PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

AUDIT DATES			
From:	4/23/2019	**To:**	4/25/2019
AUDITOR INFORMATION			
Name of auditor:	Patrick J. Zirpoli	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	570-729-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Atlanta Field Office		
Field Office Director:	Sean Gallagher		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	180 Ted Turner Drive SW #522, Atlanta, GA 30303		
Mailing address: (if different from above)			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Folkston ICE Processing Center and Annex		
Physical address:	3026 Highway 252 East, Folkston, Georgia 31537		
Mailing address: (if different from above)			
Telephone number:	912-496-6905		
Facility type:	D-IGSA		
PREA Incorporation Date:	12/16/2016		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	912-496-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	912-496-
ICE HQ USE ONLY			
Form Key:	29		
Revision Date:	12/08/2018		
Notes:			

AUDIT FINDINGS

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS:

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

Pre-Onsite Audit Phase

Audit Planning and Logistics:

On April 23-25, 2019 the Prison Rape Elimination Act (PREA) on-site audit of the Folkston ICE Processing Center in Folkston, Georgia was conducted by Department of Justice and U.S. Department of Homeland Security (DHS) certified PREA Auditors for Creative Corrections, LLC, Patrick J. Zirpoli and (b) (6), (b) (7)(C). The Lead Auditor, Patrick J. Zirpoli, was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ and DHS certified PREA Auditor. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ and DHS certified PREA Auditor. The Program's Manager role is to provide oversight to the ICE PREA audit process and liaison with the ICE External Reviews and Analysis Unit (ERAU) section during the audit report review process on behalf of Creative Corrections. The PREA audit was the first for the Folkston ICE Processing Center. The Folkston ICE Processing Center is operated by GEO Group Inc. and contracted by U.S. Immigration and Customs Enforcement (ICE) for the housing of male detainees. The audit period covered the previous twelve months from April 23, 2018 to April 25, 2019.

Posting Notice of the Audit:

The External Reviews and Analysis Unit (ERAU) Team Lead (b) (6), (b) (7)(C) forwarded the audit notification poster to the facility. The poster included the dates of the audit, the purpose of the audit, the Lead Auditor's contact information through Creative Corrections LLC, and a statement regarding the confidentiality of any communication received. The facility staff placed posters throughout the facility, including all housing units, and all common areas. The Auditor verified the placement of the audit notification poster during the facility tour, and the detainee and staff interviews. The Auditor received three letters from detainees; these letters did not pertain to any PREA allegations, they pertained to immigration issues, these concerns were referred to the Enforcement and Removal Operations (ERO). One of these letters was written by an individual with mental health issues, he was referred to a mental health professional at the facility.

Review of GEO and Facility Policies, Procedures, and Supporting Documentation:

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

Onsite Audit Phase:

Site Review:

The onsite audit began on April 23, 2019, at 8:00 a.m. at which time (b) (6), (b) (7)(C) led a short in-briefing. In attendance were the Auditors and the following GEO and ICE Staff:

- Warden Patrick Gartland (GEO)
- ICE Detention and Deportation Officer (b) (6), (b) (7)(C)
- Assistant Field Officer Director (AFOD) ICE (b) (6), (b) (7)(C)
- GEO PREA Director (b) (6), (b) (7)(C)
- ERO PREA Field Coordinator (b) (6), (b) (7)(C) (GEO)
- Health Services Administrator (b) (6), (b) (7)(C) (GEO)
- Classifications (b) (6), (b) (7)(C) (GEO)
- Compliance Administrator (b) (6), (b) (7)(C) (GEO)
- Regional PREA Coordinator (b) (6), (b) (7)(C) (GEO)
- Executive Secretary (b) (6), (b) (7)(C) (GEO)
- PSA Compliance Manager (b) (6), (b) (7)(C) (GEO)
- Major (b) (6), (b) (7)(C) (GEO)
- Maintenance Manager (b) (6), (b) (7)(C) (GEO)
- Supervisory Deportation and Detention Officer (SDDO) (b) (6), (b) (7)(C)

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

The Auditors with key staff, including the Warden, PSA Compliance Manager, and GEO PREA Director conducted a facility tour. All areas of the facility were toured, including the housing units, laundry, intake area, administrative offices, kitchen and medical. All housing units were toured, as well as, program areas, service areas, food service, control center, booking/intake, and medical areas. During the tour, the Auditors made visual observations and closely examined the bathrooms, housing area sight lines, and camera locations and camera views. At the time of the audit, the

facility was upgrading the camera system, new cameras were in place but not operational, the Auditor could not examine the sight line of these cameras. The Auditors spoke with random staff and detainees, reviewed all of the housing unit logbooks, examined the bulletin boards to ensure that the proper PREA Posters and PREA audit notifications were posted and made random phone calls on the detainee phones to ensure the detainees could contact the Office of Inspector General (OIG) and Satilla Advocacy Services.

Working in partnership with the Federal Bureau of Prisons (BOP) and U.S. Immigration and Customs Enforcement (ICE), GEO was successfully able to modify existing agreements and the physical plant to create the Folkston ICE Processing Center at the existing D. Ray James site. A separate annex, which is a self-contained facility, located approximately a half mile down the road was modified and opened on July 20, 2018. The facility houses adult males.

The main compound consists of three buildings, a building that contains all administrative offices, the kitchen, intake, the main entrance, and medical. There are two housing units similar in design; one unit has dormitory pods and the other cells. Entrance to the facility is controlled by secured fences, and doors. The GEO Detention Officers working in main control operate the locked main entrance doors and have to grant access to the facility. Two GEO Detention Officers are stationed in the lobby, anyone entering the facility is subject to search, and must pass through a metal detector.

The main compound intake area, where the detainees are processed into the facility, has multi-occupancy cells that are utilized when detainees are entering and leaving the facility. These cells have toilets located within the cells, the toilet is behind a wall, and the windows partially painted. The toilets in these cells are located behind walls that provide privacy while toileting and are not visible from outside the cell. The medical departments in both the main compound and annex have multi-occupancy cells; these are also treated in the same manner.

The A housing unit is a dormitory style unit with eight dormitory style pods, with a housing capacity of 512. The B housing unit is a celled unit with five pods with cells for housing, and a housing capacity of 268. The main entrance door to the housing unit is secured access; the unit is controlled by the housing unit officers who will unlock the door upon verification of the persons entering. A control room is elevated in the center of the building to provide an overview of all pods. The A housing unit has the showers and bathrooms located on the rear wall of each pod. The showers and toilets have curtains and walls to block view by opposite gender staff members and overall provide privacy. The B Housing unit has the toilets within the cells and the showers on the rear wall of the pod. The cell doors limit the view of the toilet, and the showers have curtains. (b) (7)(E) [redacted]

The annex consists of two buildings, this is a self-contained facility with all of the same amenities, except the meals, are brought from the main compound. The entrance is secured, and the main building contains offices, visitation, intake, and medical. The C housing unit is constructed in the same manner, with a non-operational central control room and six pods. Five of the pods are cell pods, and one is a dormitory pod. They are constructed in the same manner as the main compound pods. (b) (7)(E) [redacted]

All of the pods throughout the main compound and annex have a gender announcement reminder posted at the entrance to the pod.

All of the pods have a telephone available to the detainees. Posted by the telephones is the information on DHS Office of Inspector General Poster, ICE Detention Reporting and Information Line Poster, including addresses and phone numbers, the instructions on how to report to the Office of the Inspector General using the telephone, and consulate information. The Satilla Advocacy Services information is also posted, they provide victim advocacy for the detainees.

The kitchen in the main compound prepares all of the meals for the facility; the detainees eat the meals on the housing units. Volunteer detainees work in the kitchen and laundry.

The average detainee population for the last 12 months was 869, with the average length of time in custody at the facility being 45 days. The facility has detained 6,652 adult males over the past 12 months. It should be noted that the annex came online on July 20, 2018.

The facility is staffed by 195 GEO staff and 9 ICE staff who are on rotation at the facility. The facility does have one ICE Detention and Deportation Officer assigned permanently to the facility.

The facility has had 2 closed PREA related allegations over the past 12 months; both were unsubstantiated. The two allegations were investigated by the trained facility investigators and referred to the Folkston Police Department, with no criminal prosecution.

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

Interview Type	Number
Random Detainee Interviews	20
Detainees who are limited English proficient	16
Detainees with a Cognitive Disability	3
Detainees who identify as gay, or bisexual	3
Total Individual Detainee Interviews	42

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

The Auditors conducted the interviews with all detainees, in the same manner, a preamble to the interview was relayed to the detainee by the Auditor explaining the purpose of the interview, and how they were selected, and explaining to them that they did not have to speak with the Auditors if they choose not to. No detainees refused to speak with the Auditors. All detainees were asked questions utilizing the Detainee Interview Guides for Immigration Detention Facilities. During the interviews, the Auditors utilized a copy of the initial PREA information provided to every detainee upon arrival at the facility, which includes the ICE National Detainee Handbook, Folkston ICE Processing Center Supplement to the National Detainee Handbook, and the Sexual Abuse and Assault Awareness pamphlet. The Auditors further utilized a blank copy of the acknowledgment form they would sign for the PREA information received at intake. These materials were used to visually stimulate the detainee's recollection of their initial intake process. The Auditors utilized Language Services Associates for interpretation during 16 interviews with multiple languages.

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

Interview Type	Number
Contracted GEO Detention Officers	11
ICE Deportation Officer	1
GEO Supervisors	2
Medical/Mental Health	3
Intake Staff	1
Investigative staff	1
Human Resources	1
Warden	1
GEO PREA Director	1
PSA Compliance Manager	1
Total Staff Interviews	23

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

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

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

- Warden Patrick Gartland (GEO)
- Assistant Field Officer Director (AFOD) ICE (b) (6), (b) (7)(C)
- GEO PREA Director (b) (6), (b) (7)(C)
- ERO PREA Field Coordinator (b) (6), (b) (7)(C) (GEO)
- Health Services Administrator (b) (6), (b) (7)(C) (GEO)
- Classifications (b) (6), (b) (7)(C) (GEO)
- Compliance Administrator (b) (6), (b) (7)(C) (GEO)
- Regional PREA Coordinator (b) (6), (b) (7)(C) (GEO)
- Executive Secretary (b) (6), (b) (7)(C) (GEO)
- PSA Compliance Manager (b) (6), (b) (7)(C) (GEO)
- Maintenance Manager (b) (6), (b) (7)(C) (GEO)
- Training Officer (b) (6), (b) (7)(C) (GEO)
- Fire/Safety Officer (b) (6), (b) (7)(C) (GEO)

At this time, the Auditor provided an overview of the audit findings. The Auditor explained that overall, it was found the staff at the facility is extremely knowledgeable in the PREA Standards, sexual safety, and overall security. We further discussed the PREA Standards that the facility achieved a determination of Does Not Meet Standard. The issues causing deficiencies ratings are procedural intake issues at the facility. The Auditors found that during the intake process, the detainee would be placed in a holding cell and be individually brought out to be questioned by the Intake Officers. During this time a video will be playing that provides the PREA information in two languages, English and Spanish, the video also contained a portion on detainee rights. All detainees signed a form that stated they watched the PREA video and understood the information. The facility houses detainees who speak many languages, to include those that are uncommon. The facility also had all detainees sign for an ICE National Detainee Handbook, which is only printed in ten languages. There is reporting information in the ICE National Detainee Handbook titled Break the Silence, but is only available in eight languages. The detainee would then be brought to a separate area and wait to be screened by medical personnel. The audit interviews confirmed that on April 8, 2019, a process was implemented where medical personnel would read the PREA Detainee Comprehensive Notification to the detainees, who could not read nor understand the form. This was being conducted through language line services. The detainee would sign the form which is filed in the detainee's file. The detainee would not be provided any information in a language they understood to take with them. In the housing units, the reporting information is posted in limited languages and does not address all of the primary languages spoken at the facility. The detainee interviews suggested that the detainees who spoke uncommon languages did not understand PREA nor the reporting avenues. The majority of the interviewed detainees stated they had not received an ICE National Detainee Handbook. This process

causes the facility to be non-compliant with standards: §115.16 – Accommodating detainees with disabilities and detainees who are limited English proficient, §115.33 – Detainee education, and §115.51 – Detainee reporting. The Auditor explained in the exit briefing that the non-compliance stems from the lack of education, which causes the failure to accommodate limited English proficient detainees and fails to provide them with a reporting avenue they can understand.

For standard 115.16, until two weeks prior to the audit the facility was not providing information through the language line, they were just giving them material in in a language they could not understand. The Auditor recommended that the facility create a separate orientation/education process that takes place after the initial intake and while the detainees are waiting to see medical. The facility should identify the languages they interact with the most and have the forms translated by a language services agency into a document that detainees can understand; and provide them a copy for reporting purposes. They also need to remove any documentation that detainees are signing that state they have seen a video in a language they understand, and if they are giving them an ICE National Detainee Handbook, they have to be able to read the language. The Auditors expressed that they were further concerned over the misleading nature of the forms, which are signed by the detainees stating they watched the PREA Video and received an ICE Detainee Handbook, which both are not accurate if the video is only in English and Spanish and the ICE Detainee Handbook is not provided in all languages.

For standard 115.33, the Auditor explained that the PREA Detainee Comprehensive Notification fulfills the obligation under detainee education. However, the detainees interviewed were not knowledgeable on reporting and PREA information. The facility needs to educate the detainees in a manner they understand; which includes, in a language all detainees can understand, and they must be given materials they can take with them that explain the reporting avenues.

For standard 115.51, the detainee interviews revealed detainees were not knowledge on how to report an allegation. The facility is not complaint with this standard since they were not providing instruction on how detainees may contact their consular, DHS OIG, or designated office for reporting of an allegation. The standard states the agency shall provide and shall inform, the detainees at least one way to report to a public or private entity. This again was not occurring until two weeks prior to the audit. They have not created historical data to support compliance.

The Auditors were also unable to inspect the newly installed camera views. It is unknown what the camera views will be once they are operational.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 3
§115.17 Hiring and promotion decisions
§115.31 Staff training
§115.35 Specialized training: Medical and mental health care

Number of Standards Met: 35
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.15 Limits to cross-gender viewing and searches
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of audits.

Number of Standards Not Met: 3

§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.33 Detainee education
§115.51 Detainee reporting

Number of Standards Not Applicable: 1

§115.14 Juvenile and family detainees

PROVISIONS

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

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

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

Notes:

Documentation Reviewed:

- The GEO Group, Inc. Folkston ICE Processing Center Policy and Procedure Manual Chapter: Security and Control Title: Sexual Abuse Assault Prevention and Intervention (SAAPI) Program for Immigration Detention Facilities Number 10.1.1, (henceforth referred to as GEO/FIPC policy 10.1.1)
- Folkston ICE Processing Center Organizational Chart
- GEO Group, Inc. Organizational chart
- GEO Group PREA Policy 5.1.2
- GEO Group PREA Investigations Policy 5.1.2-E

(c): The GEO/FIPC policies 5.1.2 and 10.1.1 mandates zero tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to incidents of sexual abuse and sexual harassment. The policy furthermore defines sexual abuse and sexual harassment. The facility updated the policy 10.1.1 in 2018; the policy changes were approved by the GEO PREA Director on June 14, 2018. GEO policy 5.1.2 is published on the GEO/facility's website.

(d): GEO employs a corporate level PREA Coordinator that oversees the company's PREA compliance throughout all company facilities. The PREA Coordinator supervises three regional PREA Coordinators for the East, West, and Central regions. Their roles are to assist facilities with any PREA technical assistance and conduct mock audits. The corporate PREA office also contains one PREA Senior Contract Compliance Manager and two PREA Contract Compliance Managers, and one Data Specialist. The Data Specialist is responsible for collecting and analyzing PREA data and preparing required reports. At the facility level, the PSA Compliance Manager is responsible for overseeing policies and procedures related to the PREA standards and ensures facility compliance. The PSA Compliance Manager stated that until three weeks prior to the audit, he was still a shift commander and conducting his PREA obligations as well as running a shift. He stated that he had sufficient time to dedicate to PREA, but now he will be able to dedicate all of his time to making PREA rounds, reviewing policy, and ensuring that the facility is meeting all of its obligations. The Auditor found him to be very knowledgeable of the facility's PREA policies and procedures and his responsibilities for coordinating the facility's efforts to comply with the PREA standards. The PSA Compliance Manager was very knowledgeable and active in the audit process.

The Auditor reviewed the policies in their entirety, as well as questioned staff members on the content and applicable sections to their specific duties within the facility. The staff understood policy 10.1.1 and its practical application to the daily operation of the facility.

Before the onsite audit, the Auditor reviewed all documentation. During the onsite portion, the Auditors observed policy 10.1.1 in daily practice and further confirmed the daily practices during the interviews with both staff and detainees.

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

§115.13 - Detainee supervision and monitoring.

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

Notes:

Documentation Reviewed:

- GEO/FIPC policy 10.1.1
- Staff Rosters
- Housing Unit Post orders
- Housing unit logbooks
- Staffing Plan
- Staffing Plan Review by the PSA Compliance Manager
- Investigative Files

(a): The facility has developed facility staffing guidelines that provide for adequate levels of staffing, and, where applicable, video monitoring, to protect detainees against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring the facility, the facility has taken into consideration all areas enumerated under this standard. (b) (7)(E) [redacted] The Auditor further questioned the Warden and random staff on the policies and the ability to fully staff the facility at all times; they confirmed that shifts are filled with mandatory or voluntary overtime if needed. The facility security is overseen by the GEO staff, who deal directly with the detainees. During the interviews, the Auditor confirmed that they work three shifts (b) (7)(E) [redacted] The shift supervisors work (b) (7)(E) [redacted] They employ both female and male staff; these staffing guidelines provide direct supervision of the detainees, with staff assigned to the housing units, and to oversee detainee movement. The staffing guidelines were further confirmed during the onsite audit, where the Auditor observed staff supervising the detainee movement, housing unit supervision, video

monitor review, and random cell checks taking place. The Auditor reviewed the investigative files, and reviews conducted by the administration at the facility. Thee were no recommendations made for changes in staffing or deployment of any video monitoring.

(b): Policy 10.1.1 and the housing unit post orders outline the detainee supervision guidelines. The post orders outline the responsibility of the GEO Detention Officers to make 30-minute rounds through every housing unit and log the rounds in the logbook. In housing units, A and B, an officer is stationed in the control room, which has a direct view into each pod. The supervisors make rounds on each shift and log their rounds in the logbook. The supervisors stated that the (b) (7)(E) [redacted]. The Auditor reviewed the logbooks on every housing unit and confirmed these rounds are taking place; this practice was further confirmed during the staff interviews. An annual review of the staffing plan was conducted on August 8, 2018, by facility administration, and signed by the GEO PREA Director. All post orders were reviewed for the assessment, as well as all PREA incidents for the previous year. The assessment takes into consideration the 11 PREA incidents and the reviews that occurred from August 2017 to August 2018.

(c): The facility has developed a staffing plan that is based on the seven criteria of the standard to include generally accepted detention and correctional practices; any judicial finding of inadequacy; the physical layout, composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse; the findings and recommendations of sexual abuse incident review reports, and any other relevant factors including but not limited to the length of time detainees spend in facility custody. During the staffing plan review period, which was for 12 months prior to 8/16/18, the facility did not have any substantiated incidents of sexual abuse. The Auditor reviewed the two investigations at the facility for the auditing period, incident reviews were conducted by the PREA Coordinator and Facility Administration. The reviews did not recommend any staffing changes, and they found that staffing did not contribute to the incident. This process is outlined in policy 10.1.1. The staffing plan was developed by the facility administration, including the Warden, Chief of Security, and the facility PSA Compliance Manager with input from the GEO PREA Director. During the interviews with both the Warden and PSA Compliance Manager, the Auditor confirmed that all critical posts are being filled, and mandatory or voluntary overtime is utilized. They further stated that they have over 70 new hires who are either in the GEO background process or the ICE background process. The new hires will help minimize overtime usage. The review of the staffing plan on August 8, 2018, indicated that there were no deviations to the staffing plan; this was further confirmed by the facility in a memo to the Auditor. During the audit the Auditor reviewed daily rosters that all critical posts were being filled, this was being accomplished through the use of overtime. The staffing plan for the facility indicates that the facility had a large number of vacancies per shift, which were filled with overtime. The Human Resources Personnel confirmed that the clearance process is taking such a long time that applicants are finding employment elsewhere prior to being cleared to work at the facility. Although this hiring and vacancy process is concerning to the Auditor, the utilization of overtime ensures the critical posts are filled per shift, and supervision needs are being met.

(d): The shift supervisors make unannounced rounds on the housing units during each shift, policy 10.1.1 prohibits staff from alerting anyone that these rounds are taking place. The supervisor logs the rounds into each pod logbook in red pen. The Auditors observed these log entries when examining the logbooks for each pod. The rounds were confirmed during the detainee and GEO staff interviews. The detainees recalled supervisors making rounds on the pods. The interviewed staff included supervisors and detention officers from both shifts.

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

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The Folkston ICE Processing Center does not house juvenile or family detainees. This was confirmed during the interview with the Warden who stated that if anyone under the age of 18 was brought to the facility, they would be immediately transferred. Policy 10.1.1 and the ICE Contract further outlines that the facility will not house juvenile or family detainees.

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

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

Notes:

Documentation Reviewed:

- GEO/FIPC policy 10.1.1
- Memo to Auditor from the Facility Warden

(b)(d): Policy 10.1.1 states cross-gender pat searches of male detainees shall not be conducted unless, after reasonable diligence, the staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. When exigent circumstances are present, a supervisor will be contacted before the search, and an incident report will be filed regarding all cross-gender searches. The search will also be documented using the Cross-Gender Pat Search Log. The staff interviewed indicated that they had not conducted or were aware of any cross-gender pat-down searches conducted. Detainees interviewed confirmed that they are only searched by males. During the audit year, there were no cross-gender pat-searches conducted. A memo supported this. Pat-down searches observed during the audit were conducted by the same sex staff member.

(c): This section is non-applicable. The facility does not house female detainees.

(e/f): Policy 10.1.1 outlines cross-gender strip searches or cross-gender body cavity searches shall not be conducted except in exigent circumstances and documented on the cross-gender pat down search log. The medical staff and security staff interviewed were aware of the policy and understood the facility protocols for conducting strip or body cavity searches, and if performed shall be approved by a supervisor and documented by incident reports and on the Cross-Gender Pat Search Log. No cross-gender strip or body cavity searches were conducted in the previous 12 months. This was confirmed through a memo to the Auditor.

(g): Policy 10.1.1 outlines the policy and procedures which allow detainees to shower, perform bodily functions and change clothing without employees of the opposite gender viewing them except in exigent circumstances or when incidental to routine cell checks. Detainees interviewed

indicated they felt they had enough privacy to change their clothes, shower, and perform bodily functions. They were not observed by the staff of the opposite gender. Staff also confirmed the detainees have privacy for these functions. In the dormitory pods, the showers and toilets have curtains and walls, in the cell pods the toilet is located within the cell which has an operating door, and the showers have curtains. The intake and medical cells have the windows painted to a height where you cannot see the toilet. The policy also requires a staff of the opposite gender to announce their presence when entering detainee housing areas; this was observed during the audit. There is a sign posted on each pod door that states "Opposite Gender Must Announce When Entering." Detainees interviewed stated that staff of the opposite gender announce when entering the housing unit by loudly stating female on the unit. The limited English proficient speaking detainees stated that they recognize the females voice and other detainees will also announce in languages they understand. Staff is also provided training on unannounced rounds and during interviews indicated that announcements are made upon entering the housing units.

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

(i): Detainees will not be searched for the sole purpose of determining the detainee's genital status. Policy 10.1.1 prohibits staff from searching or physically examining a detainee to determine genitalia status. The review of the training lesson plans, PREA ICE Facilities and Pre-Service Prison Rape Elimination Act ICE 2018, documented these policies are covered in annual training. During interviews with detention and medical staff, they were aware of the policy and indicated that only medical could conduct such a search. No searches have occurred in the audit period per a memo and interview with PSA Compliance Manager. There were no transgender or intersex detainees housed during the audit to interview.

(j): Policy 10.1.1 states that security staff shall be trained in conducting pat-down searches, cross-gender pat-down searches, searches of transgender and intersex detainees in a professional and respectful manner. Other than annual training, this training is also part of the initial new hire training and covered frequently in shift briefings. During the interview with the facility training coordinator, she confirmed these practices and provided the Auditor with the signed training acknowledgment forms. The interviewed staff confirmed the training and understood the policy and indicated the transgender/intersex detainee could request the gender of the officer to conduct the pat-down search and the pat-down would be conducted using the back or blade of the hand.

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

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

- GEO/FIPC policy 10.1.1
- National detainee handbook in multiple languages
- Facility supplemental handbook
- PREA acknowledgment forms
- PREA Handout in multiple languages

(a) Policy 10.1.1 outlines the facility's procedures to ensure disabled detainees have equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. During the intake staff and medical personnel interviews, the Auditors confirmed the steps taken to effectively communicate with disabled detainees. Detainees who are deaf or hard of hearing would be provided the facility and the ICE Detainee handbooks and if needed sign language translation would be provided through video conference. A detainee with limited reading skills, cognitive disability, or blindness would have the materials read to them and explained in depth, so that they would understand. Medical staff confirmed that they now read the PREA information to all detainees during intake, and would identify any disability, and ensure the material is provided effectively, accurately, and impartially. The facility is not in compliance with subsection (b) of this standard, although the procedures are in place to educate disabled detainees, they are not providing the information in a language they can understand.

(b) As outlined in the corrective action, the facility is not in compliance with these subsections of the standard. The Auditors found that during the intake process, the detainee would be placed in a holding cell and be individually brought out to be questioned by the Intake Officers. During this time a video will be playing that provides the PREA information in two languages, English and Spanish, the video also contained a portion on detainee rights. All detainees signed a form that stated they watched the PREA video and understood the information. The facility houses detainees who speak many languages, to include those that are uncommon. The facility also had all detainees sign for an ICE National Detainee Handbook, which is only printed in ten languages. There is reporting information contained in the handbook but is only in ten languages. The detainee would then be brought to a separate area and wait to be screened by medical personnel. Until two weeks prior to the audit, the facility was not providing information through the language line, they were just giving them material in in a language they could not understand. The audit interviews confirmed that on April 8, 2019, a process was implemented where medical personnel would read the PREA Detainee Comprehensive Notification to the detainees, who could not read nor understand the form. This was being conducted through language line services. The detainee would sign the form which is filed in the detainee's file. The detainee would not be provided any information in a language they understood to take with them. On the housing units, the reporting information is posted in limited languages and does not address all of the primary languages spoken at the facility. The detainee interviews suggested that the detainees who spoke uncommon languages did not understand PREA nor the reporting avenues. The majority of the interviewed detainees stated they had not received an ICE National Detainee Handbook. This process causes the facility to be non-compliant with standards. Upon completion of a corrective action period, the evidence of compliance will be evaluated to determine compliance. The Auditor recommended that the facility create a separate orientation/education process that takes place after the initial intake and while the detainees are waiting to see medical. The facility should identify the languages they interact with the most and have the forms translated by a language services agency into a document that detainees can understand; and provide them a copy for reporting purposes. They also need to remove any documentation that detainees are signing that state they have seen a video in a language they understand, and if they are giving them an ICE National Detainee Handbook, they have to be able to read the language. The Auditors expressed that they were further concerned over the misleading nature of the forms, which are signed by the detainees stating they watched the PREA Video and received an ICE Detainee Handbook, which both are untrue if the video is only in English and Spanish and the ICE Detainee Handbook is not provided in all languages.

(c) Policy 10.1.1 states that minors, alleged abusers, detainees who witnessed the alleged abuse and detainees who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of sexual abuse. The GEO policy does not allow the detainee to express a preference for another detainee to provide interpretation. The facility has a contract with Language Line Services Inc. for translation services effective February 1, 2011. A copy of the contract was provided for documentation. Several staff at the facility are bilingual and can help communicate. During the staff interviews, they indicated that they would use a bilingual staff member or the language line for translation. The detainees interviewed with limited English proficiency indicated they communicate with a staff member utilizing the language line and would ask for those services if an incident did occur.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility is not in compliance with the standard and all provisions.

§115.17 - Hiring and promotion decisions.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Training materials from ICE PREA Training on September 25, 2018
- Background Check Process Presentation on September 25, 2018 during the ICE PREA Training
- Completed DHS Background Clearance Form for ICE Employees and Contractors
- Office of Personnel Management Part 731-Suitability
- Executive Order 10450- Security requirements for Government employment
- U.S. Immigration and Customs Enforcement Directive No.: 6-7.0
- U.S. Immigration and Customs Enforcement Directive No.: 6-8.0

(a), (b), (c), (d) The facility utilizes the Personnel Security Unit (PSU) to conduct the background investigations on any applicant, employee, or contractor with the agency. This investigation ensures that the facility does not hire or promote anyone who may have contact with detainees, nor enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. This unit promotes the integrity and efficiency of ICE by making risk-based decisions in evaluating whether applicants, employees, and contractors meet suitability, security, and National Security Information access requirements. They conduct personnel security reviews on everyone that works for ICE by ensuring they are suitable for the position selected and that they maintain a high level of character. During the background process the applicant, employee or contractor is asked questions directly related to sexual abuse in confinement settings enumerated in the standard, these questions are asked both in a written form and in person by the assigned investigator who conducts the interviews. During the staff interviews at the facility, the Auditor confirmed that all contractors and employees were asked these questions. The facility imposes a continuing affirmative duty to disclose any misconduct, whether it is related to sexual misconduct or not. The standard addresses the utilization of this process in the promotional system. After reviewing the above policies, and during the PSA Compliance Manager and Human Resources interview, the Auditor confirmed if any employee or contractor that were involved in any misconduct of this nature, they would not be employed by GEO. The Auditor completed a PREA Audit: Background and Investigation for Employees and Contractors DHS Facilities forms. This form was submitted to the PSU. The Auditor confirmed the background investigations and five-year reinvestigation for 5 ICE employees and 19 contractors at the facility. All of the backgrounds but one was in the specified time limit of five years. The Auditor was informed that the PSA Compliance Manager has failed to respond to several emails to the PSU to initiate his reinvestigation, due to the PSU having the wrong email address.

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

(e) & (f) The Auditor attended training in Arlington, Virginia where PSU Unit Chief (b) (6), (b) (7)(C) presented information on the background investigation process. During this training, he confirmed that any material omissions, intentional false statement, or deception is a factor that would make an applicant, employee, or contractor unsuitable for employment, and employees will be terminated. He further confirmed that they would, unless prohibited by law, provide information on a substantiated allegation of sexual abuse involving a former employee or contractor, to any requesting confinement facility. The Auditor confirmed with the facility's Human Resources staff that they would also follow the provisions of this standard and provide any information on a substantiated allegation of sexual abuse involving a former employee or contractor, to any requesting confinement facility.

The prevention of sexual abuse in any agency begins with the hiring process and initial background investigation. ICE utilizes a system where not only current misconduct is identified, which will make the applicant, employee, or contractor unsuitable for employment, but continually monitors their employees and contractors for any misconduct or behavior that will make them unsuitable in the future. Due to the nature of the work DHS performs this process is necessary to create a safe environment for detainees who are held in their custody or detained at a contracted facility. The process exceeds the language in the standards, they not only are considering sexual misconduct, but any misconduct, dishonesty, alcohol abuse, or any other behavior or activity that is considered unsuitable.

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

§115.18 - Upgrades to facilities and technologies.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Facility Schematic identifying camera locations

(a) The facility has had no modifications or expansions to the building. The PSA Compliance Manager and Warden stated that the overall protection of detainees would be taken into consideration during any modifications or expansions.

(b) The facility is currently going through video management upgrade at the main compound, and an upgrade is scheduled for the annex in 2020. (b) (7)(E) [redacted] (b) (7)(E)

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

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Memorandum of Understanding (MOU) with Satilla Advocacy Services
- Email from Memorial Satilla Health
- ICE Policy 11062.2 Sexual Assault and Abuse Prevention and Intervention

(a): Any allegation at the facility is immediately reported to the PSA Compliance Manager, and an investigation is immediately started. The allegations are also reported to the Folkston Police Department (PD) and ICE, including to the AFOD and ICE staff at the facility for investigation and further action. The two reviewed investigations have been conducted by the facility trained investigators, but the Folkston Police Department, Office of Professional Responsibility (OPR), or Office of Inspector General (OIG) has the option to assume responsibility of the investigation. OIG and Folkston PD declined to investigate; they were not criminal in nature. Policy 10.1.1 outlines the facility's evidence and investigation protocols. The facility utilizes the Department of Justice (DOJ's) National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents 2nd Edition for the uniform evidence protocol as indicated by the PSA Compliance Manager. The protocols are incorporated into the facility's SAAPI Coordinated Response Plan. The SAAPI Coordinated Response Plan provides a guideline for staff to follow when responding to an allegation. The protocols are approved by GEO Corporate and ICE as part of the annual policy review. The facility does not house juvenile detainees. Per policy 11062.2, when OPR accepts a case, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel by OPR policies and procedures. The OPR will coordinate with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation.

(b/d): The facility has a (MOU) agreement with Satilla Advocacy Services for victim advocacy and an agreement with Memorial Satilla Health for sexual assault examinations. The MOU states that Satilla Advocacy Services will provide immediate advocacy, crisis intervention, information, and referrals if needed. They would have a qualified advocate respond in person to the facility or other locations as requested to provide advocacy and emotional support during the sexual assault examination and investigative interviews. The MOU was executed on May 3, 2018. The PSA Compliance Manager stated during his interview that the services are free of charge to the detainee, and the hotline is available 24-hours a day for the detainees. The hotline number and victim advocacy services are provided to the detainees on a poster on the pods in English and Spanish. No services of this nature were provided as documented in the two reviewed investigation files based upon the allegations. The information on how to contact the Satilla Advocacy Services was provided to the detainees, but due to confidentiality, it is unknown if they were contacted.

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

(e): The interviewed investigators which include the PSA Compliance Manager stated that all allegations are reported to the Folkston Police Department and ICE, including to the AFOD and ICE staff at the facility for investigation and further action. The facility does have an MOU with the Folkston Police Department, but the PSA Compliance Manager stated that they had reported all incidents to them, although they have never responded to one. The MOU states that the Folkston Police Department will follow the requirements of the standards. The reviewed investigative files indicated these notifications were made.

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

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

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

Notes:

Documentation Reviewed

- Policy 10.1.1
- Policy 5.1.2 PREA Policy
- Policy 5.1.2-e Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection
- Facility PREA Investigation files
- ICE Policy 11062.2 Sexual Assault and Abuse Prevention and Intervention

(a/d): Policies 10.1.1 and 5.1.2-E Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection state all criminal allegations are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations. Upon a staff member receiving an allegation, they will immediately report the allegation to their supervisor, which will begin the investigative process. All investigations are immediately referred to the facility investigators and PSA Compliance Manager, who will notify the AFOD and the ICE staff at the facility. The PSA Compliance Manager stated that they would immediately begin the investigation. All investigations are reviewed by the OPR. The Investigator stated that OPR would review all cases to determine if an investigation is required by OIG. All allegations involving staff, volunteers, and contractors are investigated by OPR. ICE policy 11062.2 outlines the evidence and investigation protocols. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If the OPR investigators do not conduct the investigation, the facility investigators will. All reviewed investigations at the facility were conducted by the facility investigators. The PSA Compliance Manager stated that the Folkston Police Department is notified of all investigations, although they have not responded to any. While reviewing the investigations, the Auditor confirmed the investigation process, including the notifications to OPR, and the Folkston Police Department.

(b): Policies 10.1.1 and 5.1.2 outlines the responsibilities of the facility and other investigative agencies. The PSA Compliance Manager stated that he is notified of every allegation, and will follow the policies to ensure the investigative steps are being followed. He is also a trained investigator and has conducted the 2 investigations at the facility in the past 12 months. He also indicated that as per policy, all investigations are stored for at least ten years. While conducting his interview, he indicated that the investigations are stored in his office in a locked file cabinet.

(c): The Auditor reviewed the GEO website at www.geogroup.com/PREA. The website has a page dedicated to PREA, 5.1.2 PREA Policy, and 5.1.2-e are available to the public for review. The page contains the zero-tolerance policy, how to report sexual abuse or sexual harassment, and how an employee may report sexual abuse or sexual harassment. There is a paragraph that explains the investigation process that states if the allegation potentially involves criminal behavior, GEO will ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations. The ICE website, www.ice.gov/prea includes PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE Detainee Handbook, ICE PREA poster, and ICE PREA pamphlet.

(e/f): Policy 10.1.1 indicates that all incidents are promptly reported to the Joint Intake Center (JIC), ICE OPR, and/or DHS OIG, as well as, the appropriate ICE FOD. If the incident is potentially criminal and a staff member, contractor, volunteer, or detainee is alleged to be the perpetrator of sexual abuse. The incidents are reported to the Folkston Police Department for investigation. The PSA Compliance Manager stated that the notifications are being made as per policy; this was confirmed through review of the investigative files.

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

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- GEO Employees training PowerPoint and training rosters
- Training PowerPoints for Cross-gender, Transgender, and Intersex Searches

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

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

- The requirement to limit reporting of sexual abuse or assault to personnel with a need-to-know to make decisions concerning the victim's welfare and for law enforcement or investigative purposes.

(b): All training is completed every year, and quarterly refresher training is provided. The training was verified through interviews and reviewing signed training certification forms. The training certificates reviewed date back to calendar year 2016, the year of incorporation of PREA. The PREA training requirements is outlined in policy 10.1.1.

(c): The facility documents the training on a roster, they further provide quarterly refresher training to ensure that all employees know GEO's current sexual abuse and assault policies and procedures. The Auditor reviewed the training materials; these were provided to the Auditor before the onsite audit. The Auditor further reviewed the training retention schedule for the facility, which indicates the records are retained for five years. This was further confirmed during the review of the electronic training records that dated back five years.

During the staff interviews, the Auditor verified they had received the training. They verified that they had viewed the training and were able to explain their responsibility under the standards.

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

§115.32 - Other training.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Contractor and volunteer training materials

(a)(b)(c): The facility has trained all contractors and volunteers who may have contact with detainees on their responsibility under the facility's zero-tolerance policy, and their obligation to immediately report such incidents. The training is dependent upon the level of service they provide and the level of contact they have with the detainees. The training is documented by the facility training officer, and the contractor or volunteer acknowledges receipt of the training. During the interview with the training officer, she confirmed that the training took place and provided the Auditor with the signed acknowledgment forms. During the onsite audit contractors who were installing the new camera system were interviewed, they all confirmed that they received the training and understood their responsibilities under the policy 10.1.1.

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

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- PREA Video
- National Detainee Handbook
- Folkston Processing Center Supplement to the National Detainee Handbook

(a)(b)(c) Policy 10.1.1 outlines the facility intake process that ensures all detainees are notified of the facility's zero-tolerance policies for all forms of sexual abuse. This process includes instruction on prevention and intervention strategies, self-protection and indicators, definitions, examples of detainee-on-detainee sexual abuse, and staff-on-detainee sexual abuse and coercive sexual activity. They also inform the detainees of reporting methods which include reporting to staff, the DHS OIG, and the JIC. This includes the prohibition against retaliation, an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The audit interviews confirmed that on April 8, 2019, a process was implemented where medical personnel would read the PREA Detainee Comprehensive Notification to the detainees, who could not read nor understand the form. This was being conducted through language line services. The detainee would sign the form which is filed in the detainee's file. This process includes limited English proficient detainees, deaf, visually impaired, or otherwise disabled, as well as, to detainees who have limited reading skills. Prior to this date, the detainees were not receiving information in a language they could understand. The Auditor explained in the exit briefing that the non-compliance stems from the lack of education, which causes the failure to accommodate limited English proficient detainees and fails to provide them with a reporting avenue they can understand. The Auditor explained that the PREA Detainee Comprehensive Notification fulfills the obligation under detainee education. However, the detainees interviewed were not knowledgeable on reporting and PREA information. The facility needs to educate the detainees in a manner they understand; which includes, in a language all detainees can understand, and they must be given materials they can take with them that explain the reporting avenues. The Auditor recommended that the facility create a separate orientation/education process that takes place after the initial intake and while the detainees are waiting to see medical. The facility should identify the languages they interact with the most and have the forms translated by a language services agency into a document that detainees can understand and provide them a copy for reporting purposes. They also need to remove any documentation that detainees are signing that state they have seen a video in a language they understand, and if they are giving them an ICE National Detainee Handbook, they have to be able to read the language. The Auditors expressed that they were further concerned over the misleading nature of the forms, which are signed by the detainees stating they watched the PREA Video and received an ICE Detainee Handbook, which both are untrue if the video is only in English and Spanish and the ICE Detainee Handbook is not provided in all languages. As outlined in the corrective action, the facility needs to create a consistent educational program to ensure all detainees are notified and understand the facility zero tolerance policy.

(d) The facility has posted notices on all housing units the DHS-prescribed sexual assault awareness notice; the PSA Compliance Manager contact information; and name of local organizations that can assist detainees who have been victims of sexual abuse. These postings are in limited languages and cannot be read by detainees that do not read Spanish and English. The Auditor recommended that the facility identify the most commonly spoken languages and have these notices translated and posted in these languages.

(e) The facility provides the DHS-prescribed ''Sexual Assault Awareness Information'' pamphlet in English and Spanish, but again this is not translated in a language that all detainees can understand.

(f) Information about reporting sexual abuse is included in the National Detainee Handbook. The National Detainee Handbook is only translated into 10 languages, and most of the detainee handbooks provided to detainees at the facility were English versions regardless of the language they spoke. The PSA Compliance Manager confirmed during his interview that the week prior to the audit staff went to the housing units and distributed copies of the National Detainee Handbook to all detainees. This behavior indicates that they are not providing the handbook upon intake to the facility; but are still having detainees sign for them per staff interviews.

As previously stated in the corrective action all subsections of the standard are non-compliant, the facility is not properly educating the detainees upon arrival in the facility. The facility cannot comply with any provisions of this standard since they are not providing education or information in languages that all of the detainees can understand. Any posting on the housing units are in limited languages and can't be understood by all detainees. On April 8, 2019, they started a new education process where medical staff would read the materials to the detainee. This process has not been in effect long enough to produce historical data that could be used as evidence of compliance.

§115.34 - Specialized training: Investigations.

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

Notes:

Documentation Reviewed
- Policy 10.1.1
- Training certificates
- GEO Investigators Training PowerPoint

(a)(b): Policy 10.1.1 states that the allegations at the facility must be completed by qualified facility investigators. The investigators participate in an online five-hour training course that provides them the information on how to investigate sexual assault and harassment, interacting with traumatized victims, and evidence collection and retention. The investigators have issued a certificate indicating they have completed the training. The Auditor interviewed two of the three facility investigators and viewed their training certificates. One of the specialized trained investigators interviewed conducted the investigations on the two allegations reported. They understood the process of investigations; this was further confirmed during the review of the investigative reports.

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

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

Documentation Reviewed
- Policy 10.1.1
- Training materials for Specialized Medical and Mental Health PREA Training
- Training certificates for medical and mental health staff

(a)(b)(c): There are no ICE Health Services Corps. (IHSC) staff working at the facility making sections (a) and (b) non-applicable to this facility. All medical and mental health staff are employees of the facility. During the interviews, they confirmed that they received the Specialized Medical and Mental Health PREA Training. The Auditor reviewed the training materials and found that the lesson plan meets the requirements of provision (b) of the standard. This was further confirmed during the interview with the facility training officer, who provided the Auditor with the training certificates for medical and mental health staff. The facility's policy 10.1.1 was reviewed and approved by the agency on August 7, 2018.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility has substantially exceeded the requirements of this standard, and all provisions. This determination was made since the facility's policy 10.1.1 addresses the training requirements of the standard and training certificates for medical and mental health staff were provided that documented compliance with their policies and procedures. The policy ws approved by the agency.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

Documents Reviewed
- Policy 10.1.1
- GEO Folkston ICE Processing Center PREA Risk Assessment
- Detainee Risk Assessments

(a)(b)(c)(d)(e)(g): Policy 10.1.1 outlines the process utilized to assess a detainees' risk of victimization or abusiveness. The facility screens all detainees within twelve hours of arrival utilizing the GEO Folkston ICE Processing Center PREA Risk Assessment to identify those likely to be sexual aggressors or sexual victims and houses detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. The normal process is to have the detainee screened by medical following the initial intake process and if this does not occur the detainees are kept separate from the

general population on an intake pod until this process has taken place. The GEO Folkston ICE Processing Center PREA Risk Assessment tool takes into consideration the following:

- Whether the detainee has a mental, physical, or developmental disability;
- The age of the detainee;
- The physical build and appearance of the detainee;
- Whether the detainee has previously been incarcerated;
- The nature of the detainee's criminal history;
- Whether the detainee has any convictions for sex offenses against an adult or child;
- Whether the detainee has self- identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
- Whether the detainee has self- identified as having previously experienced sexual victimization; and
- The detainee's concerns about his or her physical safety.

They also take into consideration prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility.

The PSA Compliance Manager and Case Managers at the facility confirmed during interviews that the GEO PREA Vulnerability Questionnaire is utilized to reassess the detainees between 60 and 90 days or if warranted based upon receipt of additional information. The PSA Compliance Manager stated that no detainee is disciplined for refusing to answer, or for not disclosing complete information in the screening process. He also confirmed that the information is not available to the general staff, and is limited to medical, mental health, and case managers.

The facility medical personnel conduct the initial screening with the detainees, they confirmed during interviews that they utilize the Language Line Services for Limited English Proficient detainees. The Auditor reviewed both initial screening and reassessment documentation that was provided prior to the onsite audit and verified that both are taking place within the specified timeframe. While onsite, the Auditor reviewed 25 completed screening tools and reassessment documentation in the detainee files. All interviewed detainees confirmed they were assessed during the intake process by medical personnel.

The Auditor observed several detainees going through the intake process; and being assessed by the medical department utilizing the assessment tool.

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

§115.42 - Use of assessment information.

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

Notes:

Documents Reviewed

- Policy 10.1.1

(a): Policy 10.1.1 states that the information from the GEO Folkston ICE Processing Center PREA Risk Assessment is utilized to inform assignment of detainees to housing, recreation, activities, and voluntary work. The PSA Compliance Manager stated that these determinations are on an individualized basis. While onsite, the Auditor reviewed 25 completed screening tools and reassessment documentation in the detainee files.

(b): The PSA Compliance Manager stated that when making an assessment and housing decision for a transgender or intersex detainee, they consider the detainee's gender self-identification and how any placement will affect the detainee's health and safety. He also confirmed that the placement is not based solely on the identity documents or physical anatomy of the detainee, and their self-identification of his/her gender and self-assessment of safety is always taken into consideration, and all placements are consistent with the facility's safety and security. The medical staff conducts the initial assessments and consults with mental health; this was confirmed during their interviews. They can house the detainee in the medical area until they can conduct a Transgender Care Committee meeting to determine the best housing option. The placement of a transgender or intersex detainee is reassessed at least twice each year to review any threats to safety experienced by the detainee. The facility has not housed any transgender in the last 12 months where a reassessment needed to take place. The PSA Compliance Manager understood his obligations under the policy.

(c): Through policy review and Detention Officer interviews, the Auditor confirmed that a transgender and intersex detainee is allowed to shower separately from other detainees. They would have the detainee shower during count time when the other detainees were locked down, or they have the option to allow the detainee to shower in medical. They also confirmed that they assign a female Detention Officer to the pod where a transgender detainee would be housed, when concerns of cross-gender viewing of any developed female anatomy may arise.

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

§115.43 - Protective custody.

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

Notes:

Documentation reviewed

- Policy 10.1.1

(a)(b)(c)(d)(e): Policy 10.1.1 governs the management of the administrative segregation unit. These procedures were developed in consultation with the ERO FOD. The PSA Compliance Manager stated that they would document detailed reasons for the placement of an individual in administrative segregation on the basis of vulnerability to sexual abuse or assault, and as per policy notify the ICE AFOD within 72 hours. Policy 10.1.1 states that the use of administrative segregation to protect vulnerable detainees is restricted to those instances where reasonable efforts have

been made to provide appropriate housing and would be for the least amount of time practicable, and when no other viable housing options exist, as a last resort. The facility would assign detainees to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged; this would not last more than 30 days. The detainees would be provided access to programs, visitation, counsel, and other services available to the general population. Attachment G of 10.1.1 Sexual Abuse/Assault Available Alternatives Assessment is completed within 24 hours by a supervisor and emailed to the PSA Compliance Manager, and the status is reviewed within 72 hrs. The PSA Compliance Manager would conduct this review within seven days, and every week after that for the first 30 days, and every ten days after that. PSA Compliance Manager understood the policy, and his obligations if this occurred. He confirmed that they had not placed any detainees in segregated housing under these conditions during the audit period.

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

§115.51 - Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Documentation Reviewed
- Policy 10.1.1
- Facility Handbook
- National Detainee Handbook
- DHS PREA Posters

Posters for Satilla Victim Advocacy

(a)(b): Policy 10.1.1 established the facility's procedures for detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The facility provides instructions on how detainees may contact their consular official, the DHS OIG or, confidentially and, if desired, anonymously, report these incidents. The facility has also developed internal reporting avenues where the detainees can report directly to a staff member, through a request slip, and/or medical slip. The Auditor found that the information is not being provided to all detainees in a language they can understand, they have recently implemented a policy where they read the reporting information to the detainee utilizing the language line, but the detainee does not take anything with them to recall the reporting avenues. In the housing units, information is posted in limited languages, and the OIG reporting number is only in English and Spanish. The ICE National Detainee Handbook is only printed in 10 languages and does not represent the vast languages at the facility. The detainee interviews confirmed that not only did they not understand the zero-tolerance policy and they did not know how to report if something did occur. The standard is specific in stating that the agency and facility must provide instructions on how to contact their consular official, DHS OIG or another appropriate office. The Auditor found that the facility is not in compliance with these requirements of this standard. The non-compliance stems from the detainees' lack of knowledge on how to report if an incident occurred, and who to report to. The facility is not providing instruction on how detainees may contact their consular, DHS OIG, or designated office for reporting of an allegation. The standard states the agency shall provide and shall inform, the detainees at least one way to report to a public or private entity. This again was not occurring until two weeks prior to the audit. They have not created historical data to support compliance. The detainees are not provided information that outlines the reporting procedures in a language they can understand, nor is anything posted on the housing units in a language they can understand. The facility created a document that they have had translated into 20 languages they see most often. The document includes instructions on how to report an incident and who to report it too. These documents need to be provided to the detainees, so when they are on the housing units, they have something to refer to if they need to report an incident.

(c): Policy 10.1.1 states that staff will accept reports made verbally, in writing, anonymously, and from third parties. They will promptly document any verbal reports. The interviewed GEO Detention Officers and Supervisors understood their obligation under this standard, and stated they would accept reports made verbally, in writing, anonymously, and from third parties.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility is not in compliance with the requirements of this standard, and all provisions.

§115.52 - Grievances.

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

Notes:

Documentation Reviewed
- Policy 10.1.1
- Facility Handbook
- Policy 9.1.3 Detainee Grievance Procedure

(a/b): The facility policy 9.1.3 and the Facility Handbook addresses the detainee grievance procedure regarding sexual abuse. The facility does not impose a time limit for the submission of the grievance, the grievance would be considered under the emergency grievance procedure, and no informal grievance procedures are applied. The Grievance Coordinator stated that there are no time limits for sexual abuse grievances, if they received a grievance of this nature, it would immediately be reported to the PSA Compliance Manager for investigation. A locked grievance box is located on each housing unit pod.

(c)(d): Policy 9.1.3 outline the written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. The Grievance Coordinator confirmed that the Warden and PSA Compliance Manager would be immediately notified, they would then take immediate corrective action to protect the detainee. She further stated that all medical emergencies would be brought to the immediate attention of proper medical personnel.

(e): Policy 9.1.3 states that the grievance is initially responded to in 48 hours, and a final decision is provided within five days. As per policy, any appeal would be responded to within 30 days. The final grievance decision would be forwarded to the FOD. This process was confirmed by the facility Grievance Coordinator.

(f): Policy 9.1.3 and the Facility Handbook state that a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. The interviewed staff understood their obligations to expedite a grievance, and to assist if need be.

The facility has not had any grievances filed within the last 12 months for sexual abuse.

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

§115.53 - Detainee access to outside confidential support services.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- MOU with Satilla Advocacy Services

(a)(b)(c)(d): The facility has entered into an MOU with Satilla Advocacy Services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and prosecution of sexual abuse perpetrators. The MOU is dated May 3, 2018. The information, including mailing address and contact number, are posted in the housing units and further provided to victims of sexual abuse. Policy 10.1.1 establishes the procedures which include the outside agencies in the facility's sexual abuse prevention and intervention protocols. During the interview with the PSA Compliance Manager, he stated that all victims of sexual abuse are given the contact information for Satilla Advocacy Services, and informed that they could contact them at any time. He further confirmed that they would inform detainees, prior to giving them access to outside resources, of the GEO procedures which govern monitoring of communications and when reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The investigative files reviewed indicated that the detainees were given the contact information for Satilla Advocacy Services, but due to confidentiality, it is unknown if they were utilized. After the onsite audit, the Auditor contacted Satilla Advocacy Services and confirmed these procedures.

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

§115.54 - Third-party reporting.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Office of Inspector General Poster
- ICE Detention Reporting and Information Line Poster
- Contractor website www.geogroup.com/PREA

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

To report an allegation of Sexual Abuse/Sexual Harassment on behalf of an individual who is or was housed in any GEO facility or program or if you were previously housed in a GEO facility or program and needed to report an allegation of sexual abuse/harassment, you may contact the Facility Administrator's Office in the facility where the alleged incident occurred or where the individual is housed. Please see our locations page for each facility's contact information. Reports can be made over the phone, in person, in writing or anonymously if desired. You can also contact our Corporate PREA Coordinator (b) (6), (b) (7)(C) directly (see contact information below).

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

§115.61 - Staff reporting duties.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- GEO website www.geogroup.com/PREA

(a)(b): Policy 10.1.1 outlines the requirement of all staff to report immediately and according to policy any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The reporting requirement portion of the policy was reviewed and approved by both facility and GEO administration on August 8, 2018, when the PSA Compliance Manager reviewed facility policies relating to PREA. There was no documentation provided that the agency had reviewed and approved the policy. As per the standard, the Agency needs to review and approve the facility policies regarding staff reporting duties. Furthermore, GEO has established an outside reporting avenue for employees that states:

GEO Employees may report Sexual Abuse or Sexual Harassment information to the Chief of Security or facility management privately if requested. They may also report Sexual Abuse or Sexual Harassment directly to the Employee Hotline, which is an independent, professional service, available 24 hours per day, seven days a week on the Internet at www.reportlineweb.com/geogroup or the toll-free phone number (866) 568-5425. Employees may also contact the Corporate PREA Coordinator (b) (6), (b) (7)(C) directly at (561) 999-5827.

The interviewed staff understood the reporting avenues available to them.

(c): Policy 10.1.1 further states that staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, make medical treatment, investigation, law enforcement, or other security and management decisions. During all of the staff interviews, the Auditors confirmed that the staff understood their reporting requirements, reporting avenues available to them, and the requirement to not reveal any information. These procedures were further verified during the review of the investigative reports; the reports indicated only to staff directly involved in the incident were notified.

(d) The facility does not house juveniles nor family units. The PSA Compliance Manager confirmed that they would notify the appropriate state agency if a detainee who is considered a vulnerable adult was the victim of a sexual abuse. This is further outlined in policy 10.1.1. He further confirmed that they have not made any notification of this type within the past 12 months.

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

§115.62 - Protection duties.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1

Policy 10.1.1 outlines that if a staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee. During the staff interviews, they stated that they would make the safety of the detainee their priority, and ensure they were separated from the other detainees and contact their supervisor. During the supervisor interviews, they stated that they could separate detainees through pod moves and housing unit moves. Any separation for these reasons would be immediately reported to the PSA Compliance Manager. The PSA Compliance Manager stated that he would respond immediately or be available by phone to discuss the incident with the initial responders.

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

§115.63 - Report to other confinement facilities.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Memo from the Facility Warden

(a)(b)(c)(d): Policy 10.1.1 outlines the facility's obligations to report allegations that had occurred at another confinement facility. The facility will document these allegations, the facility administrator or his designee would immediately contact the facility head where the allegation took place. This notification will be made immediately, the ICE Field Office would be notified as soon as possible, but not more than 72 hours. The facility administrator would immediately document this notification, and copies will be forwarded to the PSA Compliance Manager. The PSA Compliance Manager confirmed that if an allegation was received from another facility, he would immediately begin an investigation as outlined in policy 10.1.1; and notify the ICE Field Office.

The audited facility has not received nor notified another facility under these circumstances, as documented through interviews and a memo to file. The Warden and PSA Compliance Manager understood their obligations under the policy.

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

§115.64 - Responder duties.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Policy: 10.1.1-A Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection in Detention Facilities
- Investigative files
- GEO Employees training PowerPoint and training rosters

(a) Policy 10.1.1-A and training received by the staff outlines their response to a detainee who has been sexually abused. The staff is instructed through policy and training to hold the detainee in a place of safety with sight and sound separation from other detainees and make immediate notification to their supervisor. Upon the arrival of assistance, they would preserve any potential crime scene, and the initial responders would make an initial inquiry as to the events. If the incident occurred within the last 96 hours, they would also request that the victim and abuser not do anything that may destroy potential evidence including, washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating.

The Warden and PSA Compliance Manager would be notified immediately; they would then contact the ICE Field Office and implement the PREA Coordinated Response Plan.

The interviewed staff understood their obligations as an initial responder, and all who were interviewed were able to outline the first responder obligations.

(b) Policy 10.1.1 outlines that if first staff responder is not a security staff member, the responder shall be required to request that the alleged victim and abuser not take any actions that could destroy physical evidence and then notify security staff. The Auditor reviewed an investigation where the first responder was a Case Manager and subsequently interviewed her. The detainee was kept in her company and security staff was notified immediately, she stated that she requested the detainee do nothing that may destroy evidence.

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

§115.65 - Coordinated response.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Investigative files
- Folkston ICE Processing Center PREA Coordinated Response Plan

(a)(b): The facility has developed the Folkston ICE Processing Center PREA Coordinated Response Plan. This plan outlines the guidelines for the facility to respond to sexual abuse or sexual harassment incident. The plan utilizes a multi-disciplinary approach which includes the first responders, Facility Administrator, Chief of Security, PSA Compliance Manager, Facility Investigator, and Health Services Administrator. The plan further details each team members responsibility during an incident.

(c)(d) The PSA Compliance Manager confirmed that if a victim of sexual abuse is transferred between DHS immigration detention facilities covered by either subpart A or B of the DHS PREA Standards, or to a non-DHS facility, they notify the facility of the potential need for medical or social services. The facility provided me with documentation that they had notified a non-DHS facility of a victim so that the facility could address any needs. This notification was made with the victim's permission; the PSA Compliance Manager understood that if the victim did not want this notification made, it would not be.

The coordinated response was further verified during the investigative file review.

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

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

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- Investigative files

Policy 10.1.1 states that all employees, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. A separation order requiring no contact will be documented by facility management via email or memorandum within 24 hours of the allegation. The PSA Compliance Manager and Warden both confirmed that they have non-contact posts where the individual would be placed until the investigation was completed. They also confirmed that the facility has not entered in, nor renewed any collective bargaining agreement that prevents them from removing staff from contact with detainees. These procedures were confirmed during both interviews and investigation review, where a staff was removed from detainee contact until the investigation was complete.

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

§115.67 - Agency protection against retaliation.

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

Notes:

Documentation Reviewed:
- Policy: 10.1.1
- Protection from Retaliation Log

(a)(b)(c): Policy 10.1.1 outlines the facility's protection against retaliation. The policy states that employees, contractors, and volunteers, and detainees, shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The PSA Compliance Manager confirmed that they would utilize multiple protection measures, including housing changes, removal of staff, and emotional support services. The PSA Compliance Manager stated that for at least 90 days following a report of sexual abuse, the facility will monitor to see if there are facts that may suggest possible retaliation by detainees or staff. If this is indicated, the facility will act promptly to remedy any such retaliation. The PSA Compliance Manager confirmed they would follow policy 10.1.1 which outlines the monitoring process and indicates that detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff would all be monitored. If a need is indicated, the monitoring will continue beyond the 90 days. During the onsite audit, a completed Protection from Retaliation Log was reviewed and found to be complete.

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

§115.68 - Post-allegation protective custody.

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

Notes:

Documentation Reviewed:
- Policy: 10.1.1
- Memo from facility
- Investigative Files

(a)(b)(c)(d): Policy 10.1.1 outlines the facility post-allegation protective custody. The detainee would be placed in the least restrictive, and supportive environment subject to the requirements of 115.43. They would not be held for more than five days in any type of administrative restriction, unless under unusual circumstances or at the request of the detainee. If a detainee were held in this manner, they would be reassessed before being returned to the general population. The policy further states that the ICE AFOD will be notified within 72 hours if a detainee was placed in protective custody under these circumstances. The PSA Compliance Manager understood the requirements for housing detainees under these circumstances; he further confirmed they had not had a detainee in post allegation protective custody within the past 12 months. This was confirmed through a memo from the facility. The Auditor further confirmed this through a review of the investigations.

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

§115.71 - Criminal and administrative investigations.

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

Notes:

Documentation Reviewed:
- Policy: 10.1.1-A
- Investigative Files

(a)(b): Policy 10.1.1-A outlines the facility investigators responsibility to conduct prompt, thorough and objective administrative investigations into alleged sexual assault. The facility has three trained investigators to conduct administrative investigations. The PSA Compliance Manager, who is also a trained investigator, stated that all allegations are responded to immediately, and ICE is notified. If the allegation is criminal, they will stop the administrative investigation and let OIG or the Folkston Police Department conduct the criminal investigation. The Auditor confirmed with two of the investigators that if a criminal investigation were either unsubstantiated or substantiated, they would still conduct an administrative investigation. No cases were criminal. The PSA Compliance Manager confirmed the administrative investigations in these cases would be conducted after consultation with the OIG, OPR, or the Folkston Police Department.

(c): Policy 10.1.1-A outlines the investigative procedure for administrative investigations. This policy provides provisions for the following:
- Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data;
- Interviewing alleged victims, suspected perpetrators, and witnesses;
- Reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator;
- Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph;
- An effort to determine whether actions or failures to act at the facility contributed to the abuse; and
- Documentation of each investigation by a written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and
- Retention of such reports for as long as the alleged abuser is detained or employed by the facility, plus five years
- The procedures in the policy govern the coordination of the administrative and criminal investigation, procedures to ensure that the criminal investigation is not compromised by an internal administrative investigation.

During their interviews, the facility investigators confirmed the investigative procedures for the administrative investigations.

(e)(f): Policy 10.1.1-A states that the investigation will not be terminated if the alleged abuser or victim leaves employment or control of the facility. The PSA Compliance Manager confirmed that the investigation would be conducted. He further stated that if an outside entity conducted a criminal investigation, he would stay in contact with them to ascertain the progress of the investigation. This was further confirmed during the review of the investigative files. The two investigations from the last 12 months have been investigated by the facility investigators.

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

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1-A
- Investigative files

Policy 10.1.1-A states that during an administrative investigation, the investigator shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The facility investigators stated that they do not impose any higher of a standard than a preponderance of the evidence; this was further confirmed during the review of the investigative files.

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

§115.73 - Reporting to detainees.

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

Notes:

Documentation Reviewed

- Policy: 10.1.1-A
- Investigative files
- Notification of Outcome of Allegation form

Policy 10.1.1-A outlines the procedure for reporting the results of an investigation to a detainee. The policy directs the facility investigator or designated staff to inform the detainee in writing whether the allegation has been substantiated, unsubstantiated, or unfounded. This process is completed utilizing the Notification of Outcome of Allegation form. The detainee will receive the notification in person by the PSA Compliance Manager and sign the form. If a criminal investigation takes place and the determination is different, an updated form will be provided to the detainee. The detainee would keep the original, and a copy is placed in the investigative file. An updated form would be provided to the detainee after the outcome of a criminal investigation. The PSA Compliance Manager confirmed this procedure; it was further confirmed by reviewing a completed Notification of Outcome of Allegation form for one investigation. The victim in the second investigation was no longer in custody. The facility at the time of the conclusion of the investigation forwarded the Notification of Outcome of Allegation to the Stewart Detention Center where the detainee was transferred to.

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

§115.76 - Disciplinary sanctions for staff.

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

Notes:

Documentation Reviewed

- Policy: 10.1.1-A
- Memo to Auditor from the Facility

(a)(b)(c)(d): Policy 10.1.1-A outlines the facility response to staff discipline of a substantiated allegation of violating facility sexual abuse policies. The staff member would be subject to disciplinary or adverse action up to and including removal from their position and the Federal service. The PSA Compliance Manager confirmed that removal from their position is the presumptive discipline for a violation of the policy. The facility reviewed this policy on July 24, 2018. The PSA Compliance Manager confirmed that the facility would report all removals or resignations by staff prior to removal for violations of facility sexual abuse policies to the OIG and the Folkston Police Department, unless clearly not criminal, and confirmed if the staff member was licensed, the licensing body would be notified. The facility provided the Auditor with a memo stating that no staff members have been disciplined within the last 12 months. The Auditor reviewed the investigations for the past 12 months and confirmed that no investigation involving staff was substantiated. The two reviewed investigations did not involve staff. The agency has not reviewed or approved the policy per standard. As per the standard the Agency needs to review and approve the facility policies regarding disciplinary or adverse actions for staff.

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

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

Documentation Reviewed
- Policy: 10.1.1
- Memo to Auditor from facility

(a): Policy 10.1.1 addresses any contractor or volunteer who has engaged in sexual abuse. The policy directs the facility to prohibit the contractor or volunteer from having any contact with detainees. The PSA Compliance Manager stated that the facility would also make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. These incidents, if criminal, will also be reported to law enforcement agencies.

(b)(c): The PSA Compliance Manager confirmed that contractors and volunteers suspected of perpetrating sexual abuse would be removed from all duties requiring detainee contact pending the outcome of an investigation. He further confirmed that as per policy 10.1.1 the facility would take appropriate remedial measures; and will consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within these standards. The PSA Compliance Manager and Warden both confirmed if a contractor or volunteer violated any provisions of the standards their security clearance would be immediately revoked.

The facility did not have any incidents of contractor or volunteer corrective action for the past 12 months.

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

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

Documentation Reviewed
- Policy 10.1.1
- Policy 10.3.1 Infractions and Disciplinary Sanctions
- Investigative files

(a)(b)(c)(d): Policy 10.1.1 addresses the facility disciplinary sanctions following an administrative or criminal investigation that finds a detainee engaged in sexual abuse. The disciplinary process outlined in policy 10.3.1 ensures that the discipline is commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. The policy further outlines the progressive levels of reviews, appeals, procedures, and documentation procedure. It was confirmed during the interview with the PSA Compliance Manager that this discipline process would be utilized for disciplining any detainee; there were no detainees disciplined as a result of sexual abuse or harassment. During the interviews with medical and mental staff they confirmed any detainee involved in an incident, whether victim or offender, would be evaluated. The PSA Compliance Manager confirmed, as per policy, they would consider any mental disabilities or mental illness that may have contributed to his behavior when determining what type of sanction, if any, should be imposed. No detainees have been disciplined within the past 12 months, the investigations were unsubstantiated.

(e)(f): The PSA Compliance Manager stated that the facility would follow policy 10.1.1 for detainee discipline, which states that the facility will not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. He also confirmed that a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred would not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. This is further outlined in policy 10.1.1. The Auditor further confirmed this during the investigation review.

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

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

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

Notes:

Documentation Reviewed
- Policy 10.1.1
- Memo to Auditor from facility

(a)(b)(c): Policy 10.1.1 outlines the medical and mental health screenings for a history of sexual abuse. If the detainee has experienced prior sexual victimization or perpetrated sexual abuse, they will be referred to a qualified medical or mental health practitioner for follow-up. The medical evaluation will occur immediately, and the mental health evaluation will occur within 72 hours. The detainees at the facility are screened under 115.41 by medical personnel. If they experienced prior sexual victimization or perpetrated sexual abuse, they would receive any immediate medical attention as deemed necessary. If mental health were available, they would see them immediately, if not they would be tasked with seeing the detainee within 72 hours. This process was confirmed during the interviews with medical and mental health staff. They also confirmed that they would notify the PSA Compliance Manager. The facility provided the Auditor a memo that stated they had not screened any detainee who reported past victimization or abusiveness in the last 12 months.

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

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

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

Notes:

Documentation Reviewed

- Policy 10.1.1
- Memo to Auditor from facility
- MOU with Satilla Advocacy Services
- Email from Memorial Satilla Health

(a)(b): Policy 10.1.1 states that a detainee who is a victim of sexual abuse will have timely, unimpeded access to emergency medical treatment and crisis intervention services, which include emergency contraception and sexually transmitted infections prophylaxis, by professionally accepted standards of care. The services would be conducted at the hospital, and any follow-up care would be provided by the facility providers. The services are provided to the detainee without financial cost and regardless of whether they name the abuser or cooperates with any investigation arising out of the incident. The Auditor confirmed with the medical staff and that the above procedures would be followed. The facility has a MOU agreement with Satilla Advocacy Services for victim advocacy and an agreement with Memorial Satilla Health for sexual assault examinations.

The facility provided a memo stating that emergency medical and mental health services have not been utilized within the past 12 months based on the type of allegations.

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

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

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

Notes:

Documentation Reviewed

- Policy 10.1.1
- Memo to Auditor from facility
- Folkston ICE Processing Center PREA Coordinated Response Plan

(a)(b)(c)(e)(f)(g): Policy 10.1.1 outlines ongoing medical and mental health care following a sexual abuse allegation. The medical and mental health departments are part of the coordinated response to an incident and would be immediately involved with the detainee and make any treatment determinations. These determinations will include follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The medical and mental health services offered are consistent with the community level of care. The detainee is offered tests for sexually transmitted infections; all of the treatment services are offered at no cost to the detainee. The facility also attempts to provide a mental health evaluation and offer treatment to all known detainee-on-detainee abusers within 60 days of learning of the abuse. The process was confirmed during the interviews with the PSA Compliance Manager and medical and mental health staff. A memo was provided to the Auditor where onsite mental health services were offered to a detainee victim, but the detainee refused. The medical file was reviewed by the Auditor while onsite. During the medical and mental health staff interviews the Auditor confirmed that mental health services would be offered to both the victim and abuser in a sexual abuse incident. The Auditor confirmed through review of the invstigative fies that the allegations reported did not require ongoing medical and mental health care.

(d): This provision is addressed in policy 10.1.1 but does not apply since the facility is a male-only facility.

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

§115.86 - Sexual abuse incident reviews.

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

Notes:

Documentation Reviewed

- Policy 10.1.1
- Memo to Auditor from facility
- 2018 Annual Review of Sexual Abuse Investigations and Corrective Actions
- Investigative files with incident reviews

(a)(b): Within 30 days of the conclusion of an investigation, the facility conducts an incident review of every investigation of sexual abuse; these investigations include substantiated, unsubstantiated, and unfounded. During the past 12 months, the facility had 2 unsubstantiated investigations. The review team consists of upper-level management, the PSA Compliance Manager, and medical and mental health practitioners. The review is documented on the PREA After Action Review Report. As per policy, the report is submitted to the GEO PREA Director and FOD within ten days of completion. The policy states all investigations and reviews are forwarded to OPR who are directed by 11062.2: Sexual Abuse and Assault Prevention and Intervention to forward a copy to the ICE PSA Coordinator for review. This report indicates if any changes need to be made in policy or practice that could better prevent, detect, or respond to sexual abuse. The Auditor confirmed with the Warden and PSA Compliance Manager the recommendations for improvement would be made if there were any. The review considers whether the incident or allegation was motivated by race-ethnicity or gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The Auditor reviewed the 2 incident reviews conducted on the unsubstantiated cases; no recommendations were made.

(c): The facility provided the Auditor with the 2018 Annual Review of Sexual Abuse Investigations and Corrective Actions report, which compares the facility data from 2017 and 2018. The review of the Annual Report indicated reasoning for the increase in incidents and the actions to be taken as a facility as a whole, which included quarterly PREA training and an upgrade to the facility surveillance system. The report was submitted to the local PSA Manager, GEO PREA Director, FOD, and the ICE PSA Coordinator; this is also outlined in policy 10.1.1. Both of these were confirmed to be in place by the Auditor.

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

§115.87 - Data collection.

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

Notes:

Documentation Reviewed

- Policy 10.1.1

(a): Policy 10.1.1 outlines the procedures for the facility data collection. The facility collects and retains data related to sexual abuse as directed by the Corporate PREA Director. The PSA Compliance Manager collects and retains all data including case records associated with claims of sexual abuse including investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary. The PSA Compliance Manager stated that he is responsible for compiling data collected on sexual activity and sexual abuse incidents. He forwards the DHS Monthly PREA Incident Tracking Log, to the Corporate PREA Director monthly. He also creates and submits a PREA Survey through the GEO PREA Portal for every allegation of sexual abuse and sexual activity. During his interview, the PSA Compliance Manager showed the Auditor the filing cabinet he secures all information. This filing cabinet is located in his office. The established facility retention schedule is ten years for these files.

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

§115.201 - Scope of audits.

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

Notes:

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

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

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

(j) PREA Audit Notifications were posted throughout the facility providing the Auditor contact information. The Auditor received three letters from detainees, although the letters did not pertain to PREA. Interviewed staff and detainees confirmed the PREA Audit Notifications were posted well before the audit, but they could not recall the date.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	3
Number of standards met:	35
Number of standards not met:	3
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Patrick J. Zirpoli 8/24/2019

Auditor's Signature & Date

(b) (6), (b) (7)(C) August 24, 2019

ICE PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Margaret L. Capel	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	479-521-(b) (6), (b)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Atlanta Field Office
Field Office Director:	Sean Gallagher
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	3026 Highway 252 East, Folkston, Georgia 31537
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Folkston ICE Processing Center and Annex		
Physical address:	3026 Highway 252 East, Folkston, Georgia 31537		
Mailing address: *(if different from above)*			
Telephone number:	912-496-6905		
Facility type:	DIGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	912-496-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PREA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	912-496-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) on-site audit of the Folkston ICE Processing Center and Annex (FIPC) in Folkston, Georgia was conducted on April 23 – 25, 2019 by Patrick Zirpoli and (b) (6), (b) (7)(C), PREA Auditors contracted through Creative Corrections, LLC. Patrick Zirpoli was assigned as the Lead Auditor. The Corrective Action Period (CAP) documentation was reviewed and audited by (b) (6), (b) (7)(C), a certified U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) PREA Auditor for Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the Creative Corrections ICE PREA Program Manager, (b) (6), (b) (7)(C) (b) (6), (, a DOJ and DHS certified PREA Auditor. The Program's Manager role is to provide oversight to the ICE PREA audit process and liaison with the ICE ERAU section during the audit report review process. This was the first DHS PREA Audit for this facility. The FIPC is an Immigration and Customs Enforcement contract adult facility, operated by GEO Group Inc. with a design capacity of 780 in the main compound and 338 in the annex. The facility houses adult male detainees to hold, process, and prepare individuals pending the results of judicial removal review. The purpose of the audit was to determine compliance with the DHS PREA standards.

Of the 41 standards reviewed, the Auditor found three standards exceeded the requirements of the standard, 115.17 Hiring and promotion decisions, 115.31 Staff training, 115.35 Specialized training: Medical and mental health care. There was one standard found to be non-applicable, 115.14 Juvenile and family detainees. There were three standards found non-compliant, 115.16 Accommodating detainees with disabilities and detainees who are limited English proficient, 115.33 Detainee education, 115.51 Detainee reporting. The remaining 35 standards met the requirements of the standards.

The Office of Professional Responsibility (OPR) External Review and Analysis Unit (ERAU), through (b) (6), (b) (7)(C), Inspections and Compliance Specialist, developed the Corrective Action Plan with the facility, and the plan addressed the three non-compliant standards.

The Auditor received and reviewed documentation to establish compliance on the outstanding standards from January 2, 2020 through February 3, 2020. The facility met compliance with the standards (115.16, 115.33, 115.51). The Auditor found the facility in compliance with all standards.

PROVISIONS

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

§115. 16 - Accommodating detainees with disabilities and detainees who are limited English proficient

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

Notes:

Documentation Reviewed:

- GEO/FIPC policy 10.1.1
- National detainee handbook in multiple languages
- Facility supplemental handbook
- PREA acknowledgment forms
- PREA Handout in multiple languages

(a) Policy 10.1.1 outlines the facility's procedures to ensure disabled detainees have equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. During the intake staff and medical personnel interviews, the Auditors confirmed the steps taken to effectively communicate with disabled detainees. Detainees who are deaf or hard of hearing would be provided the facility and the ICE Detainee handbooks and if needed sign language translation would be provided through video conference. A detainee with limited reading skills, cognitive disability, or blindness would have the materials read to them and explained in depth, so that they would understand. Medical staff confirmed that they now read the PREA information to all detainees during intake, and would identify any disability, and ensure the material is provided effectively, accurately, and impartially. The facility is not in compliance with subsection (b) of this standard, although the procedures are in place to educate disabled detainees, they are not providing the information in a language they can understand.

(b) As outlined in the corrective action, the facility is not in compliance with these subsections of the standard. The Auditors found that during the intake process, the detainee would be placed in a holding cell and be individually brought out to be questioned by the Intake Officers. During this time a video will be playing that provides the PREA information in two languages, English and Spanish, the video also contained a portion on detainee rights. All detainees signed a form that stated they watched the PREA video and understood the information. The facility houses detainees who speak many languages, to include those that are uncommon. The facility also had all detainees sign for an ICE National Detainee Handbook, which is only printed in ten languages. There is reporting information contained in the handbook but is only in ten languages. The detainee would then be brought to a separate area and wait to be screened by medical personnel. Until two weeks prior to the audit, the facility was not providing information through the language line, they were just giving them material in in a language they could not understand. The audit interviews confirmed that on April 8, 2019, a process was implemented where medical personnel would read the PREA Detainee Comprehensive Notification to the detainees, who could not read nor understand the form. This was being conducted through Language Line Services. The detainee would sign the form which is filed in the detainee's file. The detainee would not be provided any information in a language they understood to take with them. On the housing units, the reporting information is posted in limited languages and does not address all of the primary languages spoken at the facility. The detainee interviews suggested that the detainees who spoke uncommon languages did not understand PREA nor the reporting avenues. The majority of the interviewed detainees stated they had not received an ICE National Detainee Handbook. This process causes the facility to be non-compliant with standards. Upon completion of a corrective action period, the evidence of compliance will be evaluated to determine compliance. The Auditor recommended that the facility create a separate orientation/education process that takes place after the initial intake and while the detainees are waiting to see medical. The facility should identify the languages they interact with the most and have the forms translated by a language services agency into a document that detainees can understand; and provide them a copy for reporting purposes. They also need to remove any documentation that detainees are signing that state they have seen a video in a language they understand, and if they are giving them an ICE National Detainee Handbook, they have to be able to read the language. The Auditors expressed that they were further concerned over the misleading nature of the forms, which are signed by the detainees stating they watched the PREA Video and received an ICE Detainee Handbook, which both are untrue if the video is only in English and Spanish and the ICE Detainee Handbook is not provided in all languages.

(c) Policy 10.1.1 states that minors, alleged abusers, detainees who witnessed the alleged abuse and detainees who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of sexual abuse. The GEO policy does not allow the detainee to express a preference for another detainee to provide interpretation. The facility has a contract with Language Line Services Inc. for translation services effective February 1, 2011. A copy of the contract was provided for documentation. Several staff at the facility are bilingual and can help communicate. During the staff interviews, they indicated that they would use a bilingual staff member or the language line for translation. The detainees interviewed with limited English proficiency indicated they communicate with a staff member utilizing the language line and would ask for those services if an incident did occur.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility is not in compliance with the standard and all provisions.

Corrective Action Required:

This standard was found non-complaint as a result of detainee interviews in which the interviews confirmed the detainees did not understand the zero-tolerance policy or how to report if something was to occur. The information was not being provided in a language the detainee could understand. To meet the standard requirements for standard 115.16 the facility was required to translate the PREA Detainee Comprehensive Education and Notification form into Spanish, which is the most common housed LEP detainee, thus allowing these detainees to have information to maintain in their own language for reference. The other non-complaint issue was the detainee was signing the Intake Department Detainee Orientation Sheet acknowledging review of the orientation video and receipt of the Supplement Handbook and the ICE National Detainee Handbook prior to receiving the handbook and viewing the video. The facility was required to provide documentation showing the use of translator services for multiple languages.

The facility was required to provide a procedure/directive to correct the current practice and have the detainee sign the forms after viewing and receiving the handbooks. The facility was also required to provide documentation of staff trained on the new procedure.

Corrective Action Completed:

Initially, the facility provided 165 examples of completed PREA Detainee Comprehensive Education/Notification forms, but the examples did not show multiple languages utilizing the translator services. The facility was required to provide the PREA Detainee Comprehensive Education, Notification Intake Department Detainee Orientation Sheet and the Risk Assessment forms documentation of ten LEP detainees who spoke languages other than Spanish or English. On January 28, 2020 the Auditor requested documentation for ten LEP detainees who spoke languages other than English or Spanish.

On January 22, 2020, the facility provided copies of the updated procedures (revised September 23, 2019) for utilizing the PREA Detainee Comprehensive Education/Notification form. These procedures included the requirement to utilize a language translator to ensure LEP detainees understand the PREA Detainee Comprehensive Education/Notification material, to allow the LEP detainee to ask questions about the material, and for the detainee and officer/staff member performing the intake process to sign the PREA Detainee Comprehensive Education/Notification form and to note the language translator identification number. The facility also provided documentation of staff training for these new procedures.

The facility also provided the PREA Detainee Comprehensive Education and Notification form, which was translated into Spanish and that documented the detainee was provided the information in a language they understood through either the language line or a staff interpreter. After review of the ten PREA Detainee Comprehensive Education and Notification, Intake Department Detainee Orientation Sheet and the Risk Assessment forms provided, this Auditor finds the facility complies with this standard.

§115. 33 - Detainee education

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

Notes:

Documentation Reviewed:

- Policy: 10.1.1
- PREA Video
- National Detainee Handbook
- Folkston Processing Center Supplement to the National Detainee Handbook

(a)(b)(c) Policy 10.1.1 outlines the facility intake process that ensures all detainees are notified of the facility's zero-tolerance policies for all forms of sexual abuse. This process includes instruction on prevention and intervention strategies, self-protection and indicators, definitions, examples of detainee-on-detainee sexual abuse, and staff-on-detainee sexual abuse and coercive sexual activity. They also inform the detainees of reporting methods which include reporting to staff, the DHS OIG, and the JIC. This includes the prohibition against retaliation, an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The audit interviews confirmed that on April 8, 2019, a process was implemented where medical personnel would read the PREA Detainee Comprehensive Notification to the detainees, who could not read nor understand the form. This was being conducted through language line services. The detainee would sign the form which is filed in the detainee's file. This process includes limited English proficient detainees, deaf, visually impaired, or otherwise disabled, as well as, to detainees who have limited reading skills. Prior to this date, the detainees were not receiving information in a language they could understand. The Auditor explained in the exit briefing that the non-compliance stems from the lack of education, which causes the failure to accommodate limited English proficient detainees and fails to provide them with a reporting avenue they can understand. The Auditor explained that the PREA Detainee Comprehensive Notification fulfills the obligation under detainee education. However, the detainees interviewed were not knowledgeable on reporting and PREA

information. The facility needs to educate the detainees in a manner they understand; which includes, in a language all detainees can understand, and they must be given materials they can take with them that explain the reporting avenues. The Auditor recommended that the facility create a separate orientation/education process that takes place after the initial intake and while the detainees are waiting to see medical. The facility should identify the languages they interact with the most and have the forms translated by a language services agency into a document that detainees can understand and provide them a copy for reporting purposes. They also need to remove any documentation that detainees are signing that state they have seen a video in a language they understand, and if they are giving them an ICE National Detainee Handbook, they have to be able to read the language. The Auditors expressed that they were further concerned over the misleading nature of the forms, which are signed by the detainees stating they watched the PREA Video and received an ICE Detainee Handbook, which both are untrue if the video is only in English and Spanish and the ICE Detainee Handbook is not provided in all languages. As outlined in the corrective action, the facility needs to create a consistent educational program to ensure all detainees are notified and understand the facility zero tolerance policy.

(d) The facility has posted notices on all housing units the DHS-prescribed sexual assault awareness notice; the PSA Compliance Manager contact information; and name of local organizations that can assist detainees who have been victims of sexual abuse. These postings are in limited languages and cannot be read by detainees that do not read Spanish and English. The Auditor recommended that the facility identify the most commonly spoken languages and have these notices translated and posted in these languages.

(e) The facility provides the DHS-prescribed "Sexual Assault Awareness Information" pamphlet in English and Spanish, but again this is not translated in a language that all detainees can understand.

(f) Information about reporting sexual abuse is included in the National Detainee Handbook. The National Detainee Handbook is only translated into 10 languages, and most of the detainee handbooks provided to detainees at the facility were English versions regardless of the language they spoke. The PSA Compliance Manager confirmed during his interview that the week prior to the audit staff went to the housing units and distributed copies of the National Detainee Handbook to all detainees. This behavior indicates that they are not providing the handbook upon intake to the facility; but are still having detainees sign for them per staff interviews.

As previously stated in the corrective action all subsections of the standard are non-compliant, the facility is not properly educating the detainees upon arrival in the facility. The facility cannot comply with any provisions of this standard since they are not providing education or information in languages that all of the detainees can understand. Any posting on the housing units are in limited languages and can't be understood by all detainees. On April 8, 2019, they started a new education process where medical staff would read the materials to the detainee. This process has not been in effect long enough to produce historical data that could be used as evidence of compliance.

Corrective Action Required:

This standard was found non-compliant because the facility was not providing comprehensive education to the LEP detainees in a language they understood. The facility provided 165 completed PREA Detainee Comprehensive Education and Notification forms completed from October 7, 2019 through January 31, 2020, (following the on-site visit), however these forms did not provide examples of multiple languages. The majority were Spanish. The Auditor acknowledged in the report that the PREA Detainee Comprehensive Education and Notification form was provided in English and Spanish. To achieve compliance the facility was required to provide ten examples of completed PREA Detainee Comprehensive Education and Notification form, Intake Department Detainee Orientation Sheet, and the Risk Assessment forms for LEP detainees in languages other than English and Spanish.

Corrective Action Completed:

The facility provided the ten examples of completed PREA Detainee Comprehensive Education and Notification form, Intake Department Detainee Orientation Sheet, and the Risk Assessment forms for LEP detainees in languages other than English and Spanish that documented the detainees were provided the information in a language they understood through either the language line or a staff interpreter. The facility is in compliance with this standard.

§115. 51 - Detainee reporting

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

Notes:

Documentation Reviewed

- Policy 10.1.1
- Facility Handbook

- National Detainee Handbook
- DHS PREA Posters
- Posters for Satilla Victim Advocacy

(a)(b): Policy 10.1.1 established the facility's procedures for detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The facility provides instructions on how detainees may contact their consular official, the DHS OIG or, confidentially and, if desired, anonymously, report these incidents. The facility has also developed internal reporting avenues where the detainees can report directly to a staff member, through a request slip, and/or medical slip. The Auditor found that the information is not being provided to all detainees in a language they can understand, they have recently implemented a policy where they read the reporting information to the detainee utilizing the language line, but the detainee does not take anything with them to recall the reporting avenues. In the housing units, information is posted in limited languages, and the OIG reporting number is only in English and Spanish. The ICE National Detainee Handbook is only printed in 10 languages and does not represent the vast languages at the facility. The detainee interviews confirmed that not only did they not understand the zero-tolerance policy and they did not know how to report if something did occur. The standard is specific in stating that the agency and facility must provide instructions on how to contact their consular official, DHS OIG or another appropriate office. The Auditor found that the facility is not in compliance with these requirements of this standard. The non-compliance stems from the detainees' lack of knowledge on how to report if an incident occurred, and who to report to. The facility is not providing instruction on how detainees may contact their consular, DHS OIG, or designated office for reporting of an allegation. The standard states the agency shall provide and shall inform, the detainees at least one way to report to a public or private entity. This again was not occurring until two weeks prior to the audit. They have not created historical data to support compliance. The detainees are not provided information that outlines the reporting procedures in a language they can understand, nor is anything posted on the housing units in a language they can understand. The facility created a document that they have had translated into 20 languages they see most often. The document includes instructions on how to report an incident and who to report it too. These documents need to be provided to the detainees, so when they are on the housing units, they have something to refer to if they need to report an incident.

(c): Policy 10.1.1 states that staff will accept reports made verbally, in writing, anonymously, and from third parties. They will promptly document any verbal reports. The interviewed GEO Detention Officers and Supervisors understood their obligation under this standard, and stated they would accept reports made verbally, in writing, anonymously, and from third parties.

After a careful review of all documentation and the information received during the facility tour and interviews, the Auditor found that the facility is not in compliance with the requirements of this standard, and all provisions.

Corrective Action Required:

The facility was not providing information about how to report a PREA matter to the LEP detainees in a language the detainee understood. The facility provided the same 228 completed PREA Detainee Comprehensive Education and Notification forms as noted above. The examples were primarily of English and Spanish speaking detainees. To achieve compliance, the facility was required to provide 10 examples of completed PREA Detainee Comprehensive Education and Notification form, Intake Department Detainee Orientation Sheet, and the Risk Assessment forms for LEP detainees in languages other than English and Spanish.

Corrective Action Completed:

The facility provided the same 10 examples as requested for standard 115.33 that documented the detainees were provided the information in a language they understood either through the language line or a staff interpreter. The facility is in 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:

AUDITOR CERTIFICATION:

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

Margaret Capel February 20, 2020
Auditor's Signature & Date

(b) (6), (b) (7)(C) February 20, 2020
Program Manager's Signature & Date