Review Report of Findings and Recommendations report for this case, was also provided to the Auditor for review.

Based on a thorough review of all materials provided, the Auditor finds that FSF has demonstrated full compliance with this standard.

§115. Choose an item.
Outcome: Choose an item.

Notes:

§115. Choose an item.
Outcome: Choose an item.

Notes:

§115. Choose an item.
Outcome: Choose an item.

Notes:

§115. Choose an item.
Outcome: Choose an item.

Notes:

§115. Choose an item.
Outcome: Choose an item.

Notes:

§115.193
Outcome: Low Risk

Notes:

The physical layout of the facility, coupled with its staffing plan and use of upgraded digital video surveillance technology provide for a safe environment for detainees and staff. The use of a direct supervision model in the three primary housing areas, and two satellite trailers help enhance the security of detainees at the facility. The facility has also had no reports of sexual abuse during this audit period. Additionally, and based on a thorough review of all corrective action materials provided for previously deficient DHS PREA standard 115.186, the Auditor finds that FSF has demonstrated full compliance with this standard and therefore, is now considered low risk.

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 McCorkle May 16, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) May 19, 2022
Program Manager's Signature & Date

(b) (6), (b) (7)(C) May 19, 2022
Assistant Program Manager's Signature & Date