PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	1/25/2022	**To:**	1/27/2022
AUDITOR INFORMATION			
Name of auditor:	Sabina Kaplan	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Miami		
Field Office Director:	Garrett J. Ripa (acting)		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	865 SW 78th Avenue Suite 101 Plantation, FL 33324		
Mailing address: (if different from above)	Click or tap here to enter text.		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Glades County Detention Center		
Physical address:	1297 East State Rd. 78 Moore Haven, Fl. 33471		
Mailing address: (if different from above)	P.O Box 39		
Telephone number:	863-946-1600		
Facility type:	IGSA		
PREA Incorporation Date:	2/14/2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Commander
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	863-946-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Lieutenant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	863-946-(b) (6), (b) (7)(C)
ICE HQ USE ONLY			
Form Key:	29		
Revision Date:	02/24/2020		
Notes:	Click or tap here to enter text.		

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Glades County Detention Center (GCDC) was conducted January 25 – January 27, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Sabina Kaplan, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (PM), (b) (6), (b) (7)(C) who is also a DOJ and DHS certified PREA Auditor. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The GCDC is a county owned facility and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The facility processes detainees who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at GCDC are from Mexico, Jamaica, and Guatemala. The facility does not house juveniles or family detainees. This was the first PREA audit for GCDC and included a review of the 23-month audit period from February 14, 2020, through January 27, 2022. GCDC is in Moore Haven, Florida.

Approximately three weeks prior to the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's PAQ, Agency policies, and other pertinent documents. The documentation was provided through the ICE SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form and within folders for ease of auditing. The main policy that governs GCDC's PREA program is 720.13 (PREA) Sexual Abuse and Assault Prevention and Intervention Program (SAAPI). A review of this policy identified the term inmates is used instead of detainees and the Auditor is making a general recommendation to update the policy throughout to reflect detainees. The main policy that provides facility direction for PREA is Glades County Sherriff's Office Policy 720.13 (PREA) Sexual Abuse and Assault Prevention and Intervention Program (SAAPI). All the documentation, policies, and PAQ were reviewed by the Auditor. The Auditor communicated with the ERAU Team Lead requesting further documentation for clarification and review during the on-site audit. Responses to the requests were provided by facility staff. Facility staff also provided additional documentation via email post audit inspection.

The entry briefing was held in GCDC Conference Room at 8:15 am on Tuesday, January 25, 2022. In attendance were:

(b) (6), (b) (7)(C) ICE/OPR, Inspections and Compliance Specialist (ICS)
(b) (6), (b) (7)(C) ICE/OPR, ICS
(b) (6), (b) (7)(C) Commander, GCDC
(b) (6), (b) (7)(C) PREA Coordinator, Captain, GCDC
(b) (6), (b) (7)(C) PSA Compliance Manager, Lieutenant (Lt.), GCDC
(b) (6), (b) (7)(C) ERO PREA Field Coordinator, Supervisory Detention & Deportation Officer (SDDO), ICE
(b) (6), (b) (7)(C) Deportation Officer (DO), ICE
(b) (6), (b) (7)(C) Health Services Administrator (HSA), Armor Correctional Health Services (ACHS)
(b) (6), (b) (7)(C) Food Service Director, GCDC
Sabina Kaplan, Assistant Program Manager (APM)/Certified Auditor, Creative Corrections, LLC

The Auditor introduced herself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance to those present. The Auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. She further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews. It was shared that no correspondence was received from any detainee, outside individual, or staff member.

The facility provided the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific categories) including an alpha and housing listing of all detainees housed at the facility, both random, and from specific categories. Lists of staff by duty position and shifts was also provided. Shifts are 0600-1800 and 1800-0600. Due to the ongoing pandemic, there were zero volunteers at the facility during the on-site audit.

A facility tour was completed by the Auditor with key staff from GCDC and ICE. All housing units were toured, as well as, program areas, service areas, food service, control centers, booking/intake, recreation areas, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or provided services were observed by the Auditor. During the tour, the Auditor made visual observations of the program/service areas and housing units including bathrooms, officer's post sight lines, and camera locations. Sight lines were closely examined, as was the potential for blind spots, throughout the areas where the detainees are housed or have accessibility. The Auditor spoke to random staff and detainees regarding PREA education and facility practices during the tour. A review of the housing unit logbooks, and "Shifts After Action Reports" was conducted to verify staff rounds for security staff and supervisors. The facility PREA Incorporation Date is February 14, 2020. The facility is a single-story building and has a design capacity of 544. On the first day of the audit, the facility count was 110 and consisted of 21 male detainees, 0 female detainees, 46 county inmates, and 43 United States Marshal offenders. The custody level is Medium and High. The average detainee population for the last twelve months was 179. The average time in custody is 99 days.

The physical plant consists of three separate buildings that are inner connected using a secure concrete corridor walkway. One building is made up of administrative areas, processing, booking, and office space, to include internal court facilities. The second building is referred to as "Housing Unit One" and is comprised of one building, with four housing unit pods that can house a total of 378 detainee/inmates. The third building is referred to as "Housing Unit Two" and is comprised of one building, with five housing unit pods that can house a total of 166 general population inmates and detainees.. Housing Unit Two also contains a 20-bed segregated housing unit. Both housing units are operated by an elevated control center located above and in the center of the housing unit. The control centers allow for inmate/detainee monitoring by staff and are supplemented by additional detention staff members being assigned to the floor levels. The Auditor was able to view both control centers. Both had clear sight of the bed areas. At the time of the audit, all detainees were housed in Housing Unit Two. Delta Two contained the segregation Units, Echo Two housed the female detainees, and Charlie Two housed the male detainees. During the on-site audit, county inmates and detainees were comingled in each housing unit.

(b) (7)(E)
(b) (7)(E) All showers have privacy curtains. Phones are available for the detainees which allows reporting accessibility. PREA information, posters/brochures, posted on the bulletin boards included the PREA posters, information on correspondence including addresses and numbers, how to report outside the facility, foreign consulates with addresses and phone numbers, victim services information, and the notification of audit. A few of the DHS Sexual Assault Awareness Posters lacked the name of the PREA contact personnel; however, this issue was corrected prior to the exit briefing.

Detainees work in the kitchen and laundry areas. The kitchen is staffed with staff members and detainees. Meals are prepared in the kitchen and delivered to the dorms. The coolers and freezers are always locked and opened only by staff. Detainees are directly supervised while in these areas. (b) (7)(E) The Auditor noted that the detainee restroom was unlocked which could potentially lead to an incident of sexual abuse. The Auditor recommended that the door always be secured, giving staff the ability to control who enters and when. The facility corrected the issue immediately. (b) (7)(E) One blind spot was noted behind the washers. The Auditor suggested a mirror be placed to allow for staff observation. The mirror was obtained and placed prior to the exit briefing.

(b) (7)(E)
The cameras are monitored by three different control rooms, depending upon camera location. The video system is recorded using DVR technology. The cameras do not have sound capability. The Auditor observed the monitoring displays in all control centers. In all instances, the cameras are placed in a way that allow privacy to the detainees for showering, changing clothes, and performing bodily functions. Cameras operate 24/7 and can Pan, Tilt and Zoom (PTZ).

There were 17 formal detainee interviews during the on-site visit, randomly selected from the housing units. The Auditor attempted to interview the 21 detainees housed at the facility the first day of the on-site visit; however, 4 detainees refused. Of the 17 detainees interviewed, 14 were random and 3 were limited English proficient (LEP). The LEP detainees were interviewed using Language Services Associates (LSA), a contract language interpretative service provided through Creative Corrections. A total of 18 staff, 3 contract employees, and 2 ICE employees were interviewed. The staff interviewed included 6 random staff, and 12 specialized staff, including the facility Commander, PSA Compliance Manager, first line supervisors (2), Grievance Coordinator, Classification Supervisor, Classification staff (1), Director of Human Resources (HR), facility Investigator, Training Supervisor, and Intake staff (2). Contract employees from ACHS that were interviewed included the HSA, a Nurse, and a Licensed Mental Health Clinician (LMHC). The ICE employees interviewed included 1 DO and 1 SDDO. Due to the pandemic, there were zero volunteers at the facility to be interviewed.

The facility uses one trained investigator to complete all allegations of sexual abuse. There were 15 sexual abuse allegations reported during the audit period. Seven cases involved detainee-on-detainee, six cases involved staff-on-detainee, and two cases involved contractor-on detainee. Of the 15 cases reported, 11 were closed and 4 remain open. A review of the closed cases indicated that nine cases were determined to be unsubstantiated, and two cases were determined to be unfounded by the facility investigator. All cases were referred to ICE OPR.

On January 25, 2022, an exit briefing was conducted by the Lead Auditor in the Conference Room. In attendance were:

(b) (6), (b) (7)(C) ICE/OPR, ICS
(b) (6), (b) (7)(C) ICE/OPR, ICS
(b) (6), (b) (7)(C), Commander, GCDC
(b) (6), (b) (7)(C) PREA Coordinator, Captain, GCDC
(b) (6), (b) (7)(C) Lt., PSA Compliance Manager, GCDC
(b) (6), (b) (7)(C) Lt., GCDC
(b) (6), (b) (7)(C) Sergeant (Sgt.), GCDC
(b) (6), (b) (7)(C) (ERO) PREA Field Coordinator, SDDO, ICE
(b) (6), (b) (7)(C) DO, ICE

(b) (6), (b) (7)(C) DO, ICE
(b) (6), (b) (7)(C) HSA, ACHS
(b) (6), (b) (7)(C) LMHC ACHS
(b) (6), (b) (7)(C) Food Service Director, GCDC County
Sabina Kaplan, APM/Certified Auditor, Creative Corrections, LLC

The Auditor spoke briefly about the staff and detainee knowledge of the GCDC PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit, and that she would need to review all submitted documentation and interview notes conducted with staff and detainees. The Auditor explained the audit report process, timeframes, and thanked all present for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 1

§115.64 Responder Duties

Number of Standards Not Applicable: 2

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

Number of Standards Met: 23

§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
§115.21 Evidence protocols and forensic medical examinations
§115.32 Other training
§115.34 Specialized training: Investigations
§115.35 Specialized training: Medical and Mental Health Care
§115.51 Detainee reporting
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff Reporting Duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.67 Agency protection against retaliation
§115.68 post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.77 Corrective action for contractors and volunteers
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data Collection
§115.201 Scope of Audits

Number of Standards Not Met: 15

§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff Training
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.52 Grievances
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.71 Criminal and Administrative Investigations
§115.76 Disciplinary sanctions for staff
§115.78 Disciplinary sanctions for detainees
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

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

Notes:

(c): The facility follows Glades County Sheriff's Office (GCSO) written policy 720.13, (PREA) Sexual Abuse and Assault Prevention and Intervention (SAAPI), mandating zero-tolerance towards all forms of sexual abuse and sexual harassment. Policy 720.13 outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and sexual harassment and provides definitions of sexual abuse and general PREA definitions. The zero-tolerance policy is publicly posted on the GCDC's website (www.gladessheriff.org). In an interview with the facility Commander, it was confirmed that policy 720.13 had not yet been reviewed and approved by ICE as required by the standard, however, during the on-site audit, the Commander forwarded the policy to ICE and requested they review and approve the policy as written. During the facility tour the Auditor observed on the housing unit bulletin boards, and in other locations throughout the facility, signage that included the ICE Zero-Tolerance posters. The Auditor did not see the ICE Zero-Tolerance posters in the visiting room area. It was suggested that the staff add the posters to this area so that visitors were aware of the facility's zero-tolerance policy. Formal and informal interviews with staff, and detainees, further confirmed GCDC's commitment to zero tolerance of sexual abuse.

Recommendation: The Auditor recommended that the ICE Zero-Tolerance posters be displayed in the visiting room area so that visitors are made aware of the facility's zero-tolerance policy.

(d): Per policy 720.13, "The Glades County Sheriff's Office designates a PREA Coordinator. The PREA Coordinator is an upper-level, agency-wide person with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards within the facility. The PREA Coordinator will be an upper-level position with sufficient time and authority to develop, implement, and oversee the Jail efforts to comply with PREA standards. The PREA Coordinator is tasked with auditing, collecting, and maintaining information on each instance of alleged inmate-on inmate sexual acts or abusive sexual contact, and each instance of staff-on-inmate sexual misconduct or sexual harassment." Policy 720.13 delineates this role to the Detention Chief of Security, (Detention Captain). Policy 720.13 further states, "The Grievance Lieutenant, (Admin Lieutenant), is designated as the PREA Compliance Manager. The PREA Compliance Manager has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards," and "The PREA Compliance Manager reports directly to the Detention Division Captain or his/her designee in the Detention Division Captain's absence." In addition to the PREA Coordinator, and the PSA Compliance Manager, the facility also utilizes an ICE DO as the Agency contact. The facility's Commander appointed both the PREA Coordinator and PSA Compliance Manager at the supervisory level. Interviews with the PREA Coordinator, PSA Compliance Manager, and ICE DO confirm that they work together managing the facility's SAAPI program. The Auditor determined compliance through the review of policy 720.13 and interviews with the PREA Coordinator, PSA Compliance Manager, and ICE DO. All three confirmed they have sufficient time and authority to oversee facility efforts to comply with the SAAPI policy.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(c): Policy 720.13 states, "The Glades County Sheriff's Office will develop, document, and make the best efforts to comply on a regular basis with a staffing plan that provides adequate levels of staffing, and where applicable, video monitoring to protect inmates against sexual abuse. A facility Post Chart will be maintained denoting officer assignment for all authorized positions." A review of the facility PAQ indicated GCDC has a total of 43 security staff, consisting of 23 males and 20 females, that may have recurring contact with detainees. The remaining staff consists of support personnel in Administration, Food Service, Maintenance, and Religious Services. The facility also employs 15 medical and 2 mental health contract/personnel employed by ACHS. During the audit period, GCDC line staff were working two 12-hour shifts. The Auditor's interview with the facility Commander, and review of the staffing plan assessment, dated December 2021, confirmed the PREA staffing plan assessment took into account the staffing levels, and the need for video monitoring, generally accepted detention and correctional practices, any judicial finding of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and other relative factors, including but not limited to, the length of time detainees spend in agency custody. The Auditor observed staffing levels during the on-site audit and determined they were adequate. (b) (7)(E) [redacted]. Video cameras operate 24-hours a day, 7 days a week, and have PTZ functionality. Cameras are continuously monitored in the three Control Rooms and the facility Investigator also has full access with the ability to save footage in the evidence locker and to burn DVDs. The Commander reported that mirrors were put in place to increase vision in areas needing more coverage.

(b)(d): Policy 720.13, and facility post orders, outline the comprehensive detainee supervision guidelines to meet detainee supervision needs. Policy 720.13 states, "Supervisors will conduct unannounced supervisor rounds of the Jail daily to identify and deter staff sexual

abuse and sexual harassment" and "the unannounced supervisor rounds are to be conducted on both day and night shifts and will cover all areas of the facility." Policy 720.13 further requires that "Each unannounced round is documented as a computer entry in the jail log and in the Shifts After Action Reports. The entry will be logged as "PREA UNANNOUNCED ROUNDS" and 'Staff are prohibited from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.'" The post orders outline the responsibilities of detainee supervision including the requirement to make several rounds of the housing units. Documentation submitted, onsite, confirmed the supervision guidelines (post orders) are reviewed by the facility Commander and distributed on an annual basis. The Auditor interviewed one Lieutenant from each shift, who indicated they conducted their rounds during their shift as required. A five-day review of housing unit logs, and Shifts After Action Reports, by the Auditor, confirmed that unannounced rounds are conducted on each shift as required by subsection (d) of the standard.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b)(c)(d): GCDC does not house juvenile and family detainees. A review of the PAQ, a Captain's memo, and an interview with the Commander confirmed the facility does not house juveniles nor family detainee units.

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

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

Notes:

(b)(c)(d): Prior to the onsite audit, Policy 720.13 stated, "The Agency does not permit cross-gender pat-down searches of female inmates, absent exigent circumstances" and "all cross-gender pat-down searches of female inmates shall be documented." During the onsite audit, the facility updated GCDC policy to include "all cross-gender pat searches would be documented." In addition, the updated policy was delivered, via email, to all staff. However, the policy does not consider cross-gender pat searches of male detainees by female staff as required by the standard. Despite the lack of policy, all staff interviewed indicated that cross-gender pat-down searches are not conducted on the detainees at GCDC. They further indicated that they had not conducted, or were aware of, any cross-gender pat-down searches conducted during the audit period. This was further supported by a memo to file and the PAQ. Interviews with 17 detainees further confirmed that cross-gender pat down searches are not conducted at GCDC. At the time of the onsite audit, GCDC did not house female detainees to interview.

Recommendation (b): The Auditor recommends that GCDC update policy 720.13 to include "cross-gender pat down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances" to mirror their current practice of not conducting cross-gender pat down searches of detainees.

(e)(f): Policy 720.13 states, "Glades County Sheriff's Office Detention Division employees will not conduct cross-gender strip searches or cross-gender visual body cavity searches (anal or genital opening) except in exigent circumstances or when performed by a medical practitioner." Policy 720.13 further states, "The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches." Interviews with line staff confirmed staff are aware of the facility's policy for conducting strip or body-cavity searches, and that if performed, shall be approved by a supervisor and documented on an incident report. During the audit period, no cross-gender strip or body-cavity searches were conducted. This was confirmed through interviews with security supervisors and line staff. The facility does not house juvenile detainees.

(g): Prior to the onsite audit, Policy 720.13 stated, "Inmates will be allowed to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera)." During the onsite audit, policy 720.13 was updated to remove "this includes via video camera." In addition, the updated policy was delivered, via email, to all staff. Policy 720.13 further states, "Staff will announce "Male on the Floor" or "Female on the Floor" each time an Officer of the opposite gender enters an inmate's housing unit; to inform inmates that an officer of the opposite gender will be on the floor." During the onsite visit, the Auditor determined through observation that the detainees were able to shower, perform bodily functions, and change their clothing as dictated by the standard. During the interviews, all staff indicated they announce themselves when entering a living area and announcements being made by female and male staff were observed by the Auditor. In addition, all the detainees interviewed indicated they recalled opposite gender staff announcing themselves on a regular basis and all felt as if they had privacy to shower, perform bodily functions, and change clothing in privacy as required by the standard.

(i): Policy 720.13 indicates, "Staff will not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status." Policy 720.13 further states, "If the genital status is unknown, it may be determined during conversations with the inmate, reviewing medical records, or as part of a broader medical examination conducted in private by medical personnel requiring approval of Detention Administration." No searches, for the sole purpose of determining a detainee's genital status, have occurred in the audit period per memo submitted with the PAQ and interviews with line and medical staff.

(j): A review of RCC's training curriculum, in addition to an interview of the Training Supervisor, confirms that security staff are trained in proper procedures for conducting pat-down searches, including cross-gender searches of transgender and intersex detainees and to conduct all pat searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security

needs, including consideration of officer safety. Interviews with the Training Supervisor and security line staff, the review of the training lesson plans, which reinforce these policies in the annual training, and the review of 10 security staff training records, confirmed that training is conducted as required by the standard. During the interviews with 6 random security staff, all indicated that they would use the "blade and back of hand" technique to reduce sensitivity and display respect to the detainees. Informal interviews with staff during the on-site portion of the audit further confirmed compliance with this section of the standard.

(h): GCDC is not designated as a Family Residential Center; therefore, provision (h) is not applicable.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy 720.13 establishes the following procedures to provide LEP and disabled detainees equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment; "a) Interpreter services for the deaf or hard of hearing inmates; b) Interpreter services for non-English speaking inmates; c) Reading of the material, by staff, to inmates." Policy 720.13 further dictates that "All inmate education materials will be in formats accessible to all inmates in accordance with Title II of the Americans with Disabilities Act, 28 CFR 35.164." There were zero intakes during the on-site visit; and therefore, the Auditor toured intake processing with the guidance of two Intake Staff who narrated step-by-step the intake process. In an interview with Intake staff, the Auditor was advised that upon intake, detainees are provided with both the ICE National Detainee Handbook and the GCDC facility handbook. According to Intake staff, if a detainee requests an ICE Handbook in any of the 14 available languages, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, one would be printed out for the detainee. In the interview with the facility Commander, he had indicated that during an Office of Detention Oversight (ODO) inspection, the facility was directed to remove the ICE National Detention Handbooks that were onsite, as they were outdated, and to print handbooks as needed. The facility Commander indicated that they removed the old handbooks and requested an order of the new handbooks. He further indicated that as of the date of the onsite audit, the new handbooks were still unavailable. This was confirmed through an interview with the ERO PREA Field Coordinator. The Commander also submitted an email to Jail Supervisors, dated January 13, 2022, confirming the direction to remove the outdated handbooks and to print handbooks as needed in booklet form. However, through observation and detainee interviews, it did not appear to the Auditor that the facility had clearly established the practice of printing out the handbooks as needed. The interviews of 17 detainees revealed that 15 did not receive the ICE National Detainee handbook. In addition, when Intake staff printed out a copy of the handbook for the Auditor's review, it was not printed in booklet form as directed by the email to Jail Supervisors confirming to the Auditor that facility staff was unclear as how to provide the detainee with a copy of the handbook in their preferred language. The facility handbook is available in English, Spanish, and Haitian Creole, and provides detainees with information on the Agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse. GCDC did not have available the handbook in any other languages. The facility also has available the DHS-prescribed Sexual Assault Awareness pamphlet that provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault in English and in Spanish. The Intake staff could not explain how the detainees would get the pamphlet in the other 7 languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, which are available through ICE. Intake staff interviewed were aware of the ability to print material in various languages from the ICE website; however, they were unaware of how the PREA information would be provided to detainees who were deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities. In addition, the Intake staff indicated that they would use the ICE Language Line to interpret for a detainee who was LEP; however, the Auditor reviewed the log that documented the use of the language line during intake and confirmed it was empty. The Auditor reviewed 10 randomly chosen detainee files, all of which contained signed, but undated, documentation indicating the distribution of the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the GCDC facility handbook to the detainees. The interviews of 17 detainees revealed that 2 had confirmed they received the ICE National Detainee handbook and zero had received the facility handbook. In their interviews the detainees indicated that they would be asked to sign the form when they first arrived and would leave the area without the handbooks or pamphlets. In an interview with Intake staff, it was confirmed that the detainee did, in fact, sign the form at the beginning of the intake process and not after officially receiving the PREA material.

Does Not Meet (a)(b): The facility does not meet subsections (a)(b) of the standard. The Auditor observed during the onsite visit that the facility did not have any copies of the ICE National Detainee Handbook available onsite. Through interviews with the facility Commander and ERO PREA Field Coordinator it was confirmed that the facility has ordered updated copies of the handbook; however, at the time of the onsite audit the new handbooks were not available. The interview with the facility Commander, and presented documentation, confirmed that the Commander directed staff to print a copy of the handbook in booklet form, in the detainee's preferred language, whenever a detainee arrived at the facility; however, observed practice in addition to detainee interviews confirmed that this practice was not being followed. In addition, Intake staff, during their interviews, did not know how to access the DHS-prescribed Sexual Assault Awareness pamphlet in languages other than English and Spanish. Intake staff also could not articulate how a detainee who was deaf or hard of hearing, was blind or had low vision, or had speech, intellectual, psychiatric difficulties would receive the PREA information in a format they would understand. To become compliant, the facility must adapt the practice of providing both the ICE National Detainee Handbook and the DHS-prescribed Sexual Awareness pamphlet to LEP detainees in a language they understand. In addition, the facility must develop a practice that allows detainees with disabilities to receive the PREA information in a format they understand. Once developed, all Intake staff must receive documented training on the new procedures and the facility must present the Auditor with 10 detainee files that are for detainees who speak languages, other than English or Spanish, to confirm that the detainees are getting the information in a format they understand.

(c): Policy 720.13 states that, "the facility would provide interpreter services for non-speaking detainees" and "the agency will not rely on inmate interpreters, inmate readers, or other type of inmate assistants except in limited circumstances, and must be fully documented, where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-responder duties under 115.64, or the investigation of the inmate's allegations." The interviews with the facility Investigator, PSA Compliance Manager, facility Commander, and random line staff all confirmed that detainees would not be involved in interpretation, either in written or dictated formats, regarding sexual abuse or sexual abuse investigations and that the language line contract, ICE Language Line Services, or staff would be used when interpreter services are needed despite the facility's lack of policy prohibiting detainee translators unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. In review of 11 investigative files, all indicated that detainee translators were not utilized throughout the course of the investigation.

Recommendation (c): The Auditor recommends that policy 720.13 be amended to prohibit the use of detainee translators unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy to mirror their current practice of not utilizing detainee translators when investigating an allegation of sexual abuse. In addition, the Auditor recommends that the facility record the date the detainee received the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the GCDC facility handbook.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(e)(f): The Federal Statue 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." The ICE Personnel Security and Suitability Program policy outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Policy 720.13 prohibits "hiring or promoting anyone who may have contact with inmates and prohibits enlisting the services of any contractor who may have contact with inmates who: a) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C 1997) b) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, open or implied threats of force, or coercions, or if the victim did not consent or was unable to consent or refuse c) Has been civilly or administratively adjudicated to have engaged in the activity described in any paragraph in this section." Policy 720.13 further states, "The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as a part of reviews of current employees. The agency shall impose upon employees a continuing affirmative duty to disclose any such misconduct," and "Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." Policy 720.13 also states, "Employees must disclose any such misconduct. Any material omission(s) regarding such misconduct, or the provision of materially false information, shall be grounds for termination." The interview with the Director of Human Resources confirmed that all elements of subpart (a) of the standard are included in the "Pre-Employment Background Investigation Questionnaire" and that all-new hires, current staff, contractors, and volunteers are required to disclose all misconduct noted above and have a continuing affirmative duty to disclose any sexual misconduct. She further stated that material omissions regarding conduct as outlined in subpart (a) of this standard or giving false information is grounds for termination or withdrawal of an offer for employment and that, unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer. The Auditor reviewed the Pre-Employment Questionnaire and confirmed it's compliance. The Director of Human Resources indicated that the facility runs an annual driver's license and criminal history query on all staff, including staff up for promotion, thus capturing the continuing affirmative duty to report any sexual misconduct. A review of 10 randomly selected personnel files confirmed that the facility runs an annual driver's license and criminal history query on all staff as required by subsection (b) of the standard. The Auditor further interviewed the ERO PREA Field Coordinator who confirmed that the Agency requires staff to have a continuing duty to report any sexual misconduct on an annual basis; however, the Agency did not require him to report any incident of sexual misconduct prior to his promotion from DO to SDDO; therefore, the Agency is not compliant with subsection (b) of the standard.

Does Not Meet (b): The Agency does not meet section (b) of the standard. During an interview with the ERO PREA Field Coordinator, who received a promotion from DO to SDDO, it was confirmed that the Agency did not require him to report any incidents of sexual misconduct prior to the promotion. To become compliant the Agency must develop a process that requires employees offered career ladder promotions to report an incident of sexual misconduct prior to the promotion.

(c)(d): During a training session in November 2021, and through review of the training documentation available on SharePoint, the Unit Chief of OPR PSO explained that all ICE staff having contact with detainees must clear a background investigation through PSO before hiring. The staff complete an Electronic Questionnaire for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE. For GCDC, ICE PSO only conducts background checks on ICE employees. The Auditor submitted five ICE employee names to PSO to verify the background check process; all were compliant. Documentation also confirmed the due dates for the five-year background rechecks. Policy 720.13 requires that "Before this agency hires any new employees who may have contact with inmates, it conducts criminal background record checks" and "a criminal background record check be completed before enlisting the services of any contractor who may have contact with inmates." Policy 720.13 further states, "Criminal background records checks will be conducted by the Human Resources Department on all current employees, volunteers, and contractors, who may have contact with inmates at least every five (5) years." The interview with the Director of Human Resources indicated that backgrounds checks are conducted on all staff, contractors, and volunteers through the Florida Department of Law Enforcement (FDLE) prior to enlisting their services. She further indicated that the facility runs an annual Driver's License and Criminal History query on all staff, contractors, and volunteers. A review of 10 randomly selected personnel files, and provided documentation for contractors and volunteers, confirmed that background checks and annual criminal history queries are conducted as required by the standard.

Recommendation (d): The Auditor recommends that policy 720.13 be updated to include volunteers requiring background checks prior to having contact with detainees to mirror their current practice of conducting background checks on all volunteers prior to enlisting their services.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b): Documentation submitted with the PAQ, and an interview with the facility Commander, determined that GCDC did not design or acquire any new facility, undergone any substantial expansion or modification during the audit period, or installed any new, or updated its current monitoring system. since 2007.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a)(e): Policy 720.13 states, "When conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol" and "the GCSO Investigative Unit's evidence protocol will be based on the most recent edition of the U.S. Department of Justice's Office on Violence against Women publication, 'A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,' or similarly comprehensive and authoritative protocols developed after 2011." In the interview with the facility Investigator, it was confirmed that the Glades County Sheriff's Office (GCSO), in which he is an employee, is responsible for conducting administrative and criminal sexual abuse investigations. He advised that the facility would investigate using a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions, and if it is determined that the reported allegation is criminal in nature, it would be referred to the Sheriff's Office Criminal Investigation Division (CID). He confirmed that both entities are part of the same agency; and therefore, are required to follow the requirements of subsection (a - d) of the standard. A review of policy 720.13 confirms that the evidence protocol maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Policy 720.13 was referred to ICE for review during the onsite audit. The facility does not house juvenile detainees.

(b)(d)(c): Policy 720.13 states "The facility attempts to make available to the victim a victim advocate from a rape crisis center, in person or by other means. All of these efforts are fully documented" and "if and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member." Policy 720.13 further states, "If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals." In addition, policy 720.13 states, "Examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility will document efforts to provide SANEs or SAFEs" and "All victims of sexual abuse will be offered access to forensic medical examinations. Such examinations will be offered without financial cost to the victim. Forensic Examinations will be conducted at a local hospital or by appropriately trained clinicians at the Abuse Counseling & Treatment Center, (ACT) in Ft. Myers, Florida." GCDC has a Memo of Understanding (MOU) with Abuse Counseling & Treatment Center (ACT). The agreement in the MOU is for ACT to provide amongst other services, emotional support, crisis information, information, and referrals. The MOU was renewed on December 9, 2021, and is continuous unless the "delivery of services be more involved than originally thought or the demand for services is higher than expected." The Auditor interviewed the facility HSA who confirmed detainees are sent to the ACT Center to be seen by a SANE practitioner. The HSA at GCDC also confirmed detainee victims would never be charged for medical services related to victimization. In addition, during the on-site portion of the audit, the Auditor contacted staff at the ACT Center and was able to further confirm that the center will provide SAFE/SANE services as required by the standard. During the on-site visit, the Auditor contacted ACT via telephone. The contacted staff member confirmed ACT's commitment to provide services to the detainees at GCDC as required by the standard.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(d): The Agency provided a written directive, Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention, section 5.7, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (b) (6), (b) (7)(C) Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." GCDC policy 720.13 requires that, "The Glades County Sheriff's Office ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment" and "allegations of sexual abuse or sexual harassment must be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior." GCDC does not, however, have an investigation protocol detailing the roles and responsibilities of both the facility and the investigating entity in performing sexual abuse investigations. According to the facility Commander, the facility Investigator, and the ICE DO onsite, all investigations are reported to the JIC, entered into the JIC Management System (the Agency's system of record), and then assessed to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG and/or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor-on-detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR Investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and in coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation, who may route it to the ERO field office for action. The ERO AFOD would assign an administrative investigation to be completed. All investigations are closed with a report of investigation. The facility Commander, and facility Investigator, confirmed that every allegation of sexual abuse made must be investigated. The facility Investigator confirmed in an interview that an administrative investigation is conducted on all allegations of sexual abuse after consultation with the investigative office within DHS. The facility had 15 allegations within the audit period that were referred for investigation; 11 were closed and 4 were actively being investigated by ICE OPR. Policy 720.13 further states, "All referrals of allegations of sexual abuse or sexual harassment for criminal investigations must be documented and maintained for a period of five years." Interviews with the facility Commander, PSA Compliance Manager, and facility Investigator confirmed compliance with the standards requirement to retain all reports and referrals of allegations of sexual abuse for at least five years.

Does Not Meet (a)(b)(d): The facility is not in compliance with subsections (a)(b)(d) of the standard that requires the facility establish a protocol to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority as required in subsection (a) of the standard. As the facility does not have a protocol, the requirements of subsections (b)(d) that require what is included in the protocol is also non-compliant. To become compliant, the facility must develop a protocol that includes all elements of subsections (b)(d) of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content.

(c): During the Auditor's review of the GCDC website (www.gladessheriff.org), it was determined that the website does not contain an investigative protocol. The Auditor also reviewed the ICE website, (https://www.ice.gov/prea), which provided the required Agency protocol.

Does Not Meet (c): The facility is not compliant with subsection (c) of the standard. The facility's investigation protocol is not located on the GCDC website. To become compliant, the facility must develop an investigative protocol and place it on its website (www.gladessheriff.org)

(e)(f): Policy 720.13 does not contain verbiage that would require the facility to report an incident of detainee-on-detainee sexual abuse, or staff/contractor/volunteer-on-detainee sexual abuse to the Joint Intake Center (JIC), ICE OPR, the DHS Office of the Inspector General (OIG), the appropriate ICE Field Office Director (FOD), or the local government entity or contractor that owns or operates the facility. The facility Commander, the facility PREA Coordinator, and ICE DO, confirmed this procedure and stated that they would immediately report any sexual abuse incidents immediately to the ICE PREA Field Coordinator, who would notify the JIC, the ICE OPR and/or the DHS OIG. There were 15 sexual abuse allegations reported during the audit period. All cases were referred to ICE OPR. Eleven cases were closed and four were actively being investigated by ICE OPR. The Auditor reviewed 11 of the reported allegations in their entirety and found them to be well organized, allowing for ease of auditing. As none of the cases were determined to be criminal in nature, none were referred to the CID.

Recommendation (e)(f): The Auditor recommends that policy 720.13 be updated to include the verbiage that would require the facility to report an incident of detainee-detainee sexual abuse, or staff/contractor/volunteer-on-detainee sexual abuse to the Joint Intake Center (JIC), ICE OPR, the DHS Office of the Inspector General (OIG), the appropriate ICE Field Office Director (FOD), or the

local government entity or contractor that owns or operates the facility to mirror their current practice of reporting all incidents of sexual abuse as required by the standard.

§115.31 - Staff training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 720.13 dictates how the facility trains all staff who may have contact with detainees and requires the training for all facility staff to be able to fulfill their responsibilities to include each element of the standard. Policy 720.13 states, "The agency trains all employees who have contact with inmates" and "between training sessions, employees are provided with information about current policies regarding sexual abuse and harassment." Policy 720.13 further states, "The agency documents employee annual refresher training in their individual training record and by signature sign in sheets." During the onsite audit, the Auditor reviewed the GCDC PREA training curriculum and determined the curriculum to be compliant with the standard in all material ways. This training is documented by staff signature and serves as acknowledgment of awareness of the content. Staff training documentation is maintained within the staff training files. The Auditor randomly selected 10 staff training files to review training documentation of staff for proof of completion. Of the 10 staff training records reviewed, all received their training within the last year. Interviews with the Training Supervisor confirmed staff receives the required PREA training and refresher training as required by the standard. Facility staff, in conjunction with policy 720.13, receive PREA training annually, plus an as-needed roll call training coverage of new areas or areas needing reinforcement or emphasis. Of the 2 ICE training verifications from PALMS e-learning reviewed by the Auditor, neither ICE employee had received PREA training since 2015. Following the onsite audit, the Auditor received the updated training verification for the two ICE employees who, during the onsite audit, were deficient in their training. The training verifications received were dated January 2022, which confirms that the ICE employees did not receive refresher training every two years as required by the standard. Therefore, the Agency is not compliant with subsection (b) of the standard.

Does Not Meet (b): The Agency is not compliant with subsection (b) of the standard. The Auditor reviewed two training verifications of ICE staff who have contact with detainees and confirmed that neither employee received PREA training since 2015. Following the onsite audit, the Auditor received the updated training verification for the two ICE employees who, during the onsite audit, were deficient in their training. The training verifications received were dated January 2022 which confirms that the ICE employees did not receive refresher training every two years as required by the standard. To become compliant, all ICE staff assigned to GCDC, who have contact with detainees, must receive documented PREA training.

§115.32 - Other training.

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

Notes:

(a)(b)(c): Policy 730.13 outlines how the facility shall train, or require the training of, all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard. Policy 720.13 states, "All volunteers and contractors, who have contact with inmates, will be trained on their responsibilities under the agency's Prison Rape Elimination Act (PREA) policy. The type and level of training is based on the services they provide and level of contact they have with inmates." Policy 720.13 further states, all volunteers and contractors who have contact with inmates have, at the very least, been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. Documentation confirming that the volunteers/contractors understand the training they receive is kept on file with the agency." The Auditor interviewed the facility's Training Supervisor, who is responsible for conducting volunteer and contractor training, and determined that contractors and volunteers receive the same level of PREA training that is provided to staff and acknowledge receipt of the training. The Auditor further reviewed training sign-in sheets for volunteers and contractors, and determined that the facility was compliant in training contractors and volunteers who may have contact with immigration detainees.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f): Policy 720.13 indicates that "All inmates, during intake, will receive Intake orientation explaining the facility zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment" and "a sexual assault awareness pamphlet is provided to each inmate during intake containing information on self-protection and prevention techniques, treatment and counseling, and reporting methods." Policy 720.13 further states, "Inmate PREA education is available in accessible formats for all inmates including those who are: [l]imited English proficient, Deaf, visually impaired, otherwise disabled, or Limited in their reading skills" and "the following procedures have been established to provide disabled inmates equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. All inmate education materials will be in formats accessible to all inmates in accordance with Title II of the Americans with Disabilities Act, 28 CFR 35.164." Policy 720.13 further dictates that "within 30 days of intake, the agency shall provide comprehensive education to new inmates/detainees either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents" and "all areas covered during orientation will be signed off by the detainee and the designated staff member presenting the material on GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement. Inmate PREA education is available in accessible formats for all inmates including those who are: Limited English proficient, deaf, visually impaired, otherwise disabled, or are limited in their reading skills." Documentation submitted with the PAQ indicates that PREA information was provided to detainees through the DHS-prescribed Sexual Assault Awareness Information pamphlets, DHS posted signage "ICE Zero-Tolerance," the ICE National Detainee Handbook, and the GCDC facility handbook. According to Intake staff, if a

detainee requests an ICE Handbook in any of the 14 available languages, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, one would be printed for the detainee. In the interview with the facility Commander, he indicated that during an ODO inspection, the facility was directed to remove the ICE National Detainee Handbooks that were onsite, as they were outdated, and to print handbooks as needed. The facility Commander indicated that they removed the old handbooks and placed an order for new ones. He further indicated that as of the date of the onsite audit the new handbooks were still unavailable. This was confirmed through an interview with the ERO PREA Field Coordinator. The facility Commander also submitted an email to Jail Supervisors, dated January 13, 2022, confirming the direction to remove the outdated handbooks and to print handbooks as needed in booklet form. However, through observation, and detainee interviews, it did not appear to the Auditor that the facility had clearly established the practice of printing the handbooks as needed. The interviews of 17 detainees revealed that 15 had confirmed they did not receive the ICE National Detainee handbook. In addition, when Intake staff printed a copy of the handbook for the Auditor's review it was not printed in booklet form as directed by the email to Jail Supervisors. The facility handbook is available in English, Spanish, and Haitian Creole, and provides detainees with information on the Agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse. GCDC did not have available the handbook in any other languages. The facility also has available the DHS-prescribed Sexual Assault Awareness pamphlet that provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault in English and in Spanish. The Intake staff had trouble locating the pamphlet onsite and could not explain how the detainees would get the pamphlet in the other 7 languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. Intake staff interviewed were aware of the ability to print the National Detainee Handbook in various languages from the ICE website; however, they were unaware of how the PREA information would be provided to detainees who were deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities. The Intake staff indicated to the Auditor that an Orientation video was shown in medical; however, interviews with the medical staff confirmed the video has not been shown in the medical area since before the COVID-19 pandemic. An interview with a Shift Lt. further confirmed that the orientation video is not shown during the intake process. The Intake staff further indicated that they would use the ERO Language Line to interpret for a detainee who was LEP; however, the Auditor reviewed the log that documented the use of the language line during intake and confirmed it was void of any detainee names. The Auditor reviewed 10 randomly chosen detainee files, all of which contained a signed GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, indicating the distribution of the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the facility handbook; however, it was not dated, therefore the Auditor could not confirm the information was distributed at intake. The signed GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, further indicated that the detainee had completed an orientation program. The interviews of 17 detainees revealed that 2 had confirmed they received the ICE National Detainee handbook and 0 had received the facility handbook or attended orientation. In their interviews, the detainees indicated they were asked to sign the GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, when they first arrived and then left the area without the handbooks, pamphlets, or viewing an orientation video. In an interview with Intake staff, it was confirmed that the detainee did, in fact, sign the form at the beginning of the intake process and not after officially receiving the PREA material or completing an orientation program which included viewing a video which contained PREA information. There were zero intakes during the on-site visit; and therefore, the Auditor could not personally observe the process.

Does Not Meet (a)(b)(c)(e)(f): The facility does not meet subsections (a)(b)(c)(e)(f) of the standard. Subsection (a) of the standard requires that "during the intake process, each facility shall ensure that the detainee orientation program notifies and informs detainees about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse…" yet facility policy 720.13 dictates that "within 30 days of intake, the agency shall provide comprehensive education to new inmates/detainees either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents." The Auditor reviewed 10 randomly chosen detainee files, all of which contained a signed GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, indicating the distribution of the DHS-prescribed Sexual Assault Awareness Information Pamphlet, the DHS ICE National Detainee Handbook, and the facility handbook; however, it was undated, therefore the Auditor could not confirm the information was distributed at intake. In addition, the Auditor observed during the onsite visit that the facility did not have any copies of the ICE National Detainee Handbook available onsite. Through interviews with the facility Commander and ERO PREA Field Coordinator, it was confirmed that the facility ordered updated copies of the handbook; however, at the time of the onsite audit the new printed handbooks were unavailable. As a solution, the interview with the facility Commander and presented documentation, confirmed that the Commander directed staff to print a copy of the handbook in booklet form and in the detainee's preferred language, whenever a detainee arrived at the facility; however, observed practice, in addition to detainee interviews, indicated that this practice was not being followed. Intake staff, during their interviews, did not know how to access the DHS-prescribed Sexual Assault Awareness pamphlet in languages other than English and Spanish. Intake staff also could not articulate how a detainee who was deaf or hard of hearing, was blind or had low vision, or had speech, intellectual, psychiatric difficulties would receive the PREA information in a format they would understand. Interviews with medical, intake, and a security supervisor confirmed that the facility was not relaying the PREA information through an intake orientation, including showing a video, that contained the information required under subsection (a) of the standard. To become compliant, The facility must adapt the practice of providing the PREA education in a manner that LEP and detainees with disabilities can understand. This includes distributing the written information in the preferred language of the detainee and/or blind, deaf, intellectually impaired, and to those who have difficulty reading. In addition, the facility must develop an orientation program that is presented in a manner that LEP and disabled detainees can understand, and they must change their practice to include the detainee signing that he/she received the information once delivered and not before. Once developed, all Intake staff must receive documented training on the new procedures. In addition, the facility must present the Auditor with 10 detainee files that are

for detainees who speak languages other than English or Spanish, to confirm that the detainees are getting the information in a format they understand.

Recommendation (a): To become compliant, the facility must update policy 720.13 verbiage "during the intake process, each facility shall ensure that the detainee notifies and informs detainees about the Agency's and the facility's zero-tolerance policies for all forms of sexual abuse…" instead of "within 30 days" as it currently requires.

(d): Policy 720.13 states, "Posters containing sexual assault awareness and reporting information are posted in the intake area and throughout all areas of the facility." The facility provided the Auditor with an exhibit containing the documentation for review. During the on-site visit, the Auditor observed posting of the DHS-prescribed sexual assault awareness notice and information for ACT, which included the toll-free telephone number and the center's address. The Auditor also observed that some of the DHS-prescribed sexual assault awareness posters did not include the name of the current facility PREA Coordinator and ICE contact; however, the facility corrected the issue prior to the exit interview.

§115.34 - Specialized training: Investigations.

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

Notes:

(a)(b): Policy 730.13 states, "Investigators who investigate allegations of sexual abuse are trained in conducting sexual abuse investigations in confinement settings." The policy further states, "The specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral." The training curriculum, Investigating Sexual Abuse in Confinement Settings, was provided off-site through the Florida Sheriff's Institute. The Auditor reviewed the curriculum and determined the training covered the unique nature of investigating sexual abuse in confinement; the techniques for interviewing sexual abuse victims; the proper uses of Miranda and Garrity warnings; the proper techniques for the collection of physical evidence; understanding best practices for reaching investigative conclusions; information about effective cross-agency coordination in the investigation process; and describing the level of evidence needed to substantiate both administrative and criminal findings. The Auditor determined the training curriculum meets the standard's requirements in all material ways. The Agency policy 11062.2 states "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement.

GCDC has one investigator who has received specialized training for conducting sexual abuse investigations. A review of the investigator's training certificate confirmed compliance. The Auditor reviewed 11 investigative files and determined, except for one investigation that was conducted by a staff person no longer employed by GCDC, the investigator was trained as required by the standard. During the interview of the facility Investigator, who conducted 10 of the investigations on file, he further verified that he received the training and was knowledgeable of the requirements needed to conduct sexual abuse investigations within a confinement setting.

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

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

Notes:

(a)(b): The facility's Health Services are provided by ACHS, and not ICE Health Services Corps (IHSC); therefore, subsections (a) and (b) are not applicable.

(c): During the onsite audit, a review of policy 720.13, and interviews with Medical and Mental Health staff, indicated that Medical and Mental Health staff did not receive the training as required by subsection (c) of the standard. Policy 720.13 was updated following the onsite audit to read, "All security and Medical Staff will be trained on the proper procedures for securing a crime scene and preserving evidence in exigent circumstances to include: a) How to detect and assess signs of sexual abuse, b) How to respond effectively and professionally to victims of sexual abuse, c) How and whom to report allegations or suspicions of sexual abuse, and d) Crime Scene security and logs." The updated policy was referred to the Agency and approved on February 2, 2022. A review of the provided training curriculum, National PREA Resource Center Event Transcript – Specialized Training: Medical and Mental Health Care, and all medical and mental health staff training records submitted post onsite audit to the Auditor, via email, confirmed the facility is now in compliance with the standard.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(c)(d): Policy 730.13 states, "All inmates will be screened during intake, using an objective screening instrument for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. The PREA Inmate Screening / Risk Assessment

Form GCSO, Form # 230, shall be completed on all inmates/detainees entering the Jail. The information collected during the initial screening will be used to determine the inmate's/detainee's risk of victimization or abusiveness and to ensure the safety of each inmate/detainee in the facility" and "the PREA Intake Screening/Risk Assessment Form shall be completed by Contract Medical Staff and the Booking Supervisor (or designee)." Policy 720.13 further states, "The intake screening will consider at the minimum the following: Whether the inmate has a mental, physical, or developmental disability, age of the inmate, physical build of the inmate, if the inmate has previously been incarcerated, if the inmate's criminal history is exclusively nonviolent, if the inmate has prior convictions for sex offenses against an adult or child, if the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, if the inmate has previously experienced sexual victimization, the Inmate's own perception of vulnerability, if the inmate is detained solely for civil immigration, if the inmate has any prior acts of sexual abuse, if the inmate has a history of prior institutional violence or sexual abuse, as known to the Agency." In addition, policy 720.13 states, "Based on the answers provided and the inmate's own perceptions of vulnerability: a determination for the inmates' housing is made during intake." The screening process involves the use of the GCSO PREA Intake Screening Risk of Sexual Victimization/Abusiveness form. Medical staff complete the top half which includes physical build, mental, physical, or developmental disability, how the detainee perceives his or herself, prior sexual abuse history, and the detainee's perception of vulnerability. The bottom half of the form is then completed by Intake staff and includes all elements of the detainee's criminal history as required by the standard. During the onsite visit, the Auditor reviewed the intake screening of a detainee who had a previous conviction for sexual assault. When asked for the procedure in housing this detainee, the Intake staff indicated that bed assignment was the responsibility of the housing unit officer. They further indicated that this type of information, including the PREA Intake Screening Risk of Sexual Victimization/Abusiveness, would be shared with the PSA Compliance Manager, but not with staff determining bed assignments. In an interview with the facility PREA Coordinator, it was confirmed that the information is shared with the PSA Compliance Manager for review; however, prior to completion of the review the detainee had already received his/her initial housing assignment.

Does Not Meet (a): The facility does not meet subsection (a) of the standard that requires "the facility to house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger" as the responsibility of initial housing is placed on the housing unit officer without information gathered during the risk screening regarding the detainee's risk of likely being a sexual aggressor or a sexual abuse victim. To become compliant, the facility must develop a practice that allows staff completing the initial housing assignments access to information gathered from the risk screening so that the detainee isn't house in a dangerous situation. In addition, the facility must demonstrate that the procedure has been put into place through demonstrated practice by providing the Auditor with 10 detainee intake risk screenings that confirm compliance. Further, all Intake and staff responsible for making housing unit assignments, must receive documented training in the new procedure.

(b) Policy 720.13 states, "Based on the answers provided and the inmate's own perceptions of vulnerability: a determination for the inmates' housing is made during intake. If the inmate feels comfortable in general population, the inmate will be placed in a housing unit. If the inmate feels uncomfortable being placed in general population, the inmate will be housed on Administrative Confinement until seen and evaluated by the PREA Compliance Manager and/or Classification; unless required by a medical practitioner to be housed in the Medical Unit." Interviews with Intake staff indicated the detainee's initial classification would be completed within 12 hours upon arrival; however, if during the risk screening the detainee was perceived to be sexually vulnerable, he/she would be held in protective custody or medical until seen by the PSA Compliance Manager. A review of 10 detainee files, all of which were not perceived to be vulnerable during intake, indicated that the initial screening was completed within 12 hours as mandated by the standard. Interviews with 17 detainees, who also were not perceived to be vulnerable during intake, further confirmed they completed intake within 12 hours. There were zero detainees who were perceived to be vulnerable during intake to interview or conduct a file review.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard which states, "The initial classification process and initial housing assignment should be completed within twelve hours of admission to the facility." Per policy 720.13 ""Based on the answers provided and the inmate's own perceptions of vulnerability: a determination for the inmates' housing is made during intake. If the inmate feels comfortable in general population, the inmate will be placed in a housing unit. If the inmate feels uncomfortable being placed in general population, the inmate will be housed on Administrative Confinement until seen and evaluated by the PREA Compliance Manager and/or Classification; unless required by a medical practitioner to be housed in the Medical Unit." Interviews with Intake staff indicated the detainee's initial classification would be completed within 12 hours upon arrival; however, if during the risk screening the detainee was perceived to be sexually vulnerable, he/she would be held in protective custody, or, medical until seen by the PSA Compliance Manager. To become compliant the facility must develop a practice that allows for all detainees to be initially housed within 12 hours of arriving at GCDC. In addition, the facility must demonstrate that the procedure has been put into place through demonstrated practice by providing the Auditor, if available, risk screenings of vulnerable detainees to confirm housing occurred within 12 hours. Further, all Intake, and staff responsible for making housing unit assignments, must receive documented training in the new procedure.

(e): Policy 720.13 requires that "Additional assessment by classification or the PREA Compliance Manager's designee within 30, 60 and 90 days from the inmate's arrival, based upon any additional relevant information received by the facility since the intake screening" and "an inmate's risk level shall be reassessed at any time and when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness." In an interview with Classification staff, it was confirmed that staff were aware of their requirement to reassess a detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any time when warranted based on the receipt of additional, relevant information; however, they were not aware that the standard required an assessment following an incident of sexual abuse or victimization. The Auditor reviewed 10 detainee files and determined that none of the detainees were reassessed

between 60 and 90 days as required by the standard. In addition, the Auditor reviewed 11 investigation files and determined that none of the detainee victims were assessed after an incident of sexual abuse.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. The Auditor's review of 10 detainee files confirmed that detainees are not reassessed between 60 and 90 days as required by the standard. In addition, the Auditor reviewed 11 investigation files that confirmed the facility does not reassess a detainee after an incident of sexual abuse. To become compliant the facility must provide, if available, a sample of one or more sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse and 10 detainee files that document that a reassessment is completed within the between 60- and 90-day timeframe. In addition, the facility must submit documentation that both classification staff, and the facility Investigator, have received training regarding the requirement to complete reassessments between 60 and 90 days, following an allegation of sexual abuse, and when additional information is obtained.

(f): Policy 720.13 states, "Inmates will not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked during the risk screening relating to the following questions: Whether the inmate has a mental, physical, or developmental disability, whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming, whether the inmate has previously experienced sexual victimization, or the inmate's own perception of vulnerability." Policy 720.13 further states, "Inmates/detainees refusing to disclose information during the screening process will be referred to the PREA Compliance Manager and if necessary, Contract Medical Staff, for a follow-up interview. Follow-up interviews shall be completed within 72 hours of the initial intake process. Documentation of a refusal to disclose information shall be noted in the PREA Intake Screening/Risk Assessment Form and by Jail Book Incident Report." Interviews with the PSA Compliance Manager, Intake staff, and medical staff indicated detainees are not disciplined for refusing to answer, or for not disclosing complete information, in response to questions asked pursuant to the standard. A review of 10 detainee files confirmed should a detainee refuse to answer questions pursuit to paragraphs (c) (1, 7, 8, 9) of the standard it is noted on the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form.

(g): Policy 720.13 states "The Agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to inmate screening, in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates." Interviews with the PSA Compliance Manager, Intake staff, the HSA, and Classification Supervisor confirmed that appropriate controls on the dissemination within the facility of the information obtained during the intake process are in place.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a): Policy 720.13 requires that "Information from the risk screening will be used to determine housing, bed, work, education, and program assignments to prevent inmates with the high risk of being sexually victimized from those at the risk of being sexually abusive." In review of 10 detainee files, the Auditor determined that the facility is not utilizing the data collected from the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form to determine initial housing, recreation, work, and other activity decisions. Interviews with the HSA, Classification, and security Intake staff further confirmed the facility was not using all the information obtained as part of the risk assessment in 115.41, as required by the standard. When asked for the procedure in housing a detainee that was determined to be a sexual predator based on his criminal history, the Intake staff indicated that bed assignment was the responsibility of the housing unit officer. They further indicated that this type of information, including the PREA Intake Screening Risk of Sexual Victimization/Abusiveness, would be shared with the PSA Compliance Manager, but not with staff determining initial housing assignments. In an interview with the facility PREA Coordinator it was confirmed that the information is shared with the PSA Compliance Manager for review; however, prior to completion of the review, the detainee has already received his/her initial housing assignment.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41 when determining initial housing, recreation and other activities, or voluntary work assignments. A review of 10 detainee files, and interviews with Intake staff who indicated that criminal history and information from the PREA Intake Screening Risk of Sexual Victimization/Abusiveness, would be shared with the PSA Compliance Manager, but not with staff determining initial housing assignments, confirm that this information is not considered when determining initial housing, recreation and other activities, or voluntary work assignments. To become compliant, the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form needs to be shared with staff determining initial housing, and other necessary staff, so that proper housing, recreation, volunteer programming and other activities can be properly assessed. In addition, all Intake and applicable staff should be trained in the proper use of the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form when determining the elements of the standard. In addition, the facility must provide 10 detainee files that document that the information from the risk screening is utilized when determining initial housing, recreation and other activities, or voluntary work assignments.

(b): Policy 720.13 states, "The Agency makes housing and program assignments for transgender or intersex inmates in the facility on a case-by-case basis to ensure the inmates' health and safety; and whether the placement would present management or security problems. Placement and programming assignments for transgender or intersex inmates shall be reassessed at least twice each year to review any threats to the inmates' safety. A transgender or intersex inmates' own views with respect to his or her own safety shall be given serious consideration. Transgender or intersex inmates shall be given the opportunity to shower separately from other

inmates. The PREA Compliance Manager or designee will assess all transgender or intersex inmates." Interviews with Intake, Classification, and medical staff indicated they lacked knowledge when it came to housing transgender detainees. In addition, during the Auditor's interview with the classification staff, the staff were unaware of the reassessment requirements for transgender detainees. The Auditor had planned to interview transgender detainees during the on-site audit; however, there were no transgender detainees housed at the facility during the visit.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. During interviews with intake, medical and classification staff, it was confirmed that staff are not knowledgeable regarding how to properly house and provide program access to transgender and intersex detainees. To become compliant, the classification and medical staff need to be trained on the requirements to house, provide program access, and reassess transgender or intersex detainees as outlined in facility policy 720.13. In addition, if available, the facility must submit the detainee and medical files of any transgender or intersex detainees housed at GCDC during the CAP period.

(c): Policy 720.13 states, "Transgender or intersex inmates who prefer to shower separately will be taken to Medical and allowed to shower in the Medical hallway shower." Interviews with intake staff, the Classification Supervisor, and security line staff confirmed that transgender or intersex detainees are allowed to shower separately from other detainees.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e): Policy 720.13 states "Inmates/detainees at high risk for sexual victimization will not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers." The policy further states, "If an involuntary segregated housing assignment is made, the facility shall clearly document: the basis for the facility's concern for the inmates' safety and the reason why no alternative means of separation can be arranged." In addition, policy 720.13 states, "Inmates/detainees placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If the facility restricts access to programs, privileges, education, or work opportunities, the facility shall document: the opportunities that have been limited, the duration of the limitation, and the reasons for such limitations." Policy 720.13 further states, "The facility shall notify the appropriate ICE Field Office Director whenever an ICE detainee victim has been held in administrative segregation for 72 hours" and "upon receiving notification that a detainee victim has been held in administrative segregation, the ICE Field Office Director shall review the placement and consider: whether the placement is only as a last resort and when no other viable housing options exist; and in cases where the detainee has been held in administrative segregation for longer than 5 days, whether the placement is justified by highly unusual circumstances or at the detainee's request." During his interview, the facility Commander indicated that policy 720.13 had not been referred to the ICE FOD during his interview; however, he forwarded the policy for review during the onsite audit. He stated that any detainee placements in segregation must be reported to the ICE FOD within 72 hours. The officer assigned to segregation confirmed that should a detainee be placed in administrative segregation for protective custody, they would be provided access to programs, visitation, counsel, and other services available to the general population detainees to the extent possible or he would document the reason they were not provided. The Auditor confirmed through interviews, documentation submitted with the PAQ, and observation during the on-site audit that no detainees identified as at risk for sexual abuse and assault were placed in segregation for protection during the audit period.

Recommendation (e): Interviews with the facility Commander confirmed that the facility is in compliance with (e) of the standard; however, the Auditor recommends that policy 720.13 be updated, in consultation with the ICE ERO FOD, to state, "the ICE FOD will be notified within 72 hours after the initial placement of a detainee victim into administrative housing." The new verbiage should replace, "whenever an ICE detainee victim has been held in administrative segregation for 72 hours."

(d): A review of policy 720.13 indicated that the facility is not in compliance with subsection (d) of the standard as the policy does not require that when a detainee is held in Administrative Segregation on the basis of a vulnerability to sexual abuse or assault the placement be reviewed by supervisory staff member within 72 hours of the detainee's placement, after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter. The Auditor confirmed through interviews, documentation submitted with the PAQ, and observation during the on-site audit that no detainees identified as a risk for sexual abuse and assault were placed in segregation for protection during the audit period.

Does Not Meet (d): The facility does not meet subsection (d) of the standard. Policy 720.13 does not require that when a detainees is held in Administrative Segregation on the basis of a vulnerability to sexual abuse or assault due to highly unusual circumstances or by their own request be the placement be reviewed by supervisory staff member within 72 hours of the detainee's placement or after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter. To become compliant, the facility must update policy 720.13, in consultation with the ICE ERO FOD, to include the language required by subsection (d) of the standard and to initiate the practice of reviewing all placement of detainees within 72 hours of the detainee's placement, after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter as required by the standard. The facility must also conduct documented training of all applicable staff on updated policy 720.13 and provide the Auditor with any detainee files where the detainee was held on Administrative Segregation to confirm reviews were conducted as required by subsection (d) of the standard.

§115.51 - Detainee reporting.

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

(a)(b)(c): Policy 720.13 states, "Staff must accept reports of sexual assault and sexual harassment made verbally, in writing, anonymously, and from third parties" and "the Glades County Sheriff's Office Detention Division allows for internal reporting, by inmates/detainees, to report privately to agency officials about: sexual abuse or sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents." Policy 720.13 states, "The multiple internal reporting methods inmates can utilize, are: verbal reporting, request forms, grievance forms, GCSO Internal PREA HOTLINE by Dialing# 9, Abuse Counseling & Treatment Center (ACT) Toll Free Hotline# 1-888 - 9 56-72 73 or 333# or write to: Abuse Counseling & Treatment (ACT), P.O. Box# 20401, Fort Myers, Fl. 33906, and the National Sexual Abuse Hotline- 1-800 -656-4673 (toll free, non-recorded line), ICE's Community & Detainee Hotline at # 1-888-351-4024 or 9116#, ICE's Joint Intakes Center at 1-877-246-8253 or 5663#, or write to Department of Homeland Security, Office of the Inspector General, 245 Murray Drive SE. Building 410, Washington, DC 20528." Policy 720.13 also requires "Staff to immediately document verbal reports." During the onsite audit, the Auditor observed postings throughout the housing units that advised detainee's how to contact their consular official, the DHS OIG, and other appropriately designated offices to confidentially and if desired anonymously report an incident of sexual abuse. During the on-site portion of the audit, the Auditor noted that the facility posted numerous ways for detainees to dial tollfree numbers to report an incident including the Consular Office and the DHS OIG. Information about ACT was also posted. The Auditor contacted ACT staff onsite and confirmed they would take a report of sexual abuse verbally and anonymously at no charge to the detainee.

§115.52 - Grievances.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(e): Policy 720.13 states, "Agency policy allows an inmate to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred" and "detainees will be permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint." However, policy 790.03, Inmate/Detainee Grievance Process, states, "Formal written grievances must be submitted no later than five days after the event or after the unsuccessful conclusion of an informal verbal grievance." Policy 720.13 states on page 20, sections 6 and 7, "The Glades County Sheriff's Office Detention Division Administration will issue a final decision on the merits of any portion of a grievance alleging sexual abuse within 5 days of the initial filing of the grievance. The Detention Division Administration may claim an extension of time to respond up to 30 days if the normal time for response is insufficient to make an appropriate decision." However, on page 20 section 14, policy 720.13 states, "Emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within five (5) days." Policy 790.03 states, "An inmate/detainee shall have the option to file a grievance of appeal if they are dissatisfied with the original grievance findings within five (5) days of receiving a response." A review of both policies confirms that neither policy addresses the facility sending a copy of the grievance to the appropriate ICE FOD at the end of the grievance process. The Auditor interviewed the Grievance Coordinator who could not confirm that grievances regarding sexual abuse can be submitted at any time as stated in policy 720.13 or within 5 days of the occurrence as stated in policy 790.03. In addition, she could not verify that a grievance regarding an incident of sexual abuse will be decided on within five days of the receipt of the grievance. A review of the GCDC Inmate/Detainee handbook mirrored requirements as outlined in policy 790.03. The Auditor reviewed 11 investigative files and confirmed none of the allegations were reported through the grievance system.

Does Not Meet (b)(e): The facility is not in compliance with subsection (b) of the standard. Policy 790.03 and the GCDC facility Inmate/Detainee handbook require that detainees file a formal grievance no later than five days after the event or after the unsuccessful conclusion of an informal verbal grievance. An interview with the Grievance Coordinator could not confirm the requirement of the standard that allows the detainee victim of sexual abuse to file a grievance at any time with no time limits. To become compliant, the facility must update policy 790.03 and the GCDC Inmate/Detainee handbook, to allow the detainee to file a grievance regarding an allegation of sexual abuse with no time limits. In addition, the facility must train all applicable staff on the standard's requirements and document the training. If applicable, the facility must submit to the Auditor any detainee investigation files, in conjunction with the filed grievance, of any detainee who submitted a grievance due to an allegation of sexual abuse. Furthermore, the facility is not in compliance with subsection (e) of the standard. Policy 790.03 and the GCDC facility Inmate/Detainee handbook require that detainees file an appeal within five days of receiving the response. To become compliant, the facility must update policy 790.03 and the GCDC Inmate/Detainee handbook, to allow the detainee to file an appeal within 30 days of receiving the response and to forward all grievances alleging sexual abuse to the appropriate ICE FOD at the end of the grievance process as required. Also, the facility must document training of all applicable staff on the standard's requirements. In addition, if applicable, the facility must submit to the Auditor any detainee investigation files, in conjunction with the filed grievance, of any detainee who submitted a grievance due to an allegation of sexual abuse.

(c)(d): Policy 790.03 states, "When a receiving staff member is approached by an inmate/detainee who verbally raises a fact or delivers a written request form identified as an emergency grievance, the following emergency grievance procedures will apply: the staff member receiving the emergency grievance document or information will immediately notify and forward the information or document to a supervisor, facility grievance officer or a facility administrator or their designee, the emergency grievance will be forwarded to the grievance officer and/or the facility administrator for processing and review, and when, after review and investigation, the emergency grievance is substantiated and represents an emergency, the facility administrator will take the required action to resolve the matter in a timely manner." Policy 790.03 further states, "Formal written grievances regarding medical care shall be distributed to designated medical personnel." In an interview with the Grievance Coordinator, she indicated that the facility handles

emergency grievances as directed in policy 790.03. She further confirmed that any emergency grievances that were medical would be distributed to medical personnel. The Auditor reviewed 11 investigative files and confirmed none of the allegations were reported through the grievance system.

(f): Policies 720.13, 790.03, and the GCDC Inmate/Detainee handbook state, "Agency policy and procedure permits third parties, including fellow inmates, staff members, family members, attorneys, and outside advocates to assist inmates in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of inmates." In an interview with the Grievance Coordinator, she indicated that the facility would allow detainees to obtain assistance in filing a grievance relating to sexual abuse as dictated by policy and the GCDC facility Inmate/Detainee handbook.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d): Policy 720.13 states "The agency shall maintain or attempt to enter into memoranda of understanding (MOU) or other agreements with community service providers." Documentation submitted with the PAQ confirmed GCDC has an MOU with ACT to provide support in areas of crisis intervention, counseling, and support during the investigation and prosecution. The most recent MOU was entered into during December of 2021 and is continuous unless the delivery of services be more involved than originally thought or the demand for services higher than expected. During the on-site visit, the Auditor observed information pertaining to ACT prominently posted in the housing units. The posted signage included the ACT address and telephone number, and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. While onsite, the Auditor contacted the staff at ACT and confirmed that they would provide support in the areas of crisis intervention, counseling, and support during the investigation and prosecution. A review of the GCDC facility handbook confirmed detainees are notified that "All telephone calls are subject to monitoring;" however, it lacked information pertaining to ACT. The Auditor confirmed during the detainee interviews that only three detainees were aware of ACT and their ability to receive confidential emotional support.

Recommendation (c): The Auditor recommends that the information pertaining to ACT is placed in the GCDC detainee handbook.

§115.54 - Third-party reporting.

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

Notes:

Policy 720.13 states, "The Agency provides a method to receive third-party reports of inmate sexual abuse or sexual harassment by posting reporting information and contact numbers on the Agency's website." The Auditor reviewed the ICE website, www.ice.gov/prea, and the facility website (www.gladessheriff.org) and confirmed the information regarding third party reporting was posted on both. In addition, a review of the GCDC facility Inmate/Detainee handbook confirmed that it contained information on how to report through external confidential reporting resources such as the DHS OIG. In the interviews with 17 detainees, 8 stated they would use the 1-800 number. None of the detainees indicated that they knew they could have someone report for them.

Recommendation: The Auditor recommends that the facility update the GCDC Inmate/Detainee handbook to include information pertaining to having someone report for you under third party reporting, thus enabling the detainee to have access to this information and provide it to a third-party if need be.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b): Policy 720.13 states, "All staff are required to report immediately, even going outside the chain of command any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, even if that facility is not the Glades County Sheriff's Office Detention Division." Policy 720.13 further states, "All staff are required to immediately report any retaliation against inmates or staff who report such incidents" and "all staff are required to immediately report any staff neglector violation of responsibilities that may have contributed to an incident or retaliation." In an interview with the facility Commander, it was confirmed that policy 720.13 had not yet been reviewed and approved by ICE as required by the standard; however, during the on-site audit, the facility Commander forwarded the policy to ICE and requested they review and approve the policy as written. The Auditor interviewed six random staff members, and each confirmed their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Staff were also aware of their ability to make a report to the national #800 hotline number. Staff interviewed further indicated reporting obligations and maintaining confidentiality are presented in the annual PREA training they receive.

(c): Policy 720.13 states, "Apart from reporting to the designated supervisors or officials and designated state or local services agencies, staff is prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decision." Interviews with six random staff confirmed that they are aware of their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor and that information they become aware of is to remain confidential, except when disclosing to a supervisor or during the investigation to an investigator.

(d): Policy 720.13 requires "If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person's statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws." The facility Commander confirmed that, although it has not yet happened at GCDC, if an alleged victim was designated as a vulnerable adult, he would be the person responsible for the reporting as required under the Florida state vulnerable person's statue. As previously noted, GCDC does not accept juvenile detainees.

§115.62 - Protection duties.

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

Notes:

Policy 720.13 requires that "When the agency or facility learns that an inmate is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the inmate (i.e., it takes some action to assess appropriate protective measures without unreasonable delay.)" The six random line staff interviewed confirmed if they become aware a detainee is at substantial risk of sexual abuse, their first response would be the safety of the detainee at risk; and therefore, their first course of action would be to seek out the detainee, isolate him, and notify their supervisor. The facility Commander, in his interview, confirmed detainee safety would be his paramount concern. He confirmed his options would depend on the situation, but he would make sure the detainee is placed in the least restrictive housing available and would immediately ensure an investigation was conducted. In a review of the 11 investigative files, the Auditor determined the facility took the appropriate action required to protect the detainee victim.

§115.63 - Report to other confinement facilities.

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

Notes:

(a)(b)(c): Policy 730.13 states that "Upon receiving an allegation that an inmate was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency/facility where sexual abuse is alleged to have occurred." Policy 720.13 further states, "The facility head will provide such notification as soon as possible, but no later than 72 hours after receiving the allegation" and "Glades County Sheriff's Office Detention Division will fully document that it provided such notification within 72 hours of receiving the allegation." Out of the 11 investigation files reviewed, the Auditor did not detect any allegations of sexual abuse at another facility that were made during the PREA risk screening. In addition, the facility Commander interview indicated there had been no occurrences where a detainee, transferred from another facility, reported an incident of sexual abuse.

(d): Policy 720.13 states, "The Glades County Sheriff's Office Detention Division is required to fully investigate allegations received from other facilities/agencies." The facility Commander confirmed that, as with any allegation of sexual assault, he would immediately report the alleged incident to the FOD, the PREA Compliance Manager, and the facility Investigator. The facility Commander further stated, he would also ensure that the facility investigates the allegation as required by policy.

§115.64 - Responder duties.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b): Policy 720.13 outlines first responder procedures for allegations of sexual abuse. The policy requires the first responder to: "a) Separate the alleged victim and abuser; b) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence." Policy 720.13 further requires, "The first Officer on the scene has the responsibility to secure, preserve, and control access to and from the crime scene." In addition, policy 720.13 states, "If the abuse occurred within a time period that still allows for the collection of physical evidence, staff will ensure that the alleged abuser not take any action that could destroy physical evidence; including washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating" and "if the first staff responder is not a security staff member, that responder shall be required to: request that the alleged victim not take any actions that could destroy evidence and immediately notify security staff." The six random security staff interviewed detailed their responsibilities as required under subpart (a) of this standard. The staff also carry a small card outlining their specific responsibilities as required by the standard. Staff randomly interviewed confirmed if a detainee reported an allegation to them, they would request the detainee victim not take any actions that could destroy physical evidence and would contact the closest security staff member. A review of the 11 investigation files indicated that the first staff responders acted per the requirements of the standard. According to documentation submitted with the PAQ, and the interview with the PSA Compliance Manager, there were zero non-security responder occasions during the audit period. Based on the staff's extreme knowledge as to how they would perform if they acted as a first responder to an incident of sexual abuse, and the issuance of individual PREA response cards carried by all staff, the Auditor finds that the facility exceeds standard 115.64.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b): Policy 720.13 establishes a First Responder and Coordinated Response plan. Outlined in policy 720.13, is 'GCDC Allegation of Sexual Response Plan' to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to any incident of sexual abuse." First Responder cards were issued to all staff to enhance compliance in incident response. The policy provides an Allegation of Sexual Response flowchart that clearly delineates each team member's responsibility in the event of a sexual abuse allegation. The Auditor interviewed the PSA Compliance Manager, medical and mental health staff, and the facility Investigator; all staff interviewed clearly described their responsibilities when responding to incidents of sexual abuse.

(c)(d): A review of the GCDC Allegation of Sexual Response Plan and policy 720.13 indicated that the facility is not in compliance with subsections (c) and (d) of the standard. The standard requires a coordinated plan that includes, "if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise," which is not covered in either the plan or the policy. In an interview with the facility Commander, he indicated that he "assumed subsections (c) and (d) would be handled by ICE," thus further confirming the facility has not included sections (c) and (d) in their coordinated response.

Does Not Meet (c)(d): Neither the facility's coordinated response plan nor policy 720.13 include the requirements mandated by subsections (c) and (d) of the standard. To become compliant, the facility must update the GCDC Allegation of Sexual Response Plan, and facility policy 720.13, to include the language required by subsections (c) and (d) of the standard and to initiate the practice of informing the receiving facility covered by subpart (a) and (b) of the incident and the victim's potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise." The facility must also conduct documented training of all applicable staff on the change in the Allegation of Sexual Response Plan and policy 720.13 that includes notifying facilities as required by the standard. In addition, if applicable, the facility must provide the Auditor with any detainee files where the detainee victim of sexual abuse, or assault, was transferred to confirm the facility is following the updated Sexual Response Plan.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Policy 720.13 states, "Any staff, contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring inmate or detainee contact pending the outcome of an investigation." A review of four closed investigative files that alleged sexual abuse by staff (3), or contractors (1), indicated that none of the alleged abusers were removed from duties requiring detainee contact. In an interview the facility Commander, he stated staff would be removed, placed on administrative leave, and even terminated depending on the outcome of investigation; however, he confirmed the facility did not remove the staff, or contractors, involved in the allegations.

Does Not Meet: The facility does not meet standard 115.66. In a review of four closed investigative files that involved staff, or contractors, none of the alleged abusers were removed from all duties requiring detainee contact. In the interview with the facility Commander, it was confirmed that the facility did not remove the staff, or contractors, involved in the allegations. To become compliant, the facility must follow policy 720.13 and the standard, which require the removal of all staff, volunteers, and contractors suspected of perpetrating sexual abuse. In addition, the facility must demonstrate, if applicable, that staff, volunteers, or contractors were removed from duties during the investigation process by providing the Auditor copies of investigation files that occurred during the CAP period. Finally, the facility must provide documented training of all applicable staff in the section of policy 720.13 that requires any staff, contractor, or volunteer suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of the investigation.

§115.67 - Agency protection against retaliation.

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

Notes:

(a)(b)(c): Policy 720.13 states, "The agency protects all inmates and staff who report sexual abuse or sexual harassment or those who cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff. The agency's PREA Coordinator (Detention Director of Operations) is designated to monitor for possible retaliation." The policy further states, "For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct and treatment of inmates or staff who report sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by inmate or staff and acts promptly to remedy any such retaliation. The agency shall monitor to include any inmate disciplinary reports, housing or program changes or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." Interviews with the facility PREA Coordinator confirmed that he has the responsibility to monitor both staff and detainee retaliation and that the monitoring includes periodic status checks, at least monthly, of the detainee and review of relevant documentation, including any disciplinary reports and housing or program changes. The facility PREA Coordinator further indicated that monitoring for both staff and detainees will continue beyond 90 days if the initial monitoring indicates a continuing need and that any instances of staff and/or detainees' retaliation would be brought to the attention of the facility Commander. A review of the monitoring documentation submitted confirmed monitoring has been in place since June 2021. A review of 11 investigation files, in conjunction with the submitted monitoring documentation, confirmed that detainee monitoring commenced in June 2021 and that 8 detainee victims received monitoring during the audit period. As documentation submitted confirms that monitoring has been conducted since June 2021, the Auditor finds the facility is substantially compliant with the standard. There were zero monitoring requests initiated for staff during the audit period and the PREA Coordinator confirmed that there were no instances where staff retaliation monitoring was needed.

§115.68 - Post-allegation protective custody.

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

(a)(c): Policy 720.13 states, "The facility shall take care to place inmate and detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible." Policy 720.13 further states that, "All inmate/detainees will be reassessed before being placed back in general population." The facility Commander indicated during his interview that he would place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. In addition, the facility Commander, and PSA Compliance Manager, confirmed in their interviews, that the PSA Compliance Manager would reassess all detainee victims placed in administrative segregation prior to releasing them to general population. The Auditor reviewed a memo, submitted with the facility PAQ, that no detainees were housed in protective custody due to an incident of sexual abuse during the audit period. This was confirmed in an interview with the facility PSA Compliance Manager.

(b)(d): Policy 720.13 states "ICE Detainee victims will not be held in any type of administrative segregation for more than five days, except in highly unusual circumstances or at the detainee's request." Policy 720.13 further states, "The facility shall notify the appropriate ICE Field Office Director whenever an ICE detainee victim has been held in administrative segregation for 72 hours." The facility Commander confirmed that he would not house a detainee victim of sexual abuse in administrative segregation for more than five days except in highly unusual circumstances or at the detainee's request. He further indicated that he would notify the ICE FOD whenever a detainee victim is held in administrative segregation for 72 hours. The Auditor reviewed a memo, submitted with the facility PAQ, that no detainees were housed in protective custody due to an incident of sexual abuse during the audit period. This was confirmed in an interview with the facility PSA Compliance Manager.

§115.71 - Criminal and administrative investigations.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a): Policy 720.13 states that "All investigations into allegations of sexual abuse and sexual harassment will be done promptly, thoroughly, and objectively, including third-party and anonymous reports." Policy 720.13 further states, "The Glades County Sheriff's Office Detention Division shall use investigators who have received special training pursuant to § 115.34." The facility uses one Investigator. Documentation submitted to the Auditor confirmed that the Investigator is specially trained. A review of 11 investigation files confirmed that the investigator, in all but one of the investigations, was trained as required. In an interview, the facility Investigator advised the Auditor that the one investigative file was conducted by a trained investigator who no longer works for GCDC. This was confirmed in an interview with the Director of Human Resources. The review of the 11 investigation files, in conjunction with the facility Investigator interview, confirmed that the investigations were prompt, thorough and objective.

(b): Policy 730.13 states, "Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity." In an interview with the facility Investigator, he indicated that an administrative investigation is conducted on all allegations of sexual abuse after consultation with ICE. He further stated that if the investigation reveals that the allegation maybe criminal in nature, it would be immediately referred to the GCSO CID. The review of the 11 investigation files confirmed that all elements of subsection (b) of the standard were met.

(c): Policy 720.13 states, "Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. The credibility of an alleged victim, suspect or witness shall not be determined by the person's status as inmate or staff. The agency shall not require an inmate who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation." Policy 720.13 further states, "Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse" and "shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings." In addition, policy 720.13 states, "The agency retains all written reports pertaining to administrative or criminal investigations of alleged sexual assault or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years" and "when the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution."

Interviews with the PSA Compliance Manager, and facility Investigator, confirmed that investigative files are retained in accordance with the standard and that an administrative investigation would be conducted on all allegations of sexual abuse after consultation with the investigative office within DHS. A review of 11 investigation files confirmed that all elements of subsection (c) of the standard were met.

(e)(f): Policy 720.13 states, "The departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." In interviews with the facility Commander and facility Investigator, both indicated an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. Policy 720.13 further states, "When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." Of the 11 investigative files reviewed by

the Auditor, 2 files involved a released/transferred detainee. Both files indicated that the investigation was closed due to the suspect/victim being released/transferred and unable to interview so the case was closed. The facility Investigator stated that he maintained close cooperation with the GCSO CID Investigators and would receive available updates as the cases progressed. The 11 investigative files reviewed indicated that none of the allegations were criminal; and therefore, were not referred to the GCSO CID for investigation.

Does Not Meet (e): The facility is not in compliance with subpart (e) of the standard. Policy 720.13 states, "The departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation", however, the Auditor reviewed two investigative files that involved a released/transferred detainee. Both files indicated that the investigation was closed due to the suspect/victim being released/transferred and unable to be interviewed. To become compliant the facility must follow policy 720.13 and not allow the departure of the alleged perpetrator or victim from the employment or control of the facility to terminate an investigation. In addition, if applicable the facility must provide the Auditor with copies of investigations that continued following the departure of the suspect/victim from the facility.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Policy 720.13 states that "The agency imposes a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated." The facility Investigator, during an interview, verified that the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The Auditor reviewed 11 investigation files and determined they were completed in accordance with the standard.

Recommendation: The Auditor recommends that policy 720.13 be updated to delete the verbiage "or a lower standard of proof" as it is not consistent with the DHS standard requirement.

§115.73 - Reporting to detainees.

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

Notes:

Policy 720.13 states, "The agency requires that any inmate who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency." The facility Investigator confirmed detainees are informed of investigation outcomes regardless of the entity that completes the investigation. Following the ICE final case status determination, the detainee is provided the decision by written memo which is maintained in the investigation file. The Auditor reviewed 11 investigation files and confirmed that all but five of the files contained the written memo to the detainee advising him/her of the outcome of the investigation. In addition, following the onsite audit, the Auditor, confirmed compliance on four of the investigation files not confirmed by the onsite file review via the "PREA Audit: Notification of PREA Investigation Result to Detainee - ICE Facilities." The response, although confirmed notification, did not contain a copy of the sent notification. As the Agency and the facility provided documentation for 10 of the 11 detainees supporting they received a notification of the outcome of the investigation, the Auditor finds the facility is in substantial compliance with 115.73.

Recommendation: The Auditor recommends that the detainee is given the notification in person and signs for its receipt.

§115.76 - Disciplinary sanctions for staff.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d): Policy 720.13 states, "Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Termination is the likely disciplinary sanction for staff who engaged in sexual abuse." Policy 720.13 further states, "All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies." A review of policy indicates that it was not reviewed and approved by the Agency, nor does it contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards." In addition, the policy does not indicate that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." The Auditor interviewed the facility Commander who indicated that there were no staff resignation, termination, or discipline for violating the facility's policy on sexual abuse during the audit period. In addition, the facility Commander stated staff would be removed, placed on administrative leave, and even termination depending on the outcome of investigation. The Auditor conducted three investigative file reviews of sexual abuse allegations against staff and found that none of the cases were substantiated.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of policy 720.13 indicates that the policy was not reviewed and approved by the Agency, nor does it contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or

standards." In addition, policy 720.13 does not indicate that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." To become compliant with subsections (a) and (b), the facility must update policy 720.13 to include the required verbiage of the standard. In addition, although the facility referred policy 720.13 to the Agency during the on-site audit it did not contain verbiage required by subsections (a) and (b) of the standard, therefore, the facility must submit the updated version for review and approval by the Agency. In addition, if applicable, the facility must provide investigation files that confirm a staff member was disciplined in accordance the standard 115.76 after an incident of substantiated sexual abuse.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c): Policy 720.13 states, "The agency requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Policy 720.13 further states, "Any contractor or volunteer who engages in sexual abuse is prohibited from contact with inmates" and "the facility will take remedial measures and prohibit further contact with inmates in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer." The facility Commander confirmed that any contractor or volunteer suspected of perpetrating sexual abuse would be removed from all duties involving detainee contact, and that if the allegation was substantiated, the incident would be reported to the contractor's employer, and any other relative licensing bodies. The Auditor reviewed one investigative file that pertained to an allegation of contractor-on-detainee sexual abuse and found that the case was concluded as unsubstantiated.

§115.78 - Disciplinary sanctions for detainees.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 720.13 states, "Inmates are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the inmate engaged in inmate-on-inmate sexual abuse" and "inmates are subject to disciplinary sanctions pursuant to a formal disciplinary process following a criminal finding of guilt for inmate-on-inmate sexual abuse." Policy 720.13 further states, "Sanctions are proportionate with the nature and circumstance of the abuses committed, the inmate's disciplinary history, and the sanctions imposed for the comparable offenses by other inmates with similar histories." A review of policy 720.13, and the GCDC Inmate/Detainee handbook could not confirm that the facility has a disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures. Interviews with the facility Commander and facility PSA Coordinator confirmed compliance with sections (a) and (b) of the standard; however, could not confirm compliance with subsection (c). A review of 11 investigative files confirmed there has been no detainee disciplined for an incident of sexual abuse during the audit period.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of policy 720.13 and the GCDC Inmate/Detainee handbook could not confirm that the facility has a disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures. To become compliant the facility must update policy 720.13 and the GCDC facility Inmate/Detainee handbook to include a progressive level of reviews, appeals, procedures, and documentation procedures and provide documented training to all staff on the new procedures. In addition, if applicable, the facility must provide the Auditor with a detainee file who has been disciplined due to an incident of sexual abuse or sexual assault.

(d): Policy 720.13 states, "The disciplinary process considers whether an inmate's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any should be imposed." The facility Commander confirmed that contributing factors in the case would become evident in the investigative process and that the mitigating factors would be discussed prior to a misconduct report being issued. A review of 11 investigative files confirmed there has been no detainee disciplined for any sexual abuse allegation during the audit period.

(e)(f): Policy 720.13 states, "The agency disciplines inmates for sexual conduct with staff only upon finding that the staff member did not consent to such contact" and "the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation." The facility Commander confirmed that there had been no incidents of sexual abuse with an employee during the audit period, and that if an incident occurred, the detainee would not be disciplined for sexual conduct with an employee unless that employee did not consent to such contact. The facility Commander further confirmed that if an allegation was made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation, the detainee would not be disciplined. A review of 11 investigative files confirmed there has been no detainee disciplined for any sexual abuse allegation during the audit period.

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

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

Notes:

(a)(b)(c): Policy 720.13 states, "Specific to ICE detainees, if the assessment pursuant to § 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate." Policy 720.13 further states, "When a referral for medical follow up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment" and "when a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." Interviews with the HSA and a LMHC indicated that if the

assessment pursuant to 115.41 indicated that a detainee had experiences prior sexual victimization or perpetrated sexual abuse, the detainee would immediately be referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. A review of a detainee's initial risk screening, in conjunction with both her medical and mental health records, confirmed the detainee was seen by both medical and mental health staff within the required timeframe as required by the standard.

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

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

Notes:

(a)(b): Policy 720.13 states "Inmate victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services." Policy 720.13 further states, "Inmate victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate" and "treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." In an interview with the HSA, she confirmed detainees would receive timely and unimpeded access to emergency medical treatment and crisis intervention services. In addition, she stated that detainees would be offered timely information about, and timely access, to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate and that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. According to the PAQ, and a review of 11 investigation files, it was confirmed that the facility has not had to offer a detainee access to emergency medical treatment and/or crisis intervention services. In addition, the facility has not had to offer a detainee timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis during the audit period.

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

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

Notes:

(a)(b)(c): Policy 720.13 states that "Inmate victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services." Policy 720.13 further states, "The evaluation and treatment of such victims shall include, and "the facility shall provide such victims with medical and mental health services consistent with the community level of care." In an interview with the medical HSA, she confirmed detainees would receive timely emergency access to medical and mental treatment that includes that includes as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to or placement in, other facilities, or their release from custody in accordance with professionally accepted standards of care. According to the PAQ and a review of 11 investigation files it was confirmed that all detainee victims received a medical and mental health services as required by the standard. None of the 11 files reviewed indicated the facility had to send a detainee to an outside hospital to receive emergency medical assistance for sexual assault related injuries or treatment during the audit period.

(d): Policy 720.13 states, "Female victims of sexual abuse while incarcerated are offered pregnancy tests." Policy 720.13 further states, "If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about and timely access to, all lawful pregnancy-related medical services." In an interview with the HSA, she confirmed detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated would be offered a pregnancy test and if the pregnancy results were positive the detainee would receive timely and comprehensive information about lawful pregnancy related medical services. According to the PAQ, and through a review of 11 investigation files, it was confirmed that the facility has not had a female detainee become pregnant while incarcerated at GCDC during the audit period.

(e)(f): Policy 720.13 further states, "Inmate victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate." In addition, policy 720.13 further states, "Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." In an interview with the HSA, she confirmed detainee victims of sexually abuse are offered tests for sexually transmitted infections as appropriate without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation. According to the PAQ, and a review of 11 investigation files, it was confirmed that the facility has not had a detainee need a test for sexually transmitted infections or who was transported to an outside hospital due to an incident of sexual abuse during the audit period.

(g): Policy 720.13 states, "The facility will maintain that a mental health evaluation is conducted of all inmate-on-inmate abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners." In an interview with the HSA, and a LMHC, it was confirmed detainee perpetrators of sexual abuse will be referred to Mental Health for an evaluation within learning of such abuse history. A review of 11 investigation files confirmed that all alleged detainee perpetrators were referred to mental health as required by the standard. In addition, the Auditor reviewed the medical and mental health records of one detainee, who because of the intake screening was determined to have perpetrated sexual abuse and confirmed that he was referred to Mental Health as required by the standard.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c): Policy 720.13 states, "The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, including whether the allegation has not been substantiated, unless the allegation has been determined to be unfounded." Policy 720.13 further states, "Sexual abuse incident reviews will be conducted within 30 days of concluding the investigation" and "the sexual abuse incident review team will include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health staff." In addition, policy 720.13 states, "The review team shall: a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect or respond to sexual abuse. b) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender or intersex identification status or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, c) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse, d) Assess the adequacy of staffing levels in that area during different shifts, and e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff." Policy 720.13 also requires that the facility "prepares a report of its findings and any recommendations for improvement and submit such report to the facility head and PREA compliance manager, the facility will implement the recommendations or will document the reason for not doing so, and the facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, ICE Field Office Director and the agency PREA Coordinator."

During the Auditor's interview with the PSA Compliance Manager, it was indicated that the review team consists of the PSA Compliance Manager, the Health Services ICE Liaison, a Classification staff member, a DO, and the facility PREA Coordinator, using a generic PREA standard checklist. The Auditor observed the completed checklist in all 11 investigation files reviewed; however, each review indicated, "The committee has not identified any agency procedures, processes, physical plant layout or detention environmental conditions that may have contributed to the events that led to the reported allegations" even though in three of the investigations the facility Investigator made viable recommendations for a change in practice that could better prevent, detect, or respond to sexual abuse. An interview with the PSA Compliance Manager, and a review of GCDC's' annual PREA report, confirmed the facility completed the report and forwarded it to the ICE FOD and Agency PREA Coordinator as required.

Does Not Meet (a): The facility is not compliant with subsection (a) of the standard. A review of 11 investigation files confirmed that incident reviews are completed in a timely manner; however, all incident reviews stated, "The committee has not identified any agency procedures, processes, physical plant layout or detention environmental conditions that may have contributed to the events that led to the reported allegations" even though the investigator in three of the investigations made viable recommendations for a change in practice that could better prevent, detect, or respond to sexual abuse. To become compliant, the facility must update their practice to include considering recommendations made by the Facility Investigator that may indicate a need to make policy and practice changes that could better protect, detect, or respond to sexual abuse. In addition, the facility must document that all members of the incident review team are trained in the updated practice. The facility must supply the Auditor with any detainee investigative files that occur during the CAP period, in conjunction with the corresponding incident review form, in which the Facility Investigator made a recommendation for a change in practice that could better prevent, detect, or respond to sexual abuse.

§115.87 - Data collection.

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

Notes:

a): Policy 720.13 states, "The agency ensures that the incident-based and aggregate data are securely retained." The PSA Compliance Manager indicated the facility maintains these documents in a secure filing area under her control. During the on-site visit, the Auditor observed the storage of records and determined the facility complies with the standard.

§115.201 - Scope of audits.

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

Notes:

(d)(e)(i)(j): During all stages of the audit including the on-site visit, the Auditor was able to review all policies, memos, and other documents required to make assessments on PREA compliance. Interviews with detainees, staff, and contract staff, were conducted in private on-site and remained confidential. The Auditor observed the notification of audit posted throughout the facility. No detainee, outside entity, or staff, correspondence was received prior to the on-site visit.

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:	1
Number of standards met:	23
Number of standards not met:	15
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Sabina Kaplan 3/22/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 3/22/2022

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:	Sabina Kaplan	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	914-474-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	722-579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Miami		
Field Office Director:	Garrett J. Ripa		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	865 SW 78th Avenue Suite 101 Plantation, FL 33324		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Glades County Detention Center		
Physical address:	1297 East State Rd. 78 Moore Haven, Fl. 33471		
Mailing address: *(if different from above)*	P.O Box 39		
Telephone number:	863-946-1600		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Commander
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	863-946-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Lieutenant
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	863-946-(b) (6), (b) (7)(C)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of Glades County Detention Center (GCDC) was conducted on January 25 – January 27, 2022, by U. S. Department of Justice (DOJ) and DHS certified PREA Auditor/Assistant Program Manager (APM) Sabina Kaplan, employed by Creative Corrections, LLC. The Auditor was provided guidance during the report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM), also a DOJ and DHS certified PREA Auditor. The PM's role is to provide oversight to the ICE PREA audit process and liaison with the ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The GCDC is a county owned facility and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The facility processes detainees who are pending immigration review or deportation. The DHS PREA Incorporation date is December 12, 2019. This was the first PREA audit for GCDC and covered the audit period of February 14, 2020, through January 27, 2022. GCDC is in Moore Haven, Florida.

Upon completion of the initial audit, 15 standards were determined to be "Does Not Meet" by the Auditor.

§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 Staff Training
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.52 Grievances
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.71 Criminal and Administrative Investigations
§115.76 Disciplinary sanctions for staff
§115.78 Disciplinary sanctions for detainees
§115.86 Sexual abuse incident reviews

The facility's Corrective Action Period (CAP) began March 23, 2022, and ended September 24, 2022. The facility submitted documentation, through the Agency, for the CAP on May 4, 2022, through September 23, 2022. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on September 28, 2022. In a review of the submitted documentation to demonstrate compliance with the deficient standards, the Auditor determined compliance with seven of the standards: §115.22 Policies to ensure investigation of allegations and appropriate agency oversight, §115.31 Staff Training, §115.52 Grievances, §115.71 Criminal and Administrative Investigations, §115.76 Disciplinary sanctions for staff, §115.78 Disciplinary sanctions for detainees, §115.86 Sexual abuse incident reviews, and found that eight standards: §115.16 Accommodating detainees with disabilities and detainees who are limited English proficient; §115.17 Hiring and promotion decisions; §115.33 Detainee education; §115.41 Assessment for risk of victimization and abusiveness; §115.42 Use of assessment information; §115.43 Protective custody; §115.65 Coordinated response; and §115.66 Protection of detainees from contact with alleged abusers continued to be "Does Not Meet" based on submitted documentation or lack thereof.

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: Does not Meet Standard
Notes:

(a)(b): Policy 720.13 establishes the following procedures to provide LEP and disabled detainees equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment; "a) Interpreter services for the deaf or hard of hearing inmates; b) Interpreter services for non-English speaking inmates; c) Reading of the material, by staff, to inmates." Policy 720.13 further dictates that "All inmate education materials will be in formats accessible to all inmates in accordance with Title II of the Americans with Disabilities Act, 28 CFR 35.164." There were zero intakes during the on-site visit; and therefore, the Auditor toured intake processing with the guidance of two Intake staff who narrated step-by-step the intake process. In an interview with Intake staff, the Auditor was advised that upon intake, detainees are provided with both the ICE National Detainee Handbook and the GCDC facility handbook. According to Intake staff, if a detainee requests an ICE National Detainee Handbook in any of the 14 available languages, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, one would be printed out for the detainee. In an interview with the facility Commander, it was indicated that during an Office of Detention Oversight (ODO) inspection, the facility was directed to remove the ICE National Detention Handbooks that were onsite, as they were outdated, and to print handbooks as needed. The facility Commander further indicated that they removed the old handbooks and requested an order of the new handbooks. He also indicated that as of the date of the on-site audit, the new handbooks were still unavailable. This was confirmed through an interview with the ERO PREA Field Coordinator. The Commander also submitted an email to Jail Supervisors, dated January 13, 2022, confirming the direction to remove the outdated handbooks and to print handbooks as needed in booklet form. However, through observation and detainee interviews, it did not appear to the Auditor that the facility had clearly established the practice of printing out the handbooks as needed. The interviews of 17 detainees revealed that 15 did not receive the ICE National Detainee handbook. In addition, when Intake staff printed out a copy of the handbook for the Auditor's review, it was not printed in booklet form as directed by the email to Jail Supervisors confirming to the Auditor that facility staff was unclear as how to provide the detainee with a copy of the handbook in their preferred language. The facility handbook is available in English, Spanish, and Haitian Creole, and provides detainees with information on the Agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse. GCDC did not have available the handbook in any other languages. The facility also had available the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet that provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault in English and in Spanish. The Intake staff could not explain how the detainees would get the pamphlet in the other 7 languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, which are available through ICE. Intake staff interviewed were aware of the ability to print material in various languages from the ICE website; however, they were unaware of how the PREA information would be provided to detainees who were deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities. In addition, the Intake staff indicated that they would use the ICE Language Line to interpret for a detainee who was LEP; however, the Auditor reviewed the log that documented the use of the language line during intake and confirmed it was empty. The Auditor reviewed 10 randomly chosen detainee files, all of which contained signed, but undated, documentation indicating the distribution of the DHS-prescribed SAA Information Pamphlet, the DHS ICE National Detainee Handbook, and the GCDC facility handbook to the detainees. The interviews of 17 detainees revealed that 2 had confirmed they received the ICE National Detainee handbook and zero had received the facility handbook. In their interviews the detainees indicated that they would be asked to sign the form when they first arrived and would leave the area without the handbooks or pamphlets. In an interview with Intake staff, it was confirmed that the detainee did, in fact, sign the form at the beginning of the intake process and not after officially receiving the PREA material.

Does Not Meet (a)(b): The facility does not meet subsections (a) and (b) of the standard. The Auditor observed during the on-site visit that the facility did not have any copies of the ICE National Detainee Handbook available on-site. Through interviews with the facility Commander and ERO PREA Field Coordinator it was confirmed that the facility had ordered updated copies of the handbook; however, at the time of the on-site audit the new handbooks were not available. The interview with the facility Commander, and presented documentation, confirmed that the Commander directed staff to print a copy of the handbook in booklet form, in the detainee's preferred language, whenever a detainee arrived at the facility; however, observed practice in addition to detainee interviews confirmed that this practice was not being followed. In addition, Intake staff, during their interviews, did not know how to access the DHS-prescribed SAA Information pamphlet in

languages other than English and Spanish. Intake staff also could not articulate how a detainee who was deaf or hard of hearing, was blind or had low vision, or had speech, intellectual, psychiatric difficulties would receive the PREA information in a format they would understand. To become compliant, the facility must adapt the practice of providing both the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet to LEP detainees in a language they understand. In addition, the facility must develop a practice that allows detainees with disabilities to receive the PREA information in a format they understand. Once developed, all Intake staff must receive documented training on the new procedures and the facility must present the Auditor with 10 detainee files that are for detainees who speak languages, other than English or Spanish, to confirm that the detainees are getting the information in a format they understand.

Corrective Action Taken (a)(b): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period," which included 115.16. However, the Auditor did not require the facility submit allegation of sexual abuse investigation files to confirm compliance with the standard. A review of the submitted documentation confirmed that the facility did not provide documentation confirming it adapted the practice of providing both the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet to LEP detainees in their preferred language. In addition, a review of the submitted documentation confirmed the facility did not develop a practice that allows detainees with disabilities to receive the PREA information in a format they understand. The facility submitted training documentation entitled "PREA accommodating detainees with disabilities;" however, the facility did not provide a curriculum to confirm the training offered covered the requirements to provide detainees with both the ICE National Detainee Handbook and the DHS-prescribed SAA Information pamphlet to LEP detainees in their preferred language or a practice to provide detainees with disabilities the PREA information in a format they understand. The facility did not provide the Auditor with 10 detainee files that included detainees who spoke languages, other than English or Spanish, to confirm that the detainees are getting the information in a format they understand. Upon review of the submitted documentation the Auditor continues to find that the facility does not meet subsections (a) and (b) of the standard.

§115. 17 - Hiring and promotion decisions
Outcome: Does not Meet Standard
Notes:

(a)(b)(e)(f): The Federal Statue 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 require "anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." The ICE Personnel Security and Suitability Program policy outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Policy 720.13 prohibits "hiring or promoting anyone who may have contact with inmates and prohibits enlisting the services of any contractor who may have contact with inmates who: a) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C 1997) b) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, open or implied threats of force, or coercions, or if the victim did not consent or was unable to consent or refuse c) Has been civilly or administratively adjudicated to have engaged in the activity described in any paragraph in this section." Policy 720.13 further states, "The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as a part of reviews of current employees. The agency shall impose upon employees a continuing affirmative duty to disclose any such misconduct," and "unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work." Policy 720.13 also states, "Employees must disclose any such misconduct. Any material omission(s) regarding such misconduct, or the provision of materially false information, shall be grounds for termination." The interview with the Director of Human Resources confirmed that all elements of subpart (a) of the standard are included in the "Pre-Employment Background Investigation Questionnaire" and that all-new hires, current staff, contractors, and volunteers are required to disclose all misconduct noted above and have a continuing affirmative duty to disclose any sexual misconduct. She further stated that material omissions regarding conduct as outlined in subpart (a) of this standard or giving false information is grounds for termination or withdrawal of an offer for employment and that, unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an

institutional employer. The Auditor reviewed the Pre-Employment Questionnaire and confirmed it's compliance. The Director of Human Resources indicated that the facility runs an annual driver's license and criminal history query on all staff, including staff up for promotion, thus capturing the continuing affirmative duty to report any sexual misconduct. A review of 10 randomly selected personnel files confirmed that the facility runs an annual driver's license and criminal history query on all staff as required by subsection (b) of the standard. The Auditor further interviewed the ERO PREA Field Coordinator who confirmed that the Agency requires staff to have a continuing duty to report any sexual misconduct on an annual basis; however, the Agency did not require him to report any incident of sexual misconduct prior to his promotion from DO to SDDO; therefore, the Agency is not compliant with subsection (b) of the standard.

Does Not Meet (b): The Agency does not meet subsection (b) of the standard. During an interview with the ERO PREA Field Coordinator, who received a promotion from DO to SDDO, it was confirmed that the Agency did not require him to report any incidents of sexual misconduct prior to the promotion. To become compliant, the Agency must develop a process that requires employees offered promotions to report an incident of sexual misconduct prior to the promotion.

Corrective Action Taken (b): The facility/Agency submitted a job announcement for a Supervisory Deportation Officer that asks specifically if the applicant has any convictions for Domestic Violence or a felony conviction. The document does not require the applicant to directly report any incidents of sexual misconduct. In addition, the facility submitted documentation confirming background checks on new hires and ICE staff obligation to continuously report any sexual misconduct; however, the standard states, "when the agency is considering hiring or promoting staff, it shall ask all applicants who may have contact with detainees directly about previous misconduct…in written applications or interviews for promotions." Regarding the Agency deficiency, there was no documentation submitted to confirm that the Agency developed a process that requires employees offered promotions to report an incident of sexual misconduct prior to the promotion either during a written application or interview immediately preceding the promotion. Upon review of the submitted documentation the Auditor continues to find that the Agency does not meet subsection (b) of the standard.

§115. 22 - Policies to ensure investigation of allegations and appropriate agency oversight
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(d): The Agency provided a written directive, Policy 11062.2 Sexual Abuse and Assault Prevention and Intervention, section 5.7, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from (b) (6), (b) (7)(C) Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." GCDC policy 720.13 requires that, "The Glades County Sheriff's Office ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment" and "allegations of sexual abuse or sexual harassment must be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior." GCDC does not, however, have an investigation protocol detailing the roles and responsibilities of both the facility and the investigating entity in performing sexual abuse investigations. According to the facility Commander, the facility Investigator, and the ICE DO on-site, all investigations are reported to the JIC, entered into the JIC Management System (the Agency's system of record), and then assessed to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG and/or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor-on-detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR Investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and in coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Inquiry Unit (AIU) for investigation, who may route it to the ERO field office for action. The ERO AFOD would assign an administrative investigation to be completed. All investigations are closed with a report of investigation. The facility Commander, and facility Investigator, confirmed that every allegation of sexual abuse made must be investigated. The facility Investigator confirmed in an interview that an administrative investigation is conducted on all allegations of sexual abuse after consultation with the investigative office within DHS. The facility had 15 allegations within the audit period that were referred for investigation; 11 were closed and 4 were actively being investigated by ICE OPR. Policy 720.13 further states, "All referrals of allegations of sexual abuse or sexual harassment for criminal investigations must be documented and

maintained for a period of five years." Interviews with the facility Commander, PSA Compliance Manager, and facility Investigator confirmed compliance with the standards requirement to retain all reports and referrals of allegations of sexual abuse for at least five years.

Does Not Meet (a)(b)(d): The facility is not in compliance with subsections (a), (b), and (d) of the standard that requires the facility establish a protocol to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority as required in subsection (a) of the standard. As the facility does not have a protocol, the requirements of subsections (b) and (d) that require what is included in the protocol is also non-compliant. To become compliant, the facility must develop a protocol that includes all elements of subsections (b) and (d) of the standard. In addition, the facility must document that all applicable staff have received training regarding the protocol's content.

Corrective Action Taken (a)(b)(d): The facility submitted updated policy 620.05 to include all elements of the standard. In addition, the facility submitted a memo from the Commander to all Supervisors that directs staff, "when a detainee is alleged to be the perpetrator of detainee sexual abuse or when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, to promptly report the incidents to the Joint Intake Center, the ICE Office of Professional Responsibility, or the DHS Office of Inspector General, as well and the appropriate ICE Field Office Director." The Auditor accepts the memo as staff training. Upon review of the submitted documentation the Auditor finds that the facility is now in in compliance with subsections (a), (b), and (d) of the standard.

(c): During the Auditor's review of the GCDC website (www.gladessheriff.org), it was determined that the website does not contain an investigative protocol. The Auditor also reviewed the ICE website, (https://www.ice.gov/prea), which provided the required Agency protocol.

Does Not Meet (c): The facility is not compliant with subsection (c) of the standard. The facility's investigation protocol is not located on the GCDC website. To become compliant, the facility must develop an investigative protocol and place it on its website (www.gladessheriff.org)

Corrective Action Taken (c): The facility submitted to the Auditor updated policy 620.05 to include all elements of the standard. The Auditor reviewed the facility website (www.gladessheriff.org) and confirmed the website includes updated policy 620.05. Upon review of the submitted documentation the Auditor finds that the facility is now in compliance with subsection (c) of the standard.

§115. 31 - Staff training
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): Policy 720.13 dictates how the facility trains all staff who may have contact with detainees and requires the training for all facility staff to be able to fulfill their responsibilities to include each element of the standard. Policy 720.13 states, "The agency trains all employees who have contact with inmates" and "between training sessions, employees are provided with information about current policies regarding sexual abuse and harassment." Policy 720.13 further states, "The agency documents employee annual refresher training in their individual training record and by signature sign in sheets." During the onsite audit, the Auditor reviewed the GCDC PREA training curriculum and determined the curriculum to be compliant with the standard in all material ways. This training is documented by staff signature and serves as acknowledgment of awareness of the content. Staff training documentation is maintained within the staff training files. The Auditor randomly selected 10 staff training files to review training documentation of staff for proof of completion. Of the 10 staff training records reviewed, all received their training within the last year. Interviews with the Training Supervisor confirmed staff receives the required PREA training and refresher training as required by the standard. Facility staff, in conjunction with policy 720.13, receive PREA training annually, plus an as-needed roll call training coverage of new areas or areas needing reinforcement or emphasis. Of the 2 ICE training verifications from PALMS e-learning reviewed by the Auditor, neither ICE employee had received PREA training since 2015. Following the on-site audit, the Auditor received the updated training verification for the two ICE employees who, during the on-site audit, were deficient in their training. The training verifications received were dated January 2022, which confirmed that the ICE employees did not receive refresher training every two years as required by the standard. Therefore, the Agency is not compliant with subsection (b) of the standard.

Does Not Meet (b): The Agency is not compliant with subsection (b) of the standard. The Auditor reviewed two training verifications of ICE staff who have contact with detainees and confirmed that neither employee received PREA training since 2015. Following the on-site audit, the Auditor received the updated training verification for the two ICE employees who, during the onsite audit, were deficient in their training. The training verifications received were dated January 2022 which confirms that the ICE employees did not receive refresher training every two years as required by the standard. To become compliant, all ICE staff assigned to GCDC, who have contact with detainees, must receive documented PREA training.

Corrective Action Taken (b): The facility provided the training verifications of ICE staff who have contact with detainees thus confirming that the ICE staff received the training required by subsection (b) of the standard. In addition, the SDDO provided an email to the ERAU Team Lead confirming that there are no other ICE staff working at Glades that have contact with detainees. Upon review of the submitted documentation the Auditor finds that the facility is now in compliance with subsection (b) of the standard.

§115. 33 - Detainee education
Outcome: Does not Meet Standard
Notes:

(a)(b)(c)(e)(f): Policy 720.13 indicates that "All inmates, during intake, will receive Intake orientation explaining the facility zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment" and "a sexual assault awareness pamphlet is provided to each inmate during intake containing information on self-protection and prevention techniques, treatment and counseling, and reporting methods." Policy 720.13 further states, "Inmate PREA education is available in accessible formats for all inmates including those who are: limited English proficient, Deaf, visually impaired, otherwise disabled, or Limited in their reading skills" and "the following procedures have been established to provide disabled inmates equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. All inmate education materials will be in formats accessible to all inmates in accordance with Title II of the Americans with Disabilities Act, 28 CFR 35.164." Policy 720.13 further dictates that "within 30 days of intake, the agency shall provide comprehensive education to new inmates/detainees either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents" and "all areas covered during orientation will be signed off by the detainee and the designated staff member presenting the material on GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement. Inmate PREA education is available in accessible formats for all inmates including those who are: Limited English proficient, deaf, visually impaired, otherwise disabled, or are limited in their reading skills." Documentation submitted with the PAQ indicates that PREA information was provided to detainees through the DHS-prescribed SAA Information pamphlet, DHS posted signage "ICE Zero-Tolerance," the ICE National Detainee Handbook, and the GCDC facility handbook. According to Intake staff, if a detainee requests an ICE Handbook in any of the 14 available languages, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese, one would be printed for the detainee. In the interview with the facility Commander, he indicated that during an ODO inspection, the facility was directed to remove the ICE National Detainee Handbooks that were on-site, as they were outdated, and to print handbooks as needed. The facility Commander indicated that they removed the old handbooks and placed an order for new ones. He further indicated that as of the date of the on-site audit the new handbooks were still unavailable. This was confirmed through an interview with the ERO PREA Field Coordinator. The facility Commander also submitted an email to Jail Supervisors, dated January 13, 2022, confirming the direction to remove the outdated handbooks and to print handbooks as needed in booklet form. However, through observation, and detainee interviews, it did not appear to the Auditor that the facility had clearly established the practice of printing the handbooks as needed. The interviews of 17 detainees revealed that 15 had confirmed they did not receive the ICE National Detainee handbook. In addition, when Intake staff printed a copy of the handbook for the Auditor's review it was not printed in booklet form as directed by the email to Jail Supervisors. The facility handbook is available in English, Spanish, and Haitian Creole, and provides detainees with information on the Agency's and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse. GCDC did not have available the handbook in any other languages. The facility also had available the DHS-prescribed SAA Information pamphlet that provides information for detainees on the prevention, detection, and reporting of sexual abuse and assault in English and in Spanish. The Intake staff had trouble locating the pamphlet on-site and could not explain how the detainees would get the pamphlet in the other 7 languages, including Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. Intake staff interviewed were aware of the ability to print the ICE National Detainee Handbook in various languages from the ICE website; however, they were unaware of how the PREA information would be provided to detainees who were deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities. The Intake staff indicated to the Auditor that an Orientation video was shown in medical; however, interviews with the medical staff confirmed the video has not been shown in the medical area since before the COVID-19 pandemic. An interview with a Shift Lt. further confirmed that the orientation video is not shown during the intake process. The Intake staff further indicated that they would use the ERO Language Line to interpret for a detainee who was LEP; however, the Auditor reviewed the log that documented the use of the language line during intake and confirmed it was void of any detainee names. The Auditor reviewed 10 randomly chosen detainee files, all of which contained a signed GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, indicating the distribution of the DHS-prescribed SAA Information pamphlet, the DHS ICE National Detainee Handbook, and the facility handbook; however, it was not dated, therefore the Auditor could not confirm the information was distributed at intake. The signed GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, further indicated that the detainee had completed an orientation program. The interviews of 17

detainees revealed that 2 had confirmed they received the ICE National Detainee handbook and zero had received the facility handbook or attended orientation. In their interviews, the detainees indicated they were asked to sign the GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, when they first arrived and then left the area without the handbooks, pamphlets, or viewing an orientation video. In an interview with Intake staff, it was confirmed that the detainee did, in fact, sign the form at the beginning of the intake process and not after officially receiving the PREA material or completing an orientation program which included viewing a video which contained PREA information. There were zero intakes during the on-site visit; and therefore, the Auditor could not personally observe the process.

Does Not Meet (a)(b)(c)(e)(f): The facility does not meet subsections (a), (b), (c), (e), and (f) of the standard. Subsection (a) of the standard requires that "during the intake process, each facility shall ensure that the detainee orientation program notifies and informs detainees about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse…" yet facility policy 720.13 dictates that "within 30 days of intake, the agency shall provide comprehensive education to new inmates/detainees either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents." The Auditor reviewed 10 randomly chosen detainee files, all of which contained a signed GCSO Form 139, Detainee Handbook and Orientation Program Acknowledgement Form, indicating the distribution of the DHS-prescribed SAA Information pamphlet, the DHS ICE National Detainee Handbook, and the facility handbook; however, it was undated, therefore the Auditor could not confirm the information was distributed at intake. In addition, the Auditor observed during the on-site visit that the facility did not have any copies of the ICE National Detainee Handbook available onsite. Through interviews with the facility Commander and ERO PREA Field Coordinator, it was confirmed that the facility ordered updated copies of the handbook; however, at the time of the on-site audit the new printed handbooks were unavailable. As a solution, the interview with the facility Commander and presented documentation, confirmed that the Commander directed staff to print a copy of the handbook in booklet form and in the detainee's preferred language, whenever a detainee arrived at the facility; however, observed practice, in addition to detainee interviews, indicated that this practice was not being followed. Intake staff, during their interviews, did not know how to access the DHS-prescribed Sexual Assault Awareness pamphlet in languages other than English and Spanish. Intake staff also could not articulate how a detainee who was deaf or hard of hearing, was blind or had low vision, or had speech, intellectual, psychiatric difficulties would receive the PREA information in a format they would understand. Interviews with medical, intake, and a security supervisor confirmed that the facility was not relaying the PREA information through an intake orientation, including showing a video, that contained the information required under subsection (a) of the standard. To become compliant, the facility must adapt the practice of providing the PREA education in a manner that LEP and detainees with disabilities can understand. This includes distributing the written information in the preferred language of the detainee and/or blind, deaf, intellectually impaired, and to those who have difficulty reading. In addition, the facility must develop an orientation program that is presented in a manner that LEP and disabled detainees can understand, and they must change their practice to include the detainee signing that he/she received the information once delivered and not before. Once developed, all Intake staff must receive documented training on the new procedures. In addition, the facility must present the Auditor with 10 detainee files that are for detainees who speak languages other than English or Spanish, to confirm that the detainees are getting the information in a format they understand.

Corrective Action Taken (a)(b)(c)(e)(f): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period," which included 115.33. However, the Auditor did not require the facility submit allegation of sexual abuse investigation files to confirm compliance with the standard. A review of the submitted documentation confirmed the facility did not develop an orientation program that is presented in a manner that LEP and disabled detainees can understand, including distributing the written information in the preferred language of the detainee and/or blind, deaf, intellectually impaired, and to those who have difficulty reading. The facility submitted training documentation entitled "PREA Detainee Education;" however, the facility did not provide a curriculum to confirm the training offered covered the requirement to provide detainees PREA education in a manner that LEP and detainees with disabilities can understand including distributing the written information in the preferred language of the detainee and/or blind, deaf, intellectually impaired, and to those who have difficulty reading. The facility also did not submit 10 detainee files that included detainees who spoke languages other than English or Spanish, to confirm that the detainees are getting the information in a format they understand, including watching the PREA video. Upon review of the submitted documentation the Auditor continues to find that the facility does not meet subsections (a), (b), (c), (e), and (f) of the standard.

§115. 41 - Assessment for risk of victimization and abusiveness
Outcome: Does not Meet Standard
Notes:

(a)(c)(d): Policy 730.13 states, "All inmates will be screened during intake, using an objective screening instrument for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. The PREA Inmate Screening / Risk Assessment Form GCSO, Form # 230, shall be completed on all inmates/detainees entering the Jail. The information collected during the initial screening will be used to determine the inmate's/detainee's risk of victimization or abusiveness and to ensure the safety of each inmate/detainee in the facility" and "the PREA Intake Screening/Risk Assessment Form shall be completed by Contract Medical Staff and the Booking Supervisor (or designee)." Policy 720.13 further states, "The intake screening will consider at the minimum the following: Whether the inmate has a mental, physical, or developmental disability, age of the inmate, physical build of the inmate, if the inmate has previously been incarcerated, if the inmate's criminal history is exclusively nonviolent, if the inmate has prior convictions for sex offenses against an adult or child, if the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, if the inmate has previously experienced sexual victimization, the Inmate's own perception of vulnerability, if the inmate is detained solely for civil immigration, if the inmate has any prior acts of sexual abuse, if the inmate has a history of prior institutional violence or sexual abuse, as known to the Agency." In addition, policy 720.13 states, "Based on the answers provided and the inmate's own perceptions of vulnerability: a determination for the inmates' housing is made during intake." The screening process involves the use of the GCSO PREA Intake Screening Risk of Sexual Victimization/Abusiveness form. Medical staff complete the top half which includes physical build, mental, physical, or developmental disability, how the detainee perceives his or herself, prior sexual abuse history, and the detainee's perception of vulnerability. The bottom half of the form is then completed by Intake staff and includes all elements of the detainee's criminal history as required by the standard. During the on-site visit, the Auditor reviewed the intake screening of a detainee who had a previous conviction for sexual assault. When asked for the procedure in housing this detainee, the Intake staff indicated that bed assignment was the responsibility of the housing unit officer. They further indicated that this type of information, including the PREA Intake Screening Risk of Sexual Victimization/Abusiveness, would be shared with the PSA Compliance Manager, but not with staff determining bed assignments. In an interview with the facility PREA Coordinator, it was confirmed that the information is shared with the PSA Compliance Manager for review; however, prior to completion of the review the detainee has already received his/her initial housing assignment.

Does Not Meet (a): The facility does not meet subsection (a) of the standard that requires "the facility to house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger" as the responsibility of initial housing is placed on the housing unit officer without information gathered during the risk screening regarding the detainee's risk of likely being a sexual aggressor or a sexual abuse victim. To become compliant, the facility must develop a practice that allows staff completing the initial housing assignments access to information gathered from the risk screening so that the detainee isn't house in a dangerous situation. In addition, the facility must demonstrate that the procedure has been put into place through demonstrated practice by providing the Auditor with 10 detainee intake risk screenings that confirm compliance. Further, all Intake and staff responsible for making housing unit assignments, must receive documented training in the new procedure.

Corrective Action Taken (a): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.41. However, the Auditor did not require the facility submit allegation of sexual abuse investigations to confirm compliance with the standard. A review of the submitted documentation confirms the facility did not provide the Auditor with 10 detainee intake screenings to confirm the new procedure had been put into place. The facility provided training documentation entitled, "PREA reassessment 60-90 days;" however, the standard requires the facility to utilize the information from the initial screening to make initial housing unit assignments. Upon review of the submitted documentation the Auditor continues to find that the facility does not meet subsection (a) of the standard.

(b): Policy 720.13 states, "Based on the answers provided and the inmate's own perceptions of vulnerability: a determination for the inmates' housing is made during intake. If the inmate feels comfortable in general population, the inmate will be placed in a housing unit. If the inmate feels uncomfortable being placed in general population, the inmate will be housed on Administrative Confinement until seen and evaluated by the PREA Compliance Manager and/or Classification; unless required by a medical practitioner to be housed in the Medical Unit." Interviews with Intake staff indicated the detainee's initial classification would be completed within 12 hours upon arrival; however, if during the risk screening the detainee was perceived to be sexually vulnerable, he/she would be held in protective custody or medical until seen by the PSA Compliance Manager. A review of 10 detainee files, all of which were not perceived to be vulnerable during intake, indicated that the initial screening was completed within 12 hours as mandated by the standard. Interviews with 17 detainees, who also were not perceived to be vulnerable during intake, further confirmed they completed intake within 12 hours. There were zero detainees who were perceived to be vulnerable during intake to interview or conduct a file review.

Does Not Meet (b): The facility is not in compliance with subsection (b) of the standard which states, "The initial classification process and initial housing assignment should be completed within twelve hours of admission to the facility." Per policy 720.13 "Based on the answers provided and the inmate's own perceptions of vulnerability: a determination for the inmates' housing is made during intake. If the inmate feels comfortable in general population, the inmate will be placed in a housing unit. If the inmate feels uncomfortable being placed in general population, the inmate will be housed on Administrative Confinement until seen and evaluated by the PREA Compliance Manager and/or Classification; unless required by a medical practitioner to be housed in the Medical Unit." Interviews with Intake staff indicated the detainee's initial classification would be completed within 12 hours upon arrival; however, if during the risk screening the detainee was perceived to be sexually vulnerable, he/she would be held in protective custody, or, medical until seen by the PSA Compliance Manager. To become compliant the facility must develop a practice that allows for all detainees to be initially housed within 12 hours of arriving at GCDC. In addition, the facility must demonstrate that the procedure has been put into place through demonstrated practice by providing the Auditor, if available, risk screenings of vulnerable detainees to confirm housing occurred within 12 hours. Further, all Intake, and staff responsible for making housing unit assignments, must receive documented training in the new procedure.

Corrective Action Taken (b): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.41. However, the Auditor did not require the facility submit allegation of sexual abuse investigations to confirm compliance with the standard. A review of the submitted documentation confirmed the facility did not provide confirmation that a practice that allows for all detainees to be initially housed within 12 hours of arriving at GCDC has been implemented. The facility provided training documentation entitled, "PREA Reassessment 60-90 days;" however, the Auditor requested staff training to cover the requirement to initially house detainees within 12 hours of arriving at GCDC. A review of the submitted documentation further confirmed, the facility did not provide the Auditor, if available, risk screenings of vulnerable detainees to confirm housing occurred within 12 hours, nor did they submit documentation that confirmed no vulnerable detainees arrived at the facility during the CAP. Upon review of the submitted documentation, the Auditor continues to find that the facility does not meet subsection (b) of the standard.

(e): Policy 720.13 requires that "Additional assessment by classification or the PREA Compliance Manager's designee within 30, 60 and 90 days from the inmate's arrival, based upon any additional relevant information received by the facility since the intake screening" and "an inmate's risk level shall be reassessed at any time and when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness." In an interview with Classification staff, it was confirmed that staff were aware of their requirement to reassess a detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any time when warranted based on the receipt of additional, relevant information; however, they were not aware that the standard required an assessment following an incident of sexual abuse or victimization. The Auditor reviewed 10 detainee files and determined that none of the detainees were reassessed between 60 and 90 days as required by the standard. In addition, the Auditor reviewed 11 investigation files and determined that none of the detainee victims were assessed after an incident of sexual abuse.

Does Not Meet (e): The facility is not in compliance with subsection (e) of the standard. The Auditor's review of 10 detainee files confirmed that detainees are not reassessed between 60 and 90 days as required by the standard. In addition, the Auditor reviewed 11 investigation files that confirmed the facility does not reassess a detainee after an incident of sexual abuse. To become compliant the facility must provide, if available, a sample of one or more sexual abuse investigation packets that confirm the detainee was reassessed following an incident of sexual abuse and 10 detainee files that document that a reassessment is completed within the between 60- and 90-day timeframe. In addition, the facility must submit documentation that both classification staff, and the facility Investigator, have received training regarding the requirement to complete reassessments between 60 and 90 days, following an allegation of sexual abuse, and when additional information is obtained.

Corrective Action Taken (e): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.41. A review of the submitted documentation confirms the facility submitted a memo from the Commander to the Captain that states, "The Chief of Security/ PREA Coordinator or their designee will be responsible for conducting a PREA Reassessment of each detainee or a detainee that was involved as a victim in a PREA incident. This will be accomplished within a 60-to-90-day time frame after the initial incident or the receipt of any additional information. Also, a Reassessment will be conducted as soon as possible after any PREA Incident." In addition, the facility submitted documentation that confirmed all applicable staff have been trained on the new procedure; however, the facility did not provide the Auditor 10 detainee files to confirm reassessments were made between

60-and-90 days of the initial assessment, nor did they provide the Auditor with documentation confirming that there were no detainees who required a reassessment between 60-and-90 days during the CAP. Upon review of the submitted documentation the Auditor continues to find that the facility does not meet subsection (e) of the standard.

§115. 42 - Use of assessment information

Outcome: Does not Meet Standard

Notes:

(a): Policy 720.13 requires that "Information from the risk screening will be used to determine housing, bed, work, education, and program assignments to prevent inmates with the high risk of being sexually victimized from those at the risk of being sexually abusive." In review of 10 detainee files, the Auditor determined that the facility is not utilizing the data collected from the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form to determine initial housing, recreation, work, and other activity decisions. Interviews with the HSA, Classification, and security Intake staff further confirmed the facility was not using all the information obtained as part of the risk assessment in 115.41, as required by the standard. When asked for the procedure in housing a detainee that was determined to be a sexual predator based on his criminal history, the Intake staff indicated that bed assignment was the responsibility of the housing unit officer. They further indicated that this type of information, including the PREA Intake Screening Risk of Sexual Victimization/Abusiveness, would be shared with the PSA Compliance Manager, but not with staff determining initial housing assignments. In an interview with the facility PREA Coordinator it was confirmed that the information is shared with the PSA Compliance Manager for review; however, prior to completion of the review, the detainee has already received his/her initial housing assignment.

Does Not Meet (a): The facility is not in compliance with subsection (a) of the standard. Subsection (a) of the standard requires that the facility use information obtained from the risk assessment noted in standard 115.41 when determining initial housing, recreation and other activities, or voluntary work assignments. A review of 10 detainee files, and interviews with Intake staff who indicated that criminal history and information from the PREA Intake Screening Risk of Sexual Victimization/Abusiveness, would be shared with the PSA Compliance Manager, but not with staff determining initial housing assignments, confirm that this information is not considered when determining initial housing, recreation and other activities, or voluntary work assignments. To become compliant, the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form needs to be shared with staff determining initial housing, and other necessary staff, so that proper housing, recreation, volunteer programming and other activities can be properly assessed. In addition, all Intake and applicable staff should be trained in the proper use of the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form when determining the elements of the standard. In addition, the facility must provide 10 detainee files that document that the information from the risk screening is utilized when determining initial housing, recreation and other activities, or voluntary work assignments.

Corrective Action Taken (a): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.42. However, the Auditor did not require the facility submit allegation of sexual abuse investigations to confirm compliance with the standard. A review of the submitted documentation confirmed the facility provided a memo from the Captain to all Detention staff that directs staff provide the housing unit sergeant information from the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form when determining bed assignment, recreation, volunteer, and program assignments. In addition, a review of the submitted documentation confirmed the facility submitted documented staff training entitled, "PREA UCAP Corrective Action Updates;" however, the facility did not provide a curriculum to confirm the training offered covered the proper use of the PREA Intake Screening Risk of Sexual Victimization/Abusiveness Form when determining the elements of the standard. The facility also did not provide 10 detainee files documenting that the information from the risk screening is utilized when determining initial housing, recreation and other activities, or voluntary work assignments. Upon review of the submitted documentation the Auditor continues to find that the facility does not meet subsection (a) of the standard.

(b): Policy 720.13 states, "The Agency makes housing and program assignments for transgender or intersex inmates in the facility on a case-by-case basis to ensure the inmates' health and safety; and whether the placement would present management or security problems. Placement and programming assignments for transgender or intersex inmates shall be reassessed at least twice each year to review any threats to the inmates' safety. A transgender or intersex inmates' own views with respect to his or her own safety shall be given serious consideration. Transgender or intersex inmates shall be given the opportunity to shower separately from other inmates. The PREA Compliance Manager or designee will assess all transgender or intersex inmates." Interviews with Intake, Classification, and medical staff indicated they lacked knowledge when it came to housing transgender detainees. In addition, during the Auditor's interview with the classification staff, the staff were unaware of the reassessment requirements for transgender detainees. The Auditor had planned to interview transgender detainees during the on-site audit; however, there were no transgender detainees housed at the facility during the visit.

Does Not Meet (b): The facility is not compliant with subsection (b) of the standard. During interviews with intake, medical and classification staff, it was confirmed that staff are not knowledgeable regarding how to properly house and provide program access to transgender and intersex detainees. To become compliant, the classification and medical staff need to be trained on the requirements to house, provide program access, and reassess transgender or intersex detainees as outlined in facility policy 720.13. In addition, if available, the facility must submit the detainee and medical files of any transgender or intersex detainees housed at GCDC during the CAP period.

Corrective Action Taken (b): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.42. However, the Auditor did not require the facility submit allegation of sexual abuse investigations to confirm compliance with the standard. A review of the submitted documentation confirmed the facility submitted training documentation entitled, "PREA 115.42 Transgender"; however, a review of the submitted documentation confirmed the facility did not submit the detainee and medical files of any transgender or intersex detainees housed at GCDC during the CAP or a statement indicating that no transgender or intersex detainees were housed at GCDC during the CAP. Upon review of all the submitted documentation, the Auditor continues to find that the facility does not meet subsection (b) of the standard.

§115. 43 - Protective custody
Outcome: Does not Meet Standard
Notes:

(d): A review of policy 720.13 indicated that the facility is not in compliance with subsection (d) of the standard as the policy does not require that when a detainee is held in Administrative Segregation on the basis of a vulnerability to sexual abuse or assault the placement be reviewed by supervisory staff member within 72 hours of the detainee's placement, after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter. The Auditor confirmed through interviews, documentation submitted with the PAQ, and observation during the on-site audit that no detainees identified as a risk for sexual abuse and assault were placed in segregation for protection during the audit period.

Does Not Meet (d): The facility does not meet subsection (d) of the standard. Policy 720.13 does not require that when a detainees is held in Administrative Segregation on the basis of a vulnerability to sexual abuse or assault due to highly unusual circumstances or by their own request be the placement be reviewed by supervisory staff member within 72 hours of the detainee's placement or after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter. To become compliant, the facility must update policy 720.13, in consultation with the ICE ERO FOD, to include the language required by subsection (d) of the standard and to initiate the practice of reviewing all placement of detainees within 72 hours of the detainee's placement, after the detainee has spent 7 days in administrative segregation, every week thereafter for the first 30 days, and every 10 days thereafter as required by the standard. The facility must also conduct documented training of all applicable staff on updated policy 720.13 and provide the Auditor with any detainee files where the detainee was held on Administrative Segregation to confirm reviews were conducted as required by subsection (d) of the standard.

Corrective Action Taken (d): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.43. However, the Auditor did not require the facility submit allegation of sexual abuse investigations to confirm compliance with the standard. A review of the submitted documentation confirmed the facility submitted an updated policy 720.13 that states, "In addition to the 72-hour review a supervisory staff member shall conduct at a minimum an identical review after the detainee has spent 7 days in Administrative Segregation, every week thereafter for the first 30 days, and every 10 days thereafter;" however, a review of the submitted documentation further confirmed the facility did not provide the Auditor with documented training of all applicable staff on the updated policy 720.13. The facility also did not provide to the Auditor, any detainee files where the detainee was held in Administrative Segregation to confirm reviews were conducted as required by subsection (d) of the standard or a memo to confirm that no detainees were held in Administrative Segregation due to being vulnerable to sexual abuse. Upon review of the submitted documentation, the Auditor continues to find the facility does not meet subsection (d) of the standard.

§115. 52 - Grievances
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(e): Policy 720.13 states, "Agency policy allows an inmate to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred" and "detainees will be permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint." However, policy 790.03, Inmate/Detainee Grievance Process, states, "Formal written grievances must be submitted no later than five days after the event or after the unsuccessful conclusion of an informal verbal grievance." Policy 720.13 states on page 20, sections 6 and 7, "The Glades County Sheriff's Office Detention Division Administration will issue a final decision on the merits of any portion of a grievance alleging sexual abuse within 5 days of the initial filing of the grievance. The Detention Division Administration may claim an extension of time to respond up to 30 days if the normal time for response is insufficient to make an appropriate decision." However, on page 20 section 14, policy 720.13 states, "Emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within five (5) days." Policy 790.03 states, "An inmate/detainee shall have the option to file a grievance of appeal if they are dissatisfied with the original grievance findings within five (5) days of receiving a response." A review of both policies confirms that neither policy addresses the facility sending a copy of the grievance to the appropriate ICE FOD at the end of the grievance process. The Auditor interviewed the Grievance Coordinator who could not confirm that grievances regarding sexual abuse can be submitted at any time as stated in policy 720.13 or within 5 days of the occurrence as stated in policy 790.03. In addition, she could not verify that a grievance regarding an incident of sexual abuse will be decided on within five days of the receipt of the grievance. A review of the GCDC Inmate/Detainee handbook mirrored requirements as outlined in policy 790.03. The Auditor reviewed 11 investigative files and confirmed none of the allegations were reported through the grievance system.

Does Not Meet (b)(e): The facility is not in compliance with subsection (b) of the standard. Policy 790.03 and the GCDC facility Inmate/Detainee handbook require that detainees file a formal grievance no later than five days after the event or after the unsuccessful conclusion of an informal verbal grievance. An interview with the Grievance Coordinator could not confirm the requirement of the standard that allows the detainee victim of sexual abuse to file a grievance at any time with no time limits. To become compliant, the facility must update policy 790.03 and the GCDC Inmate/Detainee handbook, to allow the detainee to file a grievance regarding an allegation of sexual abuse with no time limits. In addition, the facility must train all applicable staff on the standard's requirements and document the training. If applicable, the facility must submit to the Auditor any detainee investigation files, in conjunction with the filed grievance, of any detainee who submitted a grievance due to an allegation of sexual abuse. Furthermore, the facility is not in compliance with subsection (e) of the standard. Policy 790.03 and the GCDC facility Inmate/Detainee handbook require that detainees file an appeal within five days of receiving the response. To become compliant, the facility must update policy 790.03 and the GCDC Inmate/Detainee handbook, to allow the detainee to file an appeal within 30 days of receiving the response and to forward all grievances alleging sexual abuse to the appropriate ICE FOD at the end of the grievance process as required. Also, the facility must document training of all applicable staff on the standard's requirements. In addition, if applicable, the facility must submit to the Auditor any detainee investigation files, in conjunction with the filed grievance, of any detainee who submitted a grievance due to an allegation of sexual abuse.

Corrective Action (b)(e): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.52. A review of the submitted documentation confirms, the facility provided updated policy 790.03 and the GCDC Detainee Handbook, both of which include the verbiage, "There are no time limits for filing grievances involving PREA complaints." A review of the submitted documentation further confirms, the facility provided documented training that confirmed all applicable staff were trained on the new procedure. In addition, the Auditor reviewed policy 790.03 and confirmed the verbiage that requires the facility to respond to an appeal within 30 days. Upon review of the submitted documentation, the Auditor finds that the facility is now in compliance with subsections (b) and (e) of the standard.

§115. 65 - Coordinated response

Outcome: Does not Meet Standard

Notes:

(c)(d): A review of the GCDC Allegation of Sexual Response Plan and policy 720.13 indicated that the facility is not in compliance with subsections (c) and (d) of the standard. The standard requires a coordinated plan that includes, "if a victim of sexual abuse is transferred between facilities covered by subpart (a) or (b) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise," which is not covered in either the plan or the policy. In an interview with the facility Commander, he indicated that he "assumed subsections (c) and (d) would be handled by ICE," thus further confirming the facility has not included sections (c) and (d) in their coordinated response.

Does Not Meet (c)(d): Neither the facility's coordinated response plan nor policy 720.13 include the requirements mandated by subsections (c) and (d) of the standard. To become compliant, the facility must update the GCDC Allegation of Sexual Response Plan, and facility policy 720.13, to include the language required by subsections (c) and (d) of the standard and to initiate the practice of informing the receiving facility covered by subpart (a) and (b) of the incident and the victim's potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise. The facility must also conduct documented training of all applicable staff on the change in the Allegation of Sexual Response Plan and policy 720.13 that includes notifying facilities as required by the standard. In addition, if applicable, the facility must provide the Auditor with any detainee files where the detainee victim of sexual abuse, or assault, was transferred to confirm the facility is following the updated Sexual Response Plan.

Corrective Action Taken (c)(d): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.65. A review of the submitted documentation confirms the facility submitted policy 720.13 that states, "If a victim of sexual abuse is transferred between facilities the sending facility shall, as permitted by law inform the receiving facility of the incident and the victims potential need for medical or social services. This will be accomplished by the PREA coordinator or designee." However, a review of the submitted documentation further confirms the facility did not provide an updated GCDC Allegation of Sexual Response Plan, or an updated policy 720.13 to include the language required by subsection (d) of the standard and to initiate the practice of informing the receiving facility covered by subpart (a) and (b) of the incident and the victim's potential need for medical or social services and if the victim is transferred from a DHS immigration detention facility to a facility not covered by paragraph (c) of the standard, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services, unless the victim requests otherwise. The facility also submitted training documentation entitled, "PREA U CAP Corrective Action Updates;" however, the facility did not provide a curriculum to confirm the training offered covered subsections (c) and (d) of the standard. Upon review of the submitted documentation, the Auditor continues to find that the facility does not meet subsections (c) and (d) of the standard.

§115. 66 - Protection of detainees from contact with alleged abusers

Outcome: Does not Meet Standard

Notes:

Policy 720.13 states, "Any staff, contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring inmate or detainee contact pending the outcome of an investigation." A review of four closed investigative files that alleged sexual abuse by staff (3), or contractors (1), indicated that none of the alleged abusers were removed from duties requiring detainee contact. In an interview the facility Commander, he stated staff would be removed, placed on administrative leave, and even terminated depending on the outcome of investigation; however, he confirmed the facility did not remove the staff, or contractors, involved in the allegations.

Does Not Meet: The facility does not meet standard 115.66. In a review of four closed investigative files that involved staff, or contractors, none of the alleged abusers were removed from all duties requiring detainee contact. In the interview with the facility Commander, it was confirmed that the facility did not remove the staff, or contractors, involved in the allegations. To become compliant, the facility must follow policy 720.13 and the standard, which require the removal of all staff, volunteers, and contractors suspected of perpetrating sexual abuse. In addition, the facility must demonstrate, if applicable, that staff, volunteers, or contractors were removed from duties during the investigation process by providing the Auditor copies of investigation files that occurred during the CAP period. Finally, the facility must provide documented training of all applicable staff in the section of policy 720.13 that requires any staff, contractor, or volunteer suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of the investigation.

Corrective Action Taken: The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.66 and was confirmed by the ERAU Team Lead. A review of the submitted documentation confirms the facility did not provide documented training of all applicable staff in the section of policy 720.13 that requires any staff, contractor, or volunteer suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of the investigation. Upon review of the submitted documentation, the Auditor continues to find that the facility does not meet standard 115.66.

§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:

(e)(f): Policy 720.13 states, "The departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." In interviews with the facility Commander and facility Investigator, both indicated an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. Policy 720.13 further states, "When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." Of the 11 investigative files reviewed by the Auditor, 2 files involved a released/transferred detainee. Both files indicated that the investigation was closed due to the suspect/victim being released/transferred and unable to interview so the case was closed. The facility Investigator stated that he maintained close cooperation with the GCSO CID Investigators and would receive available updates as the cases progressed. The 11 investigative files reviewed indicated that none of the allegations were criminal; and therefore, were not referred to the GCSO CID for investigation.

Does Not Meet (e): The facility is not in compliance with subpart (e) of the standard. Policy 720.13 states, "The departure of the alleged perpetrator or victim from the employment or control of the facility shall not provide a basis for terminating an investigation;" however, the Auditor reviewed two investigative files that involved a released/transferred detainee and both files indicated that the investigation was closed due to the suspect/victim being released/transferred and unable to be interviewed. To become compliant, the facility must follow policy 720.13 and not allow the departure of the alleged perpetrator or victim from the employment or control of the facility to terminate an investigation. In addition, if applicable the facility must provide the Auditor with copies of investigations that continued following the departure of the suspect/victim from the facility.

Corrective Action Taken (e): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.66. Upon review of the submitted documentation the Auditor finds the facility is now in substantial compliance with subsection (e) of the standard.

§115. 76 - Disciplinary sanctions for staff

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

Notes:

(a)(b)(c)(d): Policy 720.13 states, "Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Termination is the likely disciplinary sanction for staff who engaged in sexual abuse." Policy 720.13 further states, "All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies." A review of policy indicates that it was not reviewed and approved by the Agency, nor does it contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards." In addition, the policy does not indicate that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." The Auditor interviewed the facility Commander who indicated that there were no staff resignation, termination, or discipline for violating the facility's policy on sexual abuse during the audit period. In addition, the facility Commander stated staff would be removed, placed on administrative leave, and even termination depending on the outcome of investigation. The Auditor conducted three investigative file reviews of sexual abuse allegations against staff and found that none of the cases were substantiated.

Does Not Meet (a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of policy 720.13 indicates that the policy was not reviewed and approved by the Agency, nor does it contain the required verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" and "including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards." In addition, policy 720.13 does not indicate that "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." To become compliant with subsections (a) and (b), the facility must update policy 720.13 to include the required verbiage of the standard. In addition, although the facility referred policy 720.13 to the Agency during the on-site audit it did not contain verbiage required by subsections (a) and (b) of the standard, therefore, the facility must submit the updated version for review and approval by the Agency. In addition, if applicable, the facility must provide investigation files that confirm a staff member was disciplined in accordance the standard 115.76 after an incident of substantiated sexual abuse.

Corrective Action Taken (a)(b): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.76. A review of the submitted documentation confirms the facility submitted policy 720.13 that states, "Glades County Sheriff's Office Detention Division staff members, contractors, and volunteers will be subjected to disciplinary sanctions up to and including termination for violating the sexual abuse and sexual harassment policies." As termination is a greater penalty then removal from Federal service the Auditor finds the facility is now in substantial compliance with subsections (a) and (b) of the standard.

§115. 78 - Disciplinary sanctions for detainees

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

Notes:

(a)(b)(c): Policy 720.13 states, "Inmates are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the inmate engaged in inmate-on-inmate sexual abuse" and "inmates are subject to disciplinary sanctions pursuant to a formal disciplinary process following a criminal finding of guilt for inmate-on-inmate sexual abuse." Policy 720.13 further states, "Sanctions are proportionate with the nature and circumstance of the abuses committed, the inmate's disciplinary history, and the sanctions imposed for the comparable offenses by other inmates with similar histories." A review of policy 720.13, and the GCDC Inmate/Detainee handbook could not confirm that the facility has a disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures. Interviews with the facility Commander and facility PSA Coordinator confirmed compliance with sections (a) and (b) of the standard; however, could not confirm compliance with subsection (c). A review of 11 investigative files confirmed there has been no detainee disciplined for an incident of sexual abuse during the audit period.

Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of policy 720.13 and the GCDC Inmate/Detainee handbook could not confirm that the facility has a disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures. To become compliant the facility must update policy 720.13 and the GCDC facility Inmate/Detainee handbook to include a progressive level of reviews, appeals, procedures, and documentation procedures and provide documented training to all staff on the new procedures. In addition, if applicable, the facility must provide the Auditor with a detainee file who has been disciplined due to an incident of sexual abuse or sexual assault.

Corrective Action taken (c): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.78. A review of the submitted documentation confirmed the facility submitted training documentation entitled "PREA UCAP Corrective Action Updates." The Auditor reviewed updated policy 720.13 and confirmed it did not include a progressive level of reviews, appeals, procedures; however, the facility provided an updated GCDC Detainee Handbook which met the standard's requirement. Upon review of the submitted documentation the Auditor finds the facility is now in compliance with subsection (c) of the standard.

§115. 86 - Sexual abuse incident reviews

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

Notes:

(a)(b)(c): Policy 720.13 states, "The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, including whether the allegation has not been substantiated, unless the allegation has been determined to be unfounded." Policy 720.13 further states, "Sexual abuse incident reviews will be conducted within 30 days of concluding the investigation" and "the sexual abuse incident review team will include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health staff." In addition, policy 720.13 states, "The review team shall: a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect or respond to sexual abuse. b) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender or intersex identification status or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility, c) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse, d) Assess the adequacy of staffing levels in that area during different shifts, and e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff." Policy 720.13 also requires that the facility "prepares a report of its findings and any recommendations for improvement and submit such report to the facility head and PREA compliance manager, the facility will implement the recommendations or will document the reason for not doing so, and the facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator, ICE Field Office Director and the agency PREA Coordinator." During the Auditor's

interview with the PSA Compliance Manager, it was indicated that the review team consists of the PSA Compliance Manager, the Health Services ICE Liaison, a Classification staff member, a DO, and the facility PREA Coordinator, using a generic PREA standard checklist. The Auditor observed the completed checklist in all 11 investigation files reviewed; however, each review indicated, "The committee has not identified any agency procedures, processes, physical plant layout or detention environmental conditions that may have contributed to the events that led to the reported allegations" even though in three of the investigations the facility Investigator made viable recommendations for a change in practice that could better prevent, detect, or respond to sexual abuse. An interview with the PSA Compliance Manager, and a review of GCDC's' annual PREA report, confirmed the facility completed the report and forwarded it to the ICE FOD and Agency PREA Coordinator as required.

Does Not Meet (a): The facility is not compliant with subsection (a) of the standard. A review of 11 investigation files confirmed that incident reviews are completed in a timely manner; however, all incident reviews stated, "The committee has not identified any agency procedures, processes, physical plant layout or detention environmental conditions that may have contributed to the events that led to the reported allegations" even though the investigator in three of the investigations made viable recommendations for a change in practice that could better prevent, detect, or respond to sexual abuse. To become compliant, the facility must update their practice to include considering recommendations made by the Facility Investigator that may indicate a need to make policy and practice changes that could better protect, detect, or respond to sexual abuse. In addition, the facility must document that all members of the incident review team are trained in the updated practice. The facility must supply the Auditor with any detainee investigative files that occur during the CAP period, in conjunction with the corresponding incident review form, in which the Facility Investigator made a recommendation for a change in practice that could better prevent, detect, or respond to sexual abuse.

Corrective Action Taken (a): The facility submitted a memo dated 9/16/2022 that states, "For the following PREA standards there is no documentation as there were no incidents of sexual assault or abuse at the Glades County Detention Center during the corrective action plan period" which included 115.86. A review of the submitted documentation confirmed the facility provided the Auditor with a memo from the facility Commander to all Jail Supervisors with a Cc: to all Detention Staff that directs the Incident review Team to consider recommendations made by the facility Investigator that may indicate a need to make policy and practice changes that could better protect, detect, or respond to sexual abuse. The memo further required the Incident Review Team to document its reasons for not following a recommendation. As the memo is directed to all Detention Staff, the Auditor accepts the procedural memo as documented training. Upon review of the submitted documentation, the Auditor now finds the facility is in compliance with subsection (a) of the standard.

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.

Sabina Kaplan October 10, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) October 31, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) November 1, 2022
Program Manager's Signature & Date