PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	12/10/2019	**To:**	12/12/2019
AUDITOR INFORMATION			
Name of auditor:	Mark Stegemoller	**Organization:**	Creative Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	ICE ERO - Baltimore
Field Office Director:	Diane Witte
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C) SDDO
Field Office HQ physical address:	31 Hopkins Plaza, Suite 700, Baltimore, MD. 21201
Mailing address: (if different from above)	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Howard County Detention Center		
Physical address:	7301 Waterloo Rd. Jessup, MD. 20794		
Mailing address: (if different from above)			
Telephone number:	410-313-5200		
Facility type:	IGSA		
PREA Incorporation Date:	10/30/2014		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	410-313-(b) (6), (b
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Correction Program Supervisor
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	410-313-(b) (6), (b

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Howard County Detention Center (HCDC) was conducted on December 10-12, 2019, by Mark Stegemoller, certified United States (U.S.) Department of Justice (DOJ) and DHS PREA Auditor for Creative Corrections, LLC. The purpose of the audit was to determine compliance with the DHS PREA Standards. The PREA incorporation date for the HCDC was October 30, 2014. This is the second DHS PREA audit of the HCDC. The HCDC is operated by the Howard County Department of Corrections and contracted by ICE for housing of adult male detainees. On the first day of the audit, the facility held a total of 76 ICE adult male detainees. The HCDC contains high, medium, and low security detainees and is located in Jessup, Maryland. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ and DHS certified PREA Auditor. The Program's Manager role is to provide oversight to the ICE PREA audit process and liaison with the ICE External Review and Analysis Unit (ERAU) section during the audit report review process.

The Team Lead opened the entry briefing at 9:00 A.M. on the first day of the on-site visit. In attendance were:

- (b) (6), (b) (7)(C) Inspections and Compliance Specialist ERAU, Office of Professional Responsibility (OPR), ICE
- (b) (6), (b) (7)(C) Unit Chief, ERAU, OPR, ICE
- (b) (6), (b) (7)(C) Enforcement Removal Office (ERO),
- (b) (6), (b) (7)(C) Health Service Administrator (HSA), HCDC
- (b) (6), (b) (7)(C) Detention Services Manager (ERO), ICE
- (b) (6), (b) (7)(C) Correctional Specialist, HCDC
- (b) (6), (b) (7)(C) Deputy Field Office Director (FOD), ICE
- (b) (6), (b) (7)(C) Assistant Field Office Director (AFOD), ICE
- (b) (6), (b) (7)(C) Compliance Officer, HCDC
- (b) (6), (b) (7)(C) Deputy Director, HCDC
- (b) (6), (b) (7)(C) PREA Sexual Assault Compliance Manager (PSA), HCDC
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE
- (b) (6), (b) (7)(C) Classification Supervisor, HCDC
- (b) (6), (b) (7)(C) Work Release Rentry Superviso,r HCDC
- (b) (6), (b) (7)(C) Correctional Captain, HCDC
- (b) (6), (b) (7)(C) Captain, HCDC

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

Before the audit, ICS, ICE Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility Pre-Audit Questionnaire (PAQ), facility policies, and other relevant documents. During the on-site phase of the audit, facility staff was not accommodating to provide the Auditor with requested documentation he needed to ensure compliance with several PREA standards. Thus, the Auditor was unable to complete a comprehensive review of pertinent information while on-site. It should be noted; during the post-audit phase, the Auditor submitted a list of items to the facility necessary to gauge compliance with several standards. Approximately two weeks after the Auditor's request, the facility provided some, but not all of the requested material. Further discussion related to this matter is explained in more detail within section 115.201- Scope of Audits in this report. According to the facility's PAQ, and staff interviews, there were no allegations of sexual abuse reported during the previous 12 months. Upon arrival at the facility for the on-site portion of the audit, the Auditor was advised the facility has not had an allegation of sexual abuse involving an immigration detainee for the past 36 months. Therefore, there were no PREA investigations for the Auditor to review.

According to its website, the Howard County's original jail, in Ellicott City, opened in 1878. The Emory Street Jail was built to accommodate 12 inmates. In 1975, the Division of Corrections was established under former County Executive Edward Cochran. Gerald H. McClellan was appointed as the division's first Director of Corrections. Several years later, the Division of Corrections was established as a Department. Due to overcrowding conditions and an antiquated facility, the Department of Corrections sought and received funding for the construction of a new detention center. The Howard County Detention Center, in Jessup, opened in 1983 with a rated capacity of 108 inmates and actually housed 63 inmates at opening; within five years, the inmate population had greatly exceeded its rated capacity. The Department of Corrections again sought and obtained funding for the expansion of the Detention Center. The expansion was completed in 1994 with a rated capacity of 361 inmates. Today the Detention Center has a maximum capacity of 474, and a rated operating capacity of 398 inmates. The facility houses pre-trial offenders, as well as inmates sentenced up to 18 months. The Department also by contract houses detainees in the custody of the ICE agency. It is the policy of the Howard County Department of Corrections to only accept detainees from ICE who are **criminally involved.** This includes: those **convicted of crimes; t**hose **charged with jailable offenses;** those who are **members of criminal gangs; and** those who are deported **criminal felons** who have illegally reentered the U.S.

Following the entry-briefing, a tour of the facility was conducted. All areas of the facility, accessible to detainees, were toured by the Auditor to include detainee intake processing, medical and mental health, detainee housing units, library, chapel, and segregation. The Auditor also visited the main control center, visitation, and the facility's main lobby. There are no dining facilities currently operational at HCDC, and detainees are provided with their meals in their living units. The facility kitchen was shut down and in the process of being renovated. Staff advised the Auditor, detainees never go to the facility dining area, and all meals are brought to them in their living units. According to the facility PAQ and staff interviews, the total number of staff who may have reoccurring contact with detainees (e.g., security staff, medical staff, kitchen staff, maintenance staff, etc.) is 156. The total number of security staff is 136, of which 83 are male and 53 females.

The PAQ, indicates that the facility's designed capacity is 517. The detainee count on the first day of the on-site audit was 67 male detainees. Over the preceding year, the average detainee population was 78, and the average time in custody was 60 days. The facility is constructed entirely under one roof. There are 3 multiple occupancy cell housing units, 9 single cell housing units, 2 open bay / dorm housing units, and 24 segregation cells (administrative and disciplinary). Detainees are housed in accordance to their security classification level of low, medium or high. Detainees determined to be low security are housed within a dedicated dorm that houses both detainees and county inmates. Detainees are housed on the second range and inmates are housed on the lower range. Medium and high security detainees are housed within their own dorm. The Auditor informally spoke with both staff and detainees at will during the tour. Sightlines were carefully examined during all aspects of the tour, as was the potential for blind spots. (b) (7)(E) [redacted] The Auditor carefully reviewed video camera footage and determined opposite gender staff could not see into the bathroom areas where detainees would be in a state of undress. Cross-gender announcements were noted upon entry into detainee housing units. PREA related information was posted in numerous areas throughout the facility to include all housing units. PREA educational and reporting information was strategically located, on bulletin boards and posted on walls so that detainees are made aware of the information available to them; PREA educational information, zero-tolerance policy, methods for reporting sexual misconduct, and victim advocacy contact information were posted in both English & Spanish.

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

After the tour, the Auditor was provided with an HCDC staff and detainee roster. The Auditor randomly selected both staff and detainees for formal interviews. The Auditor interviewed 16 total staff that included: the Facility Director, PSA Compliance Manager, who also serves as the facility Investigator and Grievance Officer, Human Resource staff, Assistant Training Supervisor, intake staff, Classification Supervisor, Health Care Administrator, and random security staff, including line-staff and first-line supervisors from all three shifts. The Auditor also requested a current list of all volunteers and contractors who may have contact with detainees. It should be noted; while on-site, the facility could not provide and eventually indicated they would not provide the Auditor with a list of contractors and volunteers. As mentioned earlier, further discussion relating to this matter is discussed in more detail within section 115.201 – Scope of Audits within the report. The Auditor formally interviewed a total of 20 detainees. Seven detainees interviewed were LEP and required the use of interpretive services. The Auditor utilized the interpretive services of Language Services Associates (LSA) provided through contract by Creative Corrections. The other 13 detainees interviewed were random samples. The facility reported that during the previous year there were no detainees who reported sexual victimization during risk screening; Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI) detainees; detainees placed in segregated housing (for risk of sexual victimization/following a sexual abuse allegation); detainees who have filed a grievance related to sexual abuse; detainees who reported sexual abuse/history; or detainees with disabilities.

The countries of origin for detainees interviewed were: Mexico, El Salvador, Haiti, Honduras, Romania, Nigeria, and Guatemala.
On December 12, 2019 an exit briefing was held in the HCDC staffing conference room. The Team Lead opened the briefing and then turned it over to the Auditor.

In attendance were:

- (b) (6), (b) (7)(C) Management and Program Analyst, ERAU, OPR, ICE
- (b) (6), (b) (7)(C) ERO, ICE
- (b) (6), (b) (7)(C) Detention Services Manager, ICE
- (b) (6), (b) (7)(C) Correctional Specialist, HCDC
- (b) (6), (b) (7)(C) Assistant Field Office Director, ICE
- (b) (6), (b) (7)(C) Compliance Officer, HCDC
- (b) (6), (b) (7)(C) Deputy Director, HCDC
- (b) (6), (b) (7)(C) SDDO, ICE

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

SUMMARY OF AUDIT FINDINGS

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

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

Number of Standards Met: 29
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.34 Specialized training: Investigations
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection

Number of Standards Not Met: 8
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 Hiring and promotion decisions
§115.32 Other training
§115.33 Detainee education
§115.41 Assessment for risk of victimization and abusiveness
§115.71 Criminal and Administrative Investigations
§115.201 Scope of audits.

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

PROVISIONS

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

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

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

(c) HCDC has a written zero tolerance policy toward all forms of sexual abuse. Policy A-033 Protection From Abuse, Sexual Abuse and Harassment outlines the facility's approach to preventing, detecting, and responding to such conduct. Review of policy and interview with the PSA Compliance Manager confirms the policy has been approved by ICE. It was evident to the Auditor through multiple interviews with staff and detainees that the facility has fostered a culture for zero tolerance of sexual misconduct.

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

§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) A review of the HCDC PAQ staffing levels indicates there are a total of 156 staff who may have reoccurring contact with detainees. The facility's security staff is comprised of employees of the HCDC. Security staff work (b) (7)(E) [redacted] The Auditor was able to confirm the facility maintains sufficient supervision of detainees through on-site observations of security staff performing security rounds, to include administrative staff interacting with detainees on a routine basis, and review of facility documentation submitted with the PAQ, e.g., weekly rosters and staffing patterns for security personnel. The Auditor reviewed daily security shift rosters and provided post assignments for all shifts and determined the facility is ensuring staffing levels are being maintained per the standard. (b) (6), (b) (7)(C) [redacted] Areas that could possibly permit cross-gender viewing were pixilated and obstructed the potential view of a detainee in a state of undress. (b) (6), (b) (7)(C) [redacted] The facility reported no sexual abuse allegations for the past 36 months. Therefore, there were no sexual abuse investigations for the Auditor to review. (b) (6), (b) (7)(C) [redacted]

(b) A review of Policy A-033 outlines how the facility will develop and document comprehensive detainee supervision guidelines, to determine and meet the facility's detainee supervision needs and shall review those guidelines on an annual basis. Submitted with the PAQ was the facility supervision guidelines delineating staffing housing assignments, security round requirements, physical design, video camera placements, and security mirrors placement, etc. Security rounds are required to be completed on all three shifts. Security staff carry electronic tablets in which they make notes of rounds completed. Rounds are typically made (b) (7)(E) [redacted]. Interviews with the Facility Director and PSA Compliance Manager and documentation review of the facility's annual PREA staffing plan assessment indicates the facility is meeting the standard and, at least yearly, conducts a comprehensive review of the facility's staffing plan and detainee supervision guidelines. The annual review was conducted and approved by the Facility Director on January 15, 2019. There were no recommendations made or staffing level changes noted.

(c) A review of policy A-033 and procedures, as well as interviews with the Facility Director and PSA Compliance Manager, indicate all elements outlined in provision (c) of the standard are considered when developing and or updating the supervision guidelines. The facility takes into consideration adequate levels of detainee supervision, the need for additional video monitoring, considers the generally accepted detention and facility correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors.

(d) Policy A-033 and General Order #0 indicates staff, including supervisors and line staff, shall conduct frequent unannounced security inspections rounds to identify and deter sexual abuse of detainees. The occurrence of such rounds is documented in the facility's electronic tour watch reports. This practice is implemented on all shifts (to include night, as well as day) and in all areas where detainees are permitted. Staff is prohibited from alerting others that security rounds are occurring unless such an announcement is related to the operational functions of the facility. The Auditor was able to verify line staff to include supervisors are conducting frequent unannounced security inspections/rounds both on the day and night shifts through the review of the facility's electronic watch tour reports, and through personal observation of staff making rounds while touring the facility, and interviews with line and supervisory staff.

§115.14 - Juvenile and family detainees.

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

Review of the PAQ and interviews with the Facility Director and PSA Compliance Manager confirm HCDC does not house juveniles, females, or family detainee units. Therefore, this provision is not applicable.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b)(d) Policy E-402 Security/Searches outlines staff conducting a body search (pat-search) will be the same gender of the detainee. Searches conducted by opposite gender staff shall only be permitted during exigent circumstances. During the previous year, there have been no reports of opposite gender staff performing cross-gender pat-searches of male detainees. If such a search was to be conducted, the facility policy requires it be documented including details of exigent circumstances. Interviews with security staff corroborated same gender staff are required to pat-search same gender detainees and, if an exigent circumstance, such as a facility security emergency it would be properly documented on a facility incident report.

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

(e)(f)(i) Policy E-402 states cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. The facility shall not search or physically examine a detainee for the sole purpose of determining the detainee's genital status. If the detainee's genital status is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. During the audit reporting period, the facility reported no cross-gender strip searches or visual body cavity searches being conducted. Interviews with the Facility Director, medical, and security staff confirmed staff are aware of facility policy and procedures for conducting strip or body cavity searches, and if performed shall be documented. The facility does not house juvenile detainees.

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

(j) Policy E-402 states security staff will be trained in the proper procedures for conducting pat-down searches, including pat-down searches by staff of the opposite gender, and searches of transgender and intersex detainees. While on-site, there were no transgender or intersex detainees for the Auditor to interview. Interviews with the Assistant Training Supervisor and security line staff indicated staff have received proper training on how to perform pat searches in a professional and respectful manner, and in the least intrusive manner. Most security staff were able to articulate to the Auditor proper pat-search procedures. While on-site, the Auditor reviewed seven different staff training records acknowledging such training has been received. Submitted with the facility PAQ was employee signed acknowledgements of completing PREA training. However, the facility did not provide the training curriculum as it relates to performing proper pat down searches. The Auditor requested a copy of the training curriculum the facility utilizes to train staff on the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees and was advised by the PSA Compliance Manager it was a video she found on the PREA Resource Center's website and that the Auditor could find it there. It should be noted the PSA Compliance Manager did not specify which resource she was referring to as there are many on the PREA Resource Center's webpage.

Corrective Action Required: The facility will need to provide the Auditor with a copy of the training curriculum used to train staff on the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees in order for the Auditor to determine full compliance with standard.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Policy H-736 outlines how the facility shall ensure that detainees with disabilities and who are LEP (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. In matters relating to allegations of sexual abuse, the agency and the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless a detainee expresses a preference for another detainee to provide interpretation, and the agency determines that such interpretation is appropriate and consistent with DHS policy. Upon intake, detainees are provided with the facility's local detainee orientation handbook. The Auditor observed the handbook available in English and Spanish. The Auditor was advised detainees are provided with the ICE National Detainee Handbook while at the Baltimore Field Office Hold Room before being transferred to the HCDC. Numerous staff and detainee interviews corroborated this practice. The Auditor did observe several copies of the ICE National Detainee Handbook both in English and Spanish in the intake officer's office. The Intake staff indicated they do not normally have copies of the National Detainee Handbook located at the facility but have recently placed an order for them. The Auditor was not provided with any documentation that confirms detainees are offered or have received a copy of the Handbook. Furthermore, HCDC intake process does not include a process for confirming that detainees received a handbook from the Baltimore Field Office Hold Room and still have the handbook in their possession upon arrival to the facility. The National Detainee Handbook ensures the detainee is receiving meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited in their ability to speak or understand English (i.e. Limited English Proficiency). Therefore, the Auditor could not verify whether all detainees are receiving a copy of the National Detainee handbook either at the Baltimore Field Hold Room or upon intake at the facility. The National Detainee Handbook provides detainees with information on the agency and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse which provides information for detainees on the prevention and reporting of sexual abuse and assault, as well as, information on detainee rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS. PREA Zero Tolerance posters were strategically posted in the intake area, holding cells, and throughout the facility so that all detainees would have the opportunity to review. The Classification supervisor advised if a detainee coming through intake spoke a language that was not available in a written format, they would utilize bilingual staff or interpretive services.

The ICE National Detainee Handbook includes a section (language identification guide) in the very front of the handbook which outlines multiple languages to assist both staff and detainees in identifying the language required to communicate. DHS/ICE PREA reporting posters, Break the Silence, Keep Detention Safe, and the ICE Detainee Helpline are posted in English and Spanish languages. Posters were also displayed containing the name of the facility PSA Compliance Manager and are posted throughout the facility, to include the detainee housing unit. Also, posted is the contact information for the local rape crisis center, HopeWorks of Howard County, Inc. A PREA comprehensive, close caption educational video is played for all detainees

both in English and Spanish on each Thursday during the detainee's facility orientation. Interviews with the Facility Director, Classification Supervisor, PSA Compliance Manager, and security staff indicate there are multiple staff on each shift who speak Spanish, which is the most common language spoken by detainees who are also able to assist detainees with interpretive services if needed. The Auditor observed this practice through staff and detainee communication throughout the on-site visit and observation of detainee facility orientation. Detainees who have disabilities, including intellectual, limited reading skills, who may be deaf, blind, or hearing impaired, are afforded the same level of interpretive services if required. Staff indicated they would read the information to blind and/or vision impaired detainees. Detainees who are LEP are provided with interpretative services, either through available staff or an interpretive service. Detainees who are hearing impaired or deaf will receive services through the facility text telephone machine (TTY), and through the closed caption PREA video, detainees who have a low intellectual or limited reading skills will receive assistance from mental health personnel. The Auditor was able to determine this through interviews with the Facility Director, PSA Compliance Manager, intake, and security staff. While on-site, there were no detainees to interview who were identified as deaf, blind, or hearing impaired, or with a low level of cognitive skills. Review of facility policy indicates the provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. There were no incidents of sexual abuse reported during the audit reporting period. The Auditor interviewed seven detainees who were LEP through the use of telephonic interpretive service, Language Services Associates, provided through Creative Corrections LLC. All detainees interviewed recalled receiving information during the intake/orientation process on the facility's and agency's zero-tolerance policy and efforts to prevent, detect, and respond to sexual abuse.

Corrective Action Required: 115.16(b) - The facility was unable to provide the Auditor with documentation that all detainees are offered and/or receive the ICE National Detainee Handbook upon intake to the facility. The Agency and facility must take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited in their ability to speak or understand English (i.e. Limited English Proficiency).

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) Policy A-017- Hiring and Promotion and ICE Directives 6-7.0 and 6.8.0 outlines how the facility and agency, to the extent permitted by law, refuse to hire or promote anyone who may have contact with detainees and decline to enlist the services of any contractor or volunteer who may have contact with detainees, who has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard. New hires and staff awaiting promotions are required to complete the HCDC A-017a Self-Declaration of Sexual Abuse/Sexual Harassment form. The individual will respond directly to questions about previous misconduct as required per the standard and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The form is retained in the employee's personnel file. The Auditor was able to confirm the above mentioned through the review of six randomly selected staff personnel files. The policy further indicates every effort is to be made to contact all prior institutional employers for information on sexual abuse incidents before hiring. The interview with the facility Human Resource Manager confirmed all the elements outlined in the standard are performed.

(c)(d) Policy A-017 and ICE Directives 6-7.0 and 6.8.0 requires the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees before being allowed entrance into the facility. It further requires a background recheck to be conducted every five years on all employees and contractors. The Human Resource Manager stated the HCDC Training Officer completes all staff and contractor background checks. The Auditor requested completed background record checks for six randomly selected HCDC employees and was provided the documentation for the six staff to include their five-year background rechecks but was unable to provide background record checks for the two contractors. The Auditor also received completed background record checks through ICE's Personnel Security Unit (PSU) Unit Chief for eight ICE employees, which confirmed that the employee background checks were performed before them reporting to duty. Documentation reviewed by the Auditor also confirmed the due dates for the five-year background rechecks. There was only one staff person identified as receiving a five year background recheck, in accordance with the standards requirement and it's currently in the reinvestigation background check process. The Auditor determined the provided background check information was compliant with the standard in all material ways.

While on-site, the Auditor requested a current list of all volunteers and contractors who may have contact with detainees to randomly select sampling to confirm appropriate background checks have been completed and are documented. The Auditor also requested background check documentation for two contractors and one volunteer the Auditor interviewed while on-site, a medical and mental health contractor and the facility volunteer chaplain. The Auditor was not provided with background checks for either contractor. The PSA Compliance Manager stated the facility could not locate the volunteer chaplain's initial background check. While on-site, the facility was unable to provide the Auditor with an active list of all volunteers and contractors who were authorized to enter the facility who may have contact with immigration facility detainees. During the out brief on the first day, the Auditor was advised he would receive a list of all contractors and volunteers before his last day on site. The Auditor was not provided with a list while on-site and subsequently gave the facility an additional week to provide it. Approximately two weeks from the last day on-site, the PSA Compliance Manager advised she would not be forwarding the Auditor a list of contractors and volunteers because the list contained personal telephone numbers and addresses. Therefore, the Auditor was unable to determine if the appropriate background checks are being completed per the standards requirement.

(e) Policy A-017 states the facility has the right to decline to hire or promote and terminate the employment of anyone based on material omissions regarding sexual abuse/harassment misconduct, or the provision of materially false information shall be grounds for termination or withdraw of an offer of employment. Interview with the Human Resource Manager confirmed compliance with policy requirements. There were no staff declined for hiring or promotion and employment terminated during the audit period.

(f) Policy A-017 states that unless prohibited by law, the HCDC will 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 an employee has applied to work. Interview with the Human Resource Manager confirmed the above-mentioned would take place for all employees, contractors, and volunteers who may have contact with detainees. The facility had no requests for information on substantiated allegations of sexual abuse or sexual harassment involving an employee during the audit year.

Corrective Action Required: 115.17(a,d) Although not a standard requirement, it is essential for the facility to maintain an active list of contractors and volunteers who have contact with detainees; however, the facility was not able to provide the Auditor with one. Thus, the Auditor was unable to determine if contractors and volunteers who have contact with detainees have received a background check per the standard's requirement.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

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

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a) Policy A-033 outlines to the extent the agency or facility is responsible for investigating allegations of sexual abuse involving detainees and follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The investigating entity will offer victims of sexual abuse and assault access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate, and only with the detainee's consent. Examinations will be performed by a Sexual Assault Forensic Examiner or Sexual Assault Nurse Examiner (SAFE/SANE), where possible. SAFE/SANE exams are performed at the Howard County General Hospital. If SAFEs or SANEs cannot be made available at the hospital, the examination can be performed by other qualified medical practitioner at the hospital. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable. The Auditor was able to corroborate through the review of HCDC's policy and procedures; interviews with the Facility Director and PSA Compliance Manager further indicated evidence protocols are developed in coordination with DHS. The Auditor further reviewed documentation the evidence protocols were reviewed in coordination with DHS. Security and medical staff stated they are well aware of the facility's evidence protocols and know the necessary steps to take during a report of sexual abuse.

(b)(d) HCDC uses the service of HopeWorks of Howard County, Inc. and has signed a memorandum of understanding (MOU) in which both parties have agreed the HopeWork will provide victim advocacy services to victims of sexual abuse/assault. The Auditor placed a call and talked with the Facility Director of HopeWorks, who confirmed a qualified staff person from the organization will provide emotional support, crisis intervention, information, and referrals if needed and would accompany the victim through any forensics exams and investigative process. The facility reported that there had been no detainee sexual abuse investigations completed during the past 36 months.

(c) Interview with the HSA acknowledges victims of sexual abuse would undergo a forensic medical exam at no cost to the detainee and only with the consent of the detainee. Forensic exams are performed by SAFE/SANE at the Howard County General Hospital. The HSA indicated the facility has not needed to send out a detainee for a sexual abuse forensic medical exam within the last 36 months.

(e) Policy A-033 states to the extent that the agency is not responsible for investigating allegations of sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of paragraph (a) through (d) of this section. The Auditor was provided with a signed MOU between HCDC and the Howard County Police Department. In a review of the MOU and interview with the PSA Compliance Manager, the Auditor was satisfied that the investigating agency has agreed to follow the requirements of 115.21(a) through (d).

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

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

Notes:

a)(b) Policy A-033 outlines the facility's protocol for ensuring that all allegations of sexual abuse are investigated by the agency and facility and referred to the Howard County Police Department, who has the proper investigative authority for conducting all allegations of sexual abuse that are deemed to be criminal. The policy further outlines the roles and responsibilities of the agency, facility, and the Howard County Police Department as it relates to coordinating and the sequence of administrative and criminal investigations. Policy further states all reports and referrals of allegations of sexual abuse and any other related documentation are maintained in the Facility Director's office for at least ten years. Interviews with the Facility Director and PSA Compliance Manager, who is also in charge of conducting any PREA related investigations corroborated those mentioned above. All investigations are to be reported to the Joint Intake Center (JIC) who assesses allegations to determine which allegations fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the 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 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 Investigative Unit (AIU) for investigation. The AFOD would assign an administrative investigation to be completed. All investigations are closed with a report of investigation. The agency's policy 11062.2 outlines the evidence and investigation protocols. Criminal investigations will be referred to the Howard County Police Department, the agency with legal authority to conduct criminal investigations. Qualified investigators must perform all investigations into alleged sexual abuse. It should be noted the Auditor reviewed on the agency's website, the ICE policy, and procedures to ensure that each allegation of sexual abuse is investigated by the agency or the facility or referred to an appropriate investigative authority. Administrative investigations will include: preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviewing alleged victims, suspected perpetrators, and witnesses; and reviewing prior complaints and reports of sexual abuse and assault involving the alleged perpetrator. The PAQ indicated that there were no allegations of sexual abuse during the previous 12 months. The Auditor was further advised there have been no allegations or investigations of sexual abuse during the past 36 months.

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

(d)(e)(f) Policy A-033 outlines the facility's protocol which ensures that all allegations are promptly reported to the agency, and, unless the complaint does not involve potentially criminal behavior, are immediately referred for investigation to an appropriate law enforcement agency with the legal authority to conduct criminal investigations (Howard County Police Department). The facility reported that there had been no detainee sexual abuse investigations completed during the past 36 months; therefore, there were no investigations for the Auditor to review. Interviews with the Facility Director and PSA Compliance Manager indicated all allegations would promptly be reported to the Joint Intake Center (JIC), the ICE OPR, or the DHS Office of Inspector General (OIG), as well as, the appropriate ICE Field Office Director (FOD).

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) Policy A-033 outlines how the facility trains all full and part-time employees who may have contact with detainees and for all facility staff to be able to fulfill their responsibilities and includes each element of the standard. Training on the facility's Sexual Abuse or Assault Prevention and Intervention Program shall be included in training for all new employees. It shall also be included in annual refresher/in-service training after that. Employee training shall ensure facility staff can fulfill their responsibilities under DHS standards. Submitted with the facility PAQ was the HCDC PREA training curriculum, and supporting documentation demonstrating HCDC staff completion of training and test scores. The Auditor determined the curriculum to be compliant with the standard in all material ways. While on-site, the Auditor randomly selected six HCDC employees and reviewed their training documentation for proof of completion and determined the training was compliant per the standard's requirement, to include by the facility's PREA incorporation date. Staff training documentation is maintained both electronically and within employees' training files. Interviews with the PSA Compliance Manager, Assistant Training Officer, and random security staff indicated staff had received the required initial PREA training and annual PREA training during in-service. Facility staff receives the same level of PREA comprehensive training annually, exceeding the requirement of the standard, which calls for refresher training every two years. It was clear to the Auditor; staff understand their responsibilities in preventing, detecting, and responding to incidents of sexual misconduct.

§115.32 - Other training.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) Policy A-033 outlines how the facility shall train all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard. Submitted with the facility PAQ was the HCDC PREA training curriculum utilized for training volunteers and contractors who are required to receive training prior to providing services to the facility. In review of the training curriculum, the Auditor determined all the required elements of standard are covered. The curriculum meets the level and type of training required for volunteers and contractors who may have contact with detainees. Also submitted with the facility PAQ was supporting documentation of completed training for volunteers and contractors, i.e., signed acknowledgments of training received and training session sign in sheets. It should be noted HCDC mandates that all contractors and volunteers receive annual refresher training, such as handouts/brochures related to the agency's zero tolerance policy on sexual misconduct. The Auditor interviewed the facility's Assistant Training Officer while on-site and conducted a phone call interview with the facility Chaplain, both who stated they assist in conducting volunteer and contractor training. While on-site the facility was unable to provide the Auditor with an active list of all volunteers and contractors who were authorized to enter the facility who may have contact with immigration facility detainees. During the out brief on the first day the Auditor was advised he would receive a list of all contractors and volunteers before his last day on-site. The Auditor was not provided with a list while on-site and subsequently gave the facility an additional week to provide it. Approximately two weeks from the last day on-site, the PSA Compliance Manager advised she would not be forwarding the Auditor a list of all active contractors and volunteers because the list contained personal telephone numbers and addresses. Therefore, the Auditor was unable to randomly select a sampling of contractors and volunteers to determine whether or not all volunteers and contractors receive the required training in accordance with the standard.

Corrective Action Required: 115.32c -Although not a standard requirement, it is essential for the facility to maintain an active list of contractors and volunteers who have contact with detainees; however, the facility was not able to provide the Auditor with one. Thus, the Auditor was unable to determine if contractors and volunteers who have contact with detainees have received the required training on their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures.

§115.33 - Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(e)(f) Policy A-033 indicates how the facility provides detainees with PREA education upon intake to ensure they are informed about the facility's zero-tolerance policy for all forms of sexual abuse. The Auditor was provided with a tour of the detainee intake orientation process which occurs upon arrival and does not exceed 12 hours. In review of the facility's detainee handbook, which provides detainees with the required PREA orientation information, the Auditor determined that all six elements of the standard are covered per the standards requirements. The intake officer stated during the intake process, detainees who are determined to be LEP or who may have a disability, i.e., hearing impaired, deaf, and blind, etc. will receive interpretive services or medical and/or mental health assistance throughout the process. Detainees further receive additional PREA education during the orientation process, which takes place each Thursday. Detainees are shown the facility's PREA educational video and are required to watch the video within seven days of arrival at the facility. The video is closed-captioned and available in the two predominant languages used by detainees, English and Spanish. The Auditor had the opportunity to sit in on the PREA orientation phase. Not only was the PREA educational video played, but staff who were giving orientation instruction also communicated to the detainees both in English and Spanish regarding the agency and facility's zero-tolerance policy. The Auditor also observed in the intake holding cell areas DHS posted signage, "ICE Zero Tolerance," to include the ICE Sexual Assault Awareness Information pamphlets. The Auditor was advised by numerous staff and detainees that the ICE detainee handbook is not provided by the facility upon intake, as it is delivered to detainees while they are at the Baltimore Field Office Hold Room. The AFOD confirmed this during the audit out brief and stated documentation is maintained regarding the distribution of the ICE handbook to the detainee. It should be noted, Intake staff indicated they do not normally have copies of the National Detainee Handbook located at the facility. The Auditor was not provided with any documentation that confirms detainees are offered or have received a copy of the National Detainee Handbook. Furthermore, HCDC intake process does not include a process for confirming that detainees received a handbook from the Baltimore Field Office Hold Room and still have the handbook in their possession upon arrival to the facility. Therefore, the Auditor could not verify whether all detainees are receiving a copy of the National Detainee handbook either at the Baltimore Field Hold Room or upon intake at the facility. The National Detainee Handbook ensures the detainee is receiving

meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited in their ability to speak or understand English (i.e. Limited English Proficiency).The Handbook also provides detainees with information on the agency and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse which provides information for detainees on the prevention and reporting of sexual abuse and assault, as well as, information on detainee rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS. The Auditor was also advised detainee handbooks are available on the facility kiosk and would provide the Auditor a screen-shot of the handbooks; however, the Auditor was not provided with evidence the information is available to detainees on the kiosk.
While on-site, the Auditor interviewed 20 detainees and most recalled receiving the required PREA information in a format they could understand upon intake or there shortly after through the use of interpretive services.

(d) The Auditor observed numerous PREA related informational signage throughout the facility to include in all detainee dorms: the DHS-prescribed sexual assault awareness notice; the name of the PSA Compliance Manager; and contact information for the local rape crisis center (HopeWorks), that can assist detainees who have been victims of sexual abuse.

(c)The Auditor randomly selected ten detainees for file review in order to confirm they had received the required PREA information upon intake, and the facility could only provide five of the chosen randomly detainee intake forms indicating they received the facility intake orientation, which also includes the required PREA information. Only three of the submitted intake forms included the detainee's signature acknowledging receipt. Therefore, the Auditor could not verify that all detainees are participating in the intake process orientation process and receiving the required detainee education per the standards requirement.

Corrective Action Required:

115.33(b) Each facility shall provide the detainee notification, orientation, and instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. The facility was unable to provide the Auditor with documentation that all detainees are offered and/or receive the ICE National Detainee Handbook upon intake to the facility. The Agency and facility must take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited in their ability to speak or understand English (i.e. Limited English Proficiency).

115.33(c) -The facility must demonstrate detainees are receiving PREA education and the proper procedures for how documentation of detainee education participation during the intake process orientation is documented.

115.33(f) – The facility must ensure information about reporting sexual abuse shall be included in the agency Detainee Handbook made available to all immigration detention facility detainees.

§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 A-033 states the facility shall provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct investigations into allegations of sexual abuse at immigration detention facilities. This training covers interviewing sexual abuse and assault victims, sexual abuse and assaults evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. Interviews with the Facility Director and PSA Compliance Manager, who is also the facility Investigator, indicated required staff had received specialized training for conducting sexual abuse investigations per the standard. The PSA Compliance Manager provided the Auditor with her certificate of completion for completing the specialized training. The training curriculum - Investigating Sexual Abuse in Confinement Settings was provided electronically through the National Institute of Corrections (NIC). The Auditor determined the curriculum meets the standard requirements in all material ways. The PSA Compliance Manager/Investigator verified the completion of training and is knowledgeable of the elements needed to conduct sexual abuse investigations within a confinement setting. HCDC reported no incidents of sexual abuse during the previous 36 months.

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

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

(a)(b) N/A – HCDC does not have any ICE Health Service Corps. (IHSC) staff on-site.

(c) Policy A-033 indicates in addition to the over-all PREA training provided to all employees, all full and part-time qualified health care professionals and qualified mental health professionals, who work in the facility, shall receive specialized medical training as outlined: how to detect and assess signs of sexual abuse; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; how and to whom to report allegations of sexual abuse. It should be noted, according to the PAQ and interview with the Facility Director, the agency did a review and approved the facility's policy and procedures. The Auditor further reviewed documentation where policy A-033 was reviewed and approved by ICE. The Auditor was provided with Wellpath's Academy PREA training curriculum and completion of training certificates for one medical and mental health contractor. The Auditor concluded the specialized training curriculum meets the standard in all material ways. Interviews with medical and mental health staff indicate they are trained in procedures for examining and treating victims of sexual abuse; how to detect and assess signs of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; how and to whom to report allegations or suspicions of sexual abuse; and how to preserve physical evidence of sexual abuse. HCDC medical staff do not conduct forensic examinations. If a forensic examination would be required, the detainee is sent to the Howard County General Hospital, where a SAFE/SANE will examine the victim. The facility exceeds the standard in requiring specialized training for facility medical and mental health practitioners, as this is not a requirement of the standard.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)
Notes:

(a)(b)(c)(d) Policy's C-200 – Admission Procedures/Intake and D-307 – Establishment, Maintenance, and Access to Detainees Records, outlines all detainees shall be screened upon arrival at the facility for potential risk of sexual victimization or sexually abusive behavior. Detainees shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each new detainee shall be kept separate from the general population until he has been classified and may be housed accordingly. The initial classification process outlined in policy C-200, appendix 9, PREA screening form A-033b states initial housing assignment should be completed within 12 hours of admission to the facility and considers all nine elements of subsection 115.41(c). Review of provided documentation indicate detainees are provided with appropriate housing within the twelve-hour period. Initial screenings are conducted at intake and followed up by the classification officer normally on the next business day and shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive. The HCDC Sexual Abuse Screening Tool is used for completing the initial assessments. The Auditor randomly selected 10 detainees and reviewed their completed risk assessment forms and found they were completed appropriately. The forms are maintained in the detainee's central file and electronic records. Interviews with detainees confirmed receiving a risk screening upon intake and confirmed through the review of ten detainee files.

(e) Although interviews with detainees confirmed receiving a risk screening upon intake, they do not recall being followed-up with or reassessed with similar questions at a later time. The interview with the PSA Compliance Manager confirmed reassessments would only be completed at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. Interview with the Classification Supervisor corroborated those mentioned above. During the review of ten detainee assessments for risk of victimization and abusiveness, the Auditor confirmed the proper procedures are being followed per the standard in all material ways, except 115.41(e). Reassessments within 60 and 90 days from the date of initial assessment are not be completed per the standards requirement, thus making it non-compliant.

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

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

Corrective Action Required: 115.41e. - The facility must develop procedures for reassessing each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization.

§115.42 - Use of assessment information.

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

(a)(b)(c) Policy D- 300 Classification, outlines how the facility uses the information from the A-033b Sexual Abuse Screening Tool when conducting the initial screening for consideration of housing, recreation, work program, and other activities. In the review of ten completed risk assessments, the Auditor determined the facility is utilizing collected data, such as the detainee's physical characteristics (build and appearance), age, whether the detainee has mental, physical or development disability, previous assignment in specialized housing, alleged offense and criminal history, whether the detainee self-identifies to be LGBTI or is gender non-conforming to determine housing, recreation, work, and other activity decisions. Interviews with the PSA Compliance Manager, intake staff, and the Classification Supervisor indicated to the Auditor the facility is ensuring the safety of each detainee and are performing all the requirements of the standard. While the Auditor was on-site, HCDC did not house any transgender or intersex detainees; therefore, there were no interviews conducted with a transgender/intersex detainee. The interview with the PSA Compliance Manager indicated when making assessments and housing decisions for transgender or intersex detainees, the facility will consider the detainee's gender and self-identification, and evaluation of the effects of placement on the detainee's health and safety. The PSA Compliance Manager further stated transgender and/or intersex detainees shall be reassessed at least twice a year. Interviews with PSA Compliance Manager, Classification Officer, and medical staff indicated that a medical and mental health professional would be consulted on a case-by-case basis, to determine whether the placement would present management or security concerns. Interviews with the PSA Compliance Manager, intake staff, Classification Officer, and security staff all confirmed transgender and intersex detainees are given the opportunity to shower separately from other detainees. The degree of separation is based on the physical layout of the detainee dorms, (e.g., separate shower stalls) or by time-phasing or scheduling (e.g., allowing a detainee to shower before or after other detainees). The Auditor was able to corroborate the aforementioned facility layout through observations during the tour

§115.43 - Protective custody.

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

(a)(b)(c)(d)(e) Policy D-306 Inmate/Detainee Administrative Segregation and Medical Housing outlines the facility's use of administrative segregation to protect detainees at high risk for sexual abuse and assault and shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort, and document detailed reasons for placement. Detainees considered at risk for sexual victimization will be placed in the least restrictive housing that is available and appropriate. The facility will consult with the ICE FOD to determine if ICE can provide additional assistance. Detainees will be assigned to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. If segregated housing is warranted, the facility will take the following actions: a supervisory staff member will conduct a review within 72 hours of the detainee's placement in segregation to determine whether segregation is still warranted. A supervisory staff member will hold, at a minimum, an identical review after the detainee has spent 7 days in administrative segregation, and every week after that, for the first 30 days and every 10 days after that. Interviews with the Facility Director and PSA Compliance Manager indicated detainees placed in segregated housing would have access to programs, privileges, education, and work opportunities to the extent possible. If access to these opportunities is restricted, the facility will document the reasons why. The Facility Director or designee will notify the appropriate ICE FOD via email or other written correspondence no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in segregation based on vulnerability to sexual abuse or assault. As noted on the PAQ, submitted documentation, and staff interviews, HCDC has not put a detainee in administrative segregation/protective custody during the previous 12 months due to the vulnerability of sexual abuse. In a review of

Policy D-306, written procedures were developed in consultation with the ICE FOD, who has jurisdiction for the facility. Interviews with the Facility Director, PSA Compliance Manager, and facility staff who supervise administrative segregation corroborated the above mentioned.

§115.51 - Detainee reporting.

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

Notes:

(a)(b)(c) Policy A-033 outlines the facility's approach to ensure detainees have multiple ways to report sexual abuse and retaliation for reporting sexual abuse privately, and staff neglect or violation of responsibilities that may have contributed to any incidents. Submitted with the facility PAQ were directives on how detainees can contact their consular official, the DHS OIG, or as appropriate, another designated office, to confidentially and, if desired, anonymously report incidents of sexual misconduct. Interviews with random detainees indicated to the Auditor they are aware of the processes in place to report incidents of sexual misconduct, e.g., report to a staff member, file a grievance, place a hotline phone call, contact their consular official, the DHS OIG, or as appropriate, another designated office to anonymously report an allegation. During the tour of the facility, the Auditor observed numerous signage, both locally and agency-specific, for detainees to report incidents of sexual misconduct, to include in all housing areas, posted on bulletin boards, and/or next to detainee phones. It should be noted the facility provides an in-house hotline number (*911) for detainees also to make reports of sexual abuse. The Auditor placed a test call to the HCDC PREA hotline number, and the call went to the Chief of security's voicemail. The Auditor was advised the Chief of security was out on leave, and the number was not forwarded to another staff person during his absence. The facility has since amended policy and procedures regarding which staff will be notified if a call is placed to the *911 hotline. Calls are now automatically routed to the Facility Director, Chief of security, facility Investigative Manager, and the PSA Compliance Manager. During intake/orientation, detainees receive a copy of the local facility handbook that includes the process for detainees to report allegations of sexual abuse and misconduct. Detainees receive a copy of the ICE National Detainee Handbook while at the Baltimore Hold Room and bring it with them when transferred to the HCDC. Detainee and staff interviews corroborated the above mentioned. Detainees can also place calls to the DHS OIG Hotline number and can remain anonymous upon request. It should be noted the Auditor placed a successful test call to the DHS OIG Hotline. Policy further outlines procedures for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. Interviews with the PSA Compliance Manager, security staff, including line staff and first-line supervisors, stated if they were to receive a report of sexual misconduct, they would document it and forward it on through the appropriate channels for review and investigation. The facility reported no incidents of sexual abuse or investigations during the last 36 months.

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(f)(e) Policy H-707 Inmate/Detainee Grievance Procedures outlines the formal grievance process for detainees to utilize involving allegations of an immediate threat to their health, safety, or welfare, and related to sexual abuse. Allegations submitted via the grievance process are handled by the PSA Compliance Manager, who is also the facility Grievance Officer and Investigator for all matters PREA related. Detainees are permitted to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. A detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives with filing a grievance relating to sexual misconduct. Policy A-033 indicates, facility staff are required to bring all medical emergencies to the immediate attention of proper medical personnel for further assessment. The facility does not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Policy additional states the facility will issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. The facility shall send all grievances related to sexual abuse and the facility's decisions concerning such grievances to the appropriate ICE FOD. Interviews with the Grievance Coordinator, security staff, and front-line supervisors corroborated the above mentioned. According to the facility PAQ and interview with the Grievance Coordinator, the facility has not received any grievances in the past 12 months regarding allegations of sexual abuse. Interviews with detainees also confirmed they are aware of the facility grievance process and that they can request assistance in filing a grievance if needed.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b) Policy A-033 outlines the facility's procedures to provide outside confidential support services that will aid support in the areas of crisis intervention, counseling, investigation, the prosecution of sexual abuse perpetrators, and to address victim's needs. HCDC has an MOU with HopeWorks of Howard County. The Auditor interviewed a staff representative from Hope Works and was advised the above mentioned would take place if there were an incident requiring their service. Interview with the PSA Compliance Manager confirmed she has been in contact with staff from Hope Works, and both parties understand the services to be provided in the case of reported incidents of sexual abuse. The facility reported no incidents of sexual abuse or investigations in the last 36 months; therefore, there were no cases for the Auditor to review.

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

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

§115.54 - Third-party reporting.

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

Notes:

Policy A-033 states third party reports of sexual abuse may be made as follows: DHS OIG toll-free hotline number at 1888-323-8603; JIC toll-free hotline number 1-877-256-8253 or e-mail joint.intake@dhs.gov; and call the HCDC 24-hour Family/Friends hotline at 410-313-5200 (press "0").

A review of both ICE's website (www.ice.gov/prea) and HCDC's website (https://www.howardcountymd.gov/Departments/Corrections/Prison-Rape-Elimination-Act-PREA) confirm the public is notified how to report incidents of sexual abuse/harassment on behalf of detainees. Both websites list contact numbers for the general public to report allegations of sexual misconduct. Interviews with Facility Director and PSA Compliance Manager confirm they are aware of the requirement to accept sexual abuse notifications from third parties. It should be noted, according to the HCDC, the facility has not received a third-party allegation in the previous 36 months.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c) Policy A-033 outlines the responsibilities of staff who are required to report, immediately, and any knowledge, suspicion, or information regarding incidents of sexual abuse, retaliation against detainees or staff who have reported incidents of sexual abuse, or staff neglect or violations of responsibilities that may have contributed to an incident or retaliation. According to the PAQ and interview with the Facility Director, the agency did a review and approved the facility's policy and procedures. The Auditor also confirmed this through the review of the agency staff's initialed documentation review. Staff members who become aware of alleged sexual abuse will immediately follow the reporting requirements outlined in section F – Prevention and Training of policy A-033. Employees are required to take all allegations of sexual abuse and assault seriously, including verbal, anonymous, and third-party reports, and treat them as if the allegation is credible. Staff is required to document all verbal statements promptly. Interviews with the PSA Compliance Manager, Facility Director, and random security staff, clearly expressed to the Auditor, the protocols in place as it relates to staff reporting duties, to include how staff can report allegations of sexual misconduct outside of their normal supervisory chain of command if needed. Staff can privately report sexual abuse and assault of detainees by forwarding a letter marked "Confidential" to the Facility Director. Policy further states staff can report incidents of sexual abuse by contacting the Howard County Police Department. Apart from such reporting, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions.

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

§115.62 - Protection duties.

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

Notes:

Policy A-033 outlines the facility's approach when the staff learns that a detainee is subject to a substantial risk of imminent sexual abuse. Immediate action is taken to protect the detainee. Interviews with the Facility Director, PSA Compliance Manager, and random security staff indicate if a detainee is determined to be at imminent risk of sexual abuse, the detainee would be immediately removed from the threat. It should be noted the facility has reported they have not received an allegation of sexual abuse or have conducted any related sexual abuse investigations during the previous 36 months.

§115.63 - Report to other confinement facilities.

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

Notes:

(a)(b)(c)(d) Policy A-033 outlines the facility's process for reporting to other confinement facilities. Upon receiving an allegation that a detainee currently at the facility was sexually abused while housed at another facility (e.g., state, federal, local, or another private operator) the Facility Administrator of the facility that received the allegation will contact the Facility Administrator where the alleged abuse took place as soon as possible, but no later than 72 hours after receiving the allegation. A copy of the statement of the detainee will be forwarded to the appropriate official at the location where the incident was reported to have occurred. The facility will document it has provided such notification. Upon receiving notification from another agency or another facility that a detainee currently at their facility reported an incident/allegation of sexual abuse that occurred while the subject was a detainee at the HCDC, the following actions will take place: the facility will document the name of the agency making the report, and any information that may assist in determining whether an investigation was conducted. If an investigation was not completed, the facility would initiate an investigation. Notification is required to be made to the ICE FOD/designee as soon as possible. HCDC has reported that there were no reported claims of sexual allegations occurring at another facility during the previous 36 months. Interviews with the PSA Compliance Manager and Facility Director corroborated the above mentioned would take place if required. They further indicated they are aware of the proper steps for making such notifications, and for maintaining documentation if notification is made. The Facility Director and PSA Compliance Manager stated documentation of such notifications would be maintained through electronic means, i.e., email correspondence, faxes, facility incident reports

§115.64 - Responder duties.

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

Notes:

(a)(b) Policy A-033 states upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or if it is his or her supervisor, shall ensure that the alleged victim and perpetrator are separated and that the alleged victim is kept safe, and has no contact with the alleged perpetrator. The responder shall, to the greatest extent possible, preserve and protect any crime scene until appropriate steps can be taken to collect evidence. Interviews with security staff, policy review, and PSA Compliance Manager indicates all four elements of the standard are accounted for throughout the responder duties. According to the facility PAQ and staff interviews, there has not been a non-security staff member who acted in the capacity of a first responder. Policy states and interviews with security staff, and security supervisors, and a non-security staff person corroborate non-security first responders are required to request that the alleged victim not take any actions that could destroy physical evidence and

are required to notify security staff. Additional evidence the Auditor relied upon in determining compliance was; some staff interviewed had laminated cards, delineating first responder duties for both security and non-security staff. The facility reported no allegations or investigations of sexual abuse for the previous 36 months.

§115.65 - Coordinated response.

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

Notes:

(a)(b)(c)(d) Policy A-033 section - N Coordinated Response Plan, outlines the steps for the facility's coordinated response to incidents of sexual abuse. In a review of policy, the facility utilizes a multi-disciplinary team approach in its coordinated response to incidents of sexual abuse. It outlines the team member's roles and responsibilities, i.e., security, medical, mental health, etc. Interviews conducted with the Facility Director and PSA Compliance Manager indicated the facility uses a coordinated, multi-disciplinary team approach when responding to incidents of sexual abuse. The facility's written institutional plan outlines the responsibilities for a coordinated response for all sexual abuse allegations. According to the PSA Compliance Manager, during the past 36 months, HCDC has not needed to use the facility's coordinated response for an allegation or incident of sexual abuse. Interviews with the Facility Director and PSA Compliance Manager confirmed they are aware of the facility's coordinated response procedures for allegations of sexual abuse. Both the Facility Director and PSA Compliance Manager advised the Auditor, proper notifications per the standard would be made to the receiving facility, to include a DHS immigration detention facility subpart A and B, if a detainee victim of sexual abuse was to be transferred. The facility will also inform the receiving facility of the incident and the victim's potential need for medical or social services unless the victim requests otherwise.

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

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

Notes:

Policy A-033 section K- Discipline of Authorized Personnel, outlines staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Employees will be subject to disciplinary sanctions up to and including termination for violating HCDC sexual abuse policies. Termination is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse. Contractors or volunteers who have engaged in sexual abuse or assault are prohibited from contact with detainees. Interviews with the Facility Director and Human Resources staff corroborated that staff, contractors, or volunteers who are being investigated for sexual abuse allegations or any other serious misconduct involving a detainee are prohibited from having contact with detainees. The Facility Director further advised contractors or volunteers suspected of sexual misconduct with a detainee would not be permitted in the facility while the investigation was pending. HCDC reported no incidents of detainee sexual abuse involving staff, contractors, or volunteers within the past 36 months.

§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 A-003 outlines the facility's procedures for protection against retaliation. Interviews with the Facility Director and PSA Compliance Manager indicated, staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual abuse as a result of force, coercion, threats, or fear of force. For at least 90 days following a report of sexual abuse, the facility will monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Such monitoring shall include the monitoring of detainee housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. Interviews further indicated items the facility would monitor would include detainee disciplinary reports, housing or program changes, negative performance reviews, or reassignments of staff. The facility will continue monitoring beyond 90 days if the initial monitoring indicates a need to. This shall include periodic status checks of detainees in person and review of any relevant documentation. According to facility submitted documentation, the facility does not have a specific form that is used for monitoring retaliation. Interview with the PSA Compliance Manager indicated if monitoring for retaliation was required, it would be completed through the issuance of an internal facility memorandum. Interviews with the Facility Director and PSA Compliance Manager corroborated the above information. According to the facility PAQ and interview with the PSA Compliance Manager, there has not been a report of sexual abuse in the previous 36 months; therefore, there has not been a need to conduct monitoring for retaliation.

§115.68 - Post-allegation protective custody.

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

Notes:

(a)(b)(c) Policy D-306 Classification, outlines the facility's use of administrative segregation to protect detainees at high risk for sexual abuse and assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. Interviews with the PSA Compliance Manager and Facility Director indicated the facility should take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible. The PSA Compliance Manager confirmed detainee victims should not be held for longer than five days in any administrative segregation, except in unusual circumstances or at the request of the detainee. A detainee victim who is in protective custody after having been subjected to sexual abuse would not be returned to the general population until completion of a re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. According to the facility PAQ, and interviews with the Facility Director and PSA Compliance Manager, HCDC has not utilized segregation to protect a victim of sexual abuse. The facility reported no incidents of sexual abuse during the previous 36 months; therefore, the Auditor was unable to review any records involving the use of administrative segregation to house a detainee victim of sexual abuse.

(d) Policy D-306 Classification, outlines the facility's use of administrative segregation. Interviews with the Facility Director and PSA Compliance Manager indicated the facility would notify the appropriate ICE FOD whenever a detainee victim has been placed in administrative segregation and documentation about the use of administrative segregation would be submitted as soon as possible, normally via email, but would not exceed 72 hours per the standard.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) Policy A-033 states the Facility Director will ensure that an administrative investigation shall be prompt, thorough, objective, and conducted by specially trained, qualified investigators. A referral is initiated for a criminal investigation if potentially illegal behavior is determined to have occurred and is completed for all allegations of sexual abuse or assault. Criminal investigations shall be referred to a law enforcement agency with legal authority to conduct criminal investigations. HCDC has an MOU with the Howard County Police Department, who will conduct criminal investigations into allegations of sexual abuse. Upon the conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon completion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within ICE/DHS and the assigned criminal investigative entity. Interviews with the Facility Director and PSA Compliance Manager confirmed the aforementioned.

(c) Although interviews conducted with the Facility Director and PSA Compliance Manager, who is also responsible for conducting all PREA related investigations, indicated the facility had developed written procedures for administrative investigations, Policy A-033 section J - Investigation Requirements, was submitted with the facility PAQ as supporting documentation. In a review of the policy, the Auditor could not locate the facility written procedures incorporating each element required for administrative investigations per the standard.

(e)(f) Interviews with the Facility Director and PSA Compliance Manager revealed an investigation would not terminate with the departure of the alleged abuser or victim from the employment or control of the facility or agency. When outside law enforcement agencies investigate sexual abuse, the facility will cooperate to the fullest with outside investigators and remains informed through verbal or written communication, i.e., email correspondence, about the progress of the investigation. The facility reported no incidents of sexual abuse during the previous 36 months; therefore, the Auditor was unable to review any investigations completed according to facility policy.

Corrective Action Required: 115.71c – The facility will need to amend their current Policy (A-033 section J - Investigation Requirements) and ensure that written procedures for administrative investigations include "each" provision delineated within the standard.

§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 A-033 section J – Investigation Requirements, states the facility will impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or harassment are substantiated. Interviews with the PSA Compliance Manager, who is also responsible for conducting a PREA related investigation verified the facility would impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. According to the facility PAQ and interview with the PSA Compliance Manager, there has not been a report of sexual abuse in the previous 36 months; therefore there were no investigative files for the Auditor to review.

§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 A-033 section J – Investigation Requirements, outlines the procedures the facility will take for reporting to detainees. Following an investigation into a detainee's allegation that he/she suffered sexual abuse at the facility, the detainee shall be notified of the result of the investigation in writing whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded, and any responsive action taken. If the facility did not conduct the investigation, the relevant information should be requested from the outside investigating agency or entity to inform the detainee. The facility reported no allegations of sexual abuse during the previous 12 months; therefore, there were no investigative outcome notices to detainees available for the Auditor to review. Interviews with the Facility Director and PSA Compliance Manager, who also responsible for conducting any PREA related investigations, confirmed the process in place for reporting to detainees.

§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 A-033 section K- Discipline of Authorized Personnel, states staff is subject to discipline to include termination for violation of the department's sexual abuse and sexual harassment policies, Howard County Code, and/or Maryland State Law. According to the PAQ and interviews with the Facility Director and PSA Compliance Manager confirmed the facility's policies and procedures regarding disciplinary or adverse actions for staff were provided to the agency for review and approval. The Auditor reviewed documentation that the facility's policy was reviewed and approved by ICE. Staff removal from their position and 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. All terminations for violations of HCDC sexual abuse policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies unless the activity was not criminal, and to any relevant licensing bodies, to the extent known. The facility will also report all such incidents of substantiated abuse, removals, or resignations in lieu of removal to the ICE FOD, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known. During the past 36 months, the facility has not had an allegation involving staff sexual misconduct. Therefore, files demonstrating termination, resignation, or other disciplinary actions were not available for review. Interview with the Facility Director confirmed staff is subject to discipline for violations of the department's sexual misconduct policies, and termination is the presumptive disciplinary sanction for a staff member who has engaged in sexual abuse. Reports of removals or resignations for violations of agency or facility sexual abuse policies would be forwarded to any relevant licensing bodies by the facility to the extent known.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c) Policy A-033 section K - Discipline of Authorized Personnel, states any authorized personnel to enter the facility suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Contractors and volunteers who have engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility shall take appropriate remedial measures and

shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other provisions within these standards. Incidents of substantiated sexual abuse by a contractor or volunteer should be reported to law enforcement agencies unless the activity was not criminal. The facility will report such incidents to the ICE FOD/designee regardless of whether the activity was illegal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known. During the past 36 months, the facility has not had an allegation where a contractor or volunteer was involved in sexual misconduct. Therefore, files demonstrating termination or removal from contact with detainees were not available for review. Interview with the Facility Director confirmed volunteers and contractors are subject to termination and/or prohibited contact from detainees for violations of the department's sexual abuse policies. The facility will take appropriate measures when considering whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within the standard.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) Policy H-713 outlines if a detainee engages in sexual abuse, sanctions shall be commensurate with the nature and circumstances of the abuse committed, the detainee's disciplinary history, and the sanctions imposed for comparable offenses by other detainees with similar accounts. If a detainee is determined mentally disabled or mentally ill, but competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed. The mental health staff completes this process. A detainee may be disciplined for sexual conduct with an employee only upon a finding that the employee did not consent to such contact. Detainees who deliberately allege false claims of sexual abuse can be disciplined. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Policy 15-2 Inmates Rules and Discipline outlines the facility's disciplinary system, which incorporates progressive levels of reviews, appeals, procedures, and documentation procedures. The facility has reported no incidents of sexual abuse during the previous 36 months. Therefore, there were no detainee's disciplinary records relating to sexual misconduct for the Auditor to review. Interview with the Facility Director confirmed all elements of the standard are followed regarding disciplinary sanctions of detainees.

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

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

Notes:

(a)(b)(c) Interviews with medical and mental health care staff confirmed that if a detainee has experienced prior sexual victimization or perpetrated sexual abuse, they will receive a health evaluation no later than two working days from the date of an assessment, if not sooner. Although the PAQ indicated "No" for question 115.81(c)-1, interview with mental health staff confirmed when a referral for mental health follow-up is initiated, the detainee would receive a mental health evaluation no later than 72 hours after the referral, and she further stated the detainee would more than likely been seen much earlier. Interview with the HSA indicated when a referral for medical follow-up is initiated; the detainee shall receive a health care evaluation no later than two working days from the initial assessment. Interviews with both medical and mental health staff indicated that they could not recall any instances where a detainee was referred either to medical or mental health relating to a PREA incident or referral for victimization or abusiveness during the past 36 months Therefore, there were no mental health or medical records for the Auditor to review of detainees who have experienced prior sexual victimization or who have perpetrated sexual abuse to determine the timeliness of their follow-up. According to the facility PAQ and interview with the PSA Compliance Manager, there has not been a report of sexual abuse in the previous 36 months; therefore, there were no investigative files for the Auditor to review.

§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) A-033 section M - Victim Services, states detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. All treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall provide such victims with medical and mental health services consistent with the community level of care. There were no detainees who reported sexual abuse while on-site for the Auditor to interview. Also, there were no allegations within the last 36 months, therefore, there was no documentation for the Auditor to review that would demonstrate that the appropriate services were provided while at the facility in a timely manner. According to the PAQ and submitted memo, the facility has not had to send a detainee out to the Howard County General Hospital to receive emergency medical assistance for PREA/sexual assault-related injuries or treatment in the past 36 months. Interview with the HSA confirmed detainees will receive timely emergency access to medical and mental treatment without financial cost to the detainee and will have unimpeded access to emergency medical and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care.

§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 A-033 states the facility will offer a medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse or assault while in immigration detention. The policy also requires the evaluation and treatment of the victims, including follow-up services, treatment plans, and, when necessary, referrals for continued care consistent with the community level of care. Both the medical and mental health staff interviews confirmed that detainee treatment is instant, and based on their professional opinion, and consistent with community level of care, including additional follow up if necessary. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

(d) Policy A-033 states detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related

medical services and timely access to all lawful pregnancy-related medical services. The interview with the HSA confirmed the aforementioned. The facility does not house female detainees.

(e) Policy A-033 states detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. Interview with the HSA confirmed detainee victims of sexual abuse are offered tests for sexually transmitted infections and as medically appropriate. It should be noted there were no detainees who required the treatments mentioned above during the previous 36 months.

(f) Policy A-033 states treatment services, both emergency and ongoing, shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall provide such victims with medical and mental health services consistent with the community level of care. Interview with the HSA indicated detainees would receive appropriate treatment if needed, and free of financial cost per the standards requirement. While on-site, there were no detainees to interview who reported sexual abuse.

(g) Policy A-033 states the facility shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. There were no detainees in the previous 12 months that were identified as a sexual abuser. Interview with the Mental Health Coordinator confirmed an attempt would be made to conduct a mental health evaluation of a known detainee abuser within 60 calendar days or sooner of learning of such abuse history and offer treatment deemed as appropriate. Furthermore, all refusals for medical and mental health services will be documented.

§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 A-033 states the Facility PREA Compliance Manager will ensure that a post-investigation review of a sexual abuse incident is conducted after every sexual abuse investigation and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation. In addition to the facility PREA Compliance Manager, the incident review team shall include upper-level facility management officials, and medical and mental health practitioners. The review team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI and/or gender non-conforming identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; and examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. All findings and recommendations for improvement will be documented in a Sexual Abuse Incident Review Report. The completed reports will be forwarded to the Facility Director, the facility PSA Compliance Manager, and agency PSA Coordinator. The facility shall implement the recommendations for improvement or shall document reasons for not doing so. Policy further states the facility will complete an annual review report that the facility conducts of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts, including preparation of a negative report if the facility does not have any reports of sexual abuse during the reporting year. It should be noted the facility reported no incidents of sexual abuse during the previous 36 months. Therefore, there were no sexual abuse incident reviews for the Auditor to review. The Auditor was provided with the facility's annual Negative report for review and determined it to be compliant with the standard in all material ways. Interviews with the Facility Director and PSA Compliance Manager corroborated the aforementioned.

§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 A-033 section P - Data Collection and Reporting requirements, states all case records associated with claims of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling be retained per policy. Policy further states the PSA Compliance Manager shall review aggregate data on an annual basis and present the findings to the Facility Director, ICE FOD, and ICE /ERO headquarters for use in determining whether changes may be needed to existing policies and practices to further the goal of eliminating sexual abuse. The PSA Compliance Manager confirmed the facility maintains these documents locked in the Facility Director's office with access on a need to know basis only.

§115.201 - Scope of audits.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

Standard 115.201(e) states the agency shall provide the Auditor with relevant documentation to complete a thorough audit of the facility. During the on-site phase of the audit, facility staff was not accommodating to provide the Auditor with requested documentation he needed to ensure compliance with several PREA standards. Thus, the Auditor was unable to complete a comprehensive review of pertinent information while on-site. It should be noted; during the post-audit phase, the Auditor submitted a list of items to the facility necessary to gauge compliance with several standards. Approximately two weeks after the Auditor's request, the facility provided some, but not all of the requested material. During the on-site phase of the audit, the Auditor requested a complete and current list of all contractors and volunteers to randomly select a sampling of staff to confirm compliance with PREA standards 115.17 (Hiring and promotion decisions) and 115.32 (Other training). The Auditor was advised he would receive the information while on-site; however, the Auditor did not receive the list of contractors and volunteers while he was on-site. The Auditor gave the facility an additional week to provide the list. Approximately two weeks after the on-site visit, the Auditor was advised by the PSA Compliance Manager he would not be receiving the list as it contains personal phone numbers and addresses. The Auditor was also advised detainee handbooks are available on the facility kiosk and would provide the Auditor a screen-shot of the handbooks; however, the Auditor was not provided with evidence the information is available to detainees on the kiosk. It should be noted, the PSA Compliance Manager left the PREA audit a day early and although she appointed staff to assist the Auditor, they were unable to answer all of the Auditor's questions and obtain the relevant documentation while on site.

The Auditor requested the facility to provide a copy of the training curriculum used to train staff on the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees in order for the Auditor to determine full compliance with standard 115.15j (Limits to cross-gender viewing and searches). The training curriculum was not provided with the facility PAQ; therefore, the Auditor was not able to review and make a determination whether or not the training curriculum was compliant with the standard. The

Auditor gave the facility an additional week from the last day of the on-site visit to provide the training curriculum. Approximately two weeks later, the Auditor was advised by the facility PSA Compliance Manager via email, the training curriculum used for training staff on the proper procedures for conducting pat-down searches was located on the PREA Resource Centers website, and that is where the Auditor could find it.

115.201(e) – Corrective e Action Required: The agency shall provide the Auditor with relevant documentation to complete a thorough audit of the facility. During the on-site phase of the audit, facility staff was not accommodating to provide the Auditor with requested documentation he needed to ensure compliance with several PREA standards.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	29
Number of standards not met:	8
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Mark Stegemolleer 3/14/2020

Auditor's Signature & Date

(b) (6), (b) (7)(C) 2/10/2020

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Mark Stegemoller	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	ICE ERO - Baltimore
Field Office Director:	Diane Witte
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C) SDDO
Field Office HQ physical address:	31 Hopkins Plaza, Suite 700, Baltimore, MD. 21201
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Howard County Detention Center		
Physical address:	7301 Waterloo Rd. Jessup, MD. 20794		
Mailing address: *(if different from above)*			
Telephone number:	410-313-5200		
Facility type:	Choose an item.		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	410-313-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Correction Program Supervisor
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	410-313-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

On December 10-12, 2019, the Prison Rape Elimination Act (PREA) on-site audit of the Howard County Detention Center (HCDC) located in Jessup, Maryland, was conducted by the U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Mark Stegemoller for Creative Corrections, LLC. The purpose of the audit was to determine compliance with the DHS PREA Standards. The PREA audit was the second one for the Howard County Department of Corrections (HCDC). HCDC is contracted by ICE for the housing of adult male detainees. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ, and DHS certified PREA Auditor. The Program Manager's role is to provide oversight to the ICE PREA Audit process and liaison with the ICE External Reviews and Analysis Unit (ERAU) during the audit report review process.

On 12/12/2019, the last day of the on-site visit, during the exit-briefing, the Auditor discussed his primary findings and reiterated the documentation requests he made while on-site but did not receive, and advised the facility of the importance of receiving the documentation to make a final determination on several standards. Although neither required by the standards nor a normal auditor practice to give facilities additional time to provide documentation after an audit has concluded, on the morning of Tuesday 12/17/2019 the Auditor, via ERAU, followed-up with the facility, providing a list of the pending documentation needed, and requested that the facility provide the requested documentation by close of business (COB) the next day. A few hours later, ERO advised the Auditor that HCDC received a surprise OIG inspection and doubted they'd be able to provide by then. The Auditor then extended the deadline to Friday, 12/20/2019, to accommodate them. On 12/20/2019, the Auditor received an email notification from the ICE Team Lead, (b) (6), (b) (7)(C), advising that the facility would not be providing the requested documentation by the end of the day. The facility Director took it upon himself to extend the deadline to submit the documentation by COB, Friday, 12/27/2019, and on Thursday, 12/26/2019, the facility provided the Auditor with some, but not all, of the requested documentation. Further discussion regarding the lack of requested and provided documentation during the corrective action period is outlined within each standard throughout the report.

Of the 41 standards reviewed, the Auditor found two standards (115.31 Staff training and 115.35 Specialized Training: Medical and Mental Health Care) exceeded the requirements of the standard; two standards were not applicable (115.14 Juvenile and Family Detainees, 115.18 Upgrades to Facilities and Technologies); eight standards did not meet the requirements of the standard (115.15 Limits to cross-gender viewing and searches, 115.16 Accommodating detainees with disabilities and detainees who are limited English proficient, 115.17 Hiring and promotion decisions, 115.32 Other training, 115.33 Detainee education, 115.41 Assessment for risk of victimization and abusiveness, 115.71 Criminal and Administrative Investigations, and 115.201 Scope of audits.); and, the remaining 29 standards complied with the requirements of the standards. On 3/7/2020, ERAU Team Lead, (b) (6), (b) (7)(C) sent the Notification of PREA Corrective Action Plan required with a copy of the final PREA Compliance Audit Report to ERO, notifying them of the 9/13/2020 CAP end date and their initial corrective action plan, which was due by 4/16/20.

On 04/16/2020, the Auditor received the ICE PREA Corrective Action Plan (CAP) from the ERAU Team Lead, (b) (6), (b) (7)(C) ERO developed the CAP with the facility, and the plan addressed the eight standards that did not meet compliance during the PREA audit on-site visit and documentation review. The Auditor reviewed the CAP and did not concur with the proposed recommendations for achieving compliance with the eight deficient standards. Throughout the corrective action period, the Auditor received and reviewed documentation provided 04/16/2020 through 09/11/20 to establish compliance with five of the seven deficient standards. Per the DHS PREA regulations, the auditor cannot accept any documentation past September 13, 2020, the day the regulatory 180-day CAP period ends. The Auditor has determined the facility has not met full compliance with the standards 115.32 and 115.41.

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. 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:

(j) Policy E-402 states security staff will be trained in the proper procedures for conducting pat-down searches, including pat-down searches by staff of the opposite gender, and searches of transgender and intersex detainees. While on-site, there were no transgender or intersex detainees for the Auditor to interview. Interviews with the Assistant Training Supervisor and security line staff indicated staff have received proper training on how to perform pat-searches in a professional and respectful manner, and in the least intrusive manner. Most security staff were able to articulate to the Auditor proper pat-search procedures. While on-site, the Auditor reviewed seven different staff training records acknowledging such training has been received. Submitted with the facility Pre-Audit Questionnaire (PAQ) and initial documentation upload was employee signed acknowledgements of completing PREA training. However, the facility did not provide the training curriculum as it relates to performing proper pat-down searches. The Auditor requested a copy of the training curriculum the facility utilizes to train staff on the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees and was advised by the PSA Compliance Manager it was a video she found on the PREA Resource Center's website and that the Auditor could find it there. It should be noted the PSA Compliance Manager did not specify which resource she was referring to as there are many on the PREA Resource Center's webpage.

Does not meet: The facility did not provide the Auditor with the requested PREA training Curriculum (video) as supporting evidence to validate the standard compliance.

Corrective Action Taken: On 5/08/20, the facility provided the Auditor with a link to the PREA Resource Center (PRC) video on Cross-Gender & Transgender Pat Searches. The Auditor reviewed the training curriculum and determined the training met all the elements outlined within the standard. Standard 115.15 is compliant in all material ways.

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

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

Notes:

(a)(b)(c) Policy H-736 outlines how the facility shall ensure that detainees with disabilities and who are limited English proficient (LEP) (including, but not limited to, detainees who are deaf or hard of hearing, those who are blind or have low vision or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse. In matters relating to allegations of sexual abuse, the agency and the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless a detainee expresses a preference for another detainee to provide interpretation, and the agency determines that such interpretation is appropriate and consistent with DHS policy. Upon intake, detainees are provided with the facility's local detainee orientation handbook. The Auditor observed the handbook available in English and Spanish. The Auditor was advised detainees are provided with the ICE National Detainee Handbook while at the Baltimore Field Office Hold Room before being transferred to the HCDC. Numerous staff and detainee interviews corroborated this practice. The Auditor did observe several copies of the ICE National Detainee Handbook both in English and Spanish in the intake officer's office. The Intake staff indicated they do not normally have copies of the ICE National Detainee Handbook located at the facility but have recently placed an order for them. The Auditor was not provided with any documentation that confirms detainees are offered or have received a copy of the ICE National Detainee Handbook at HCDC. Furthermore, HCDC intake process does not include a process for confirming that detainees received a handbook from the Baltimore Field Office Hold Room and still have the handbook in their possession upon arrival to the facility. The ICE National Detainee Handbook ensures the detainee is receiving meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited in their ability to speak or understand English (i.e. limited English proficiency). Therefore, the Auditor could not verify whether all detainees are receiving a copy of the ICE National Detainee handbook either at the Baltimore Field Hold Room or upon intake at the facility. The ICE National Detainee Handbook provides detainees with information on the agency and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse which provides information for detainees on the prevention and reporting of sexual abuse and assault, as well as, information on detainee rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS. PREA Zero Tolerance posters were strategically posted in the intake area, holding cells, and throughout the facility so that all detainees would have the opportunity to review. The Classification Supervisor advised if a detainee coming through intake spoke a language that was not available in a written format, they would utilize bilingual staff or interpretive services.

The ICE National Detainee Handbook includes a section (language identification guide) in the very front of the handbook which outlines multiple languages to assist both staff and detainees in identifying the language required to communicate. DHS/ICE PREA reporting posters, Break the Silence, Keep Detention Safe, and the ICE Detainee Helpline are posted in English and Spanish languages. Posters were also displayed containing the name of the facility PSA Compliance Manager and are posted throughout the facility, to include the detainee housing unit. Also, posted is the contact information for the local rape crisis center, HopeWorks of Howard County, Inc. A PREA comprehensive, closed caption educational video is played for all detainees both in English and Spanish on each Thursday during the detainee's facility orientation. Interviews with the Facility Director, Classification Supervisor, PSA Compliance Manager, and security staff

indicate there are multiple staff on each shift who speak Spanish, which is the most common language spoken by detainees, who are also able to assist detainees with interpretive services if needed. The Auditor observed this practice through staff and detainee communication throughout the on-site visit and observation of detainee facility orientation. Detainees who have disabilities, including intellectual, limited reading skills, who may be deaf, blind, or hearing impaired, are afforded the same level of interpretive services if required. Staff indicated they would read the information to blind and/or vision impaired detainees. Detainees who are LEP are provided with interpretative services, either through available staff or an interpretive service. Detainees who are hearing impaired or deaf will receive services through the facility text telephone machine (TTY), and through the closed caption PREA video and detainees who have a low intellectual or limited reading skills will receive assistance from mental health personnel. The Auditor was able to determine this through interviews with the Facility Director, PSA Compliance Manager, intake, and security staff. While on-site, there were no detainees to interview who were identified as deaf, blind, or hearing impaired, or with a low level of cognitive skills. Review of facility policy indicates the provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. There were no incidents of sexual abuse reported during the audit reporting period. The Auditor interviewed seven detainees who were LEP through the use of telephonic interpretive service, Language Services Associates, provided through Creative Corrections, LLC. All detainees interviewed recalled receiving information during the intake/orientation process on the facility's and agency's zero-tolerance policy and efforts to prevent, detect, and respond to sexual abuse.

Does not meet: 115.16(b) - The facility could not provide the Auditor with documentation that all detainees are offered and/or receive the ICE National Detainee Handbook upon intake to the facility. The agency and facility must take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited in their ability to speak or understand English (i.e., limited English proficiency).

Corrective Action Taken: On 04/16/2020, the Auditor received the facility's response and supporting documentation to remedy the deficient standard. The Auditor did not concur with the initially submitted documentation. The facility only provided documentation that detainees receive the ICE National Detainee Handbook & the Sexual Assault Awareness Pamphlet while at the ICE Baltimore Field Office Hold Room. HCDC did not demonstrate and document a process for confirming that detainees received a handbook from the Baltimore Field Office Hold Room and still have the handbook in their possession upon arrival/intake to the facility. The facility also did not specify if a detainee does not have the handbook upon arrival to HCDC, if they are provided one by the facility. The facility was also required to provide documentation of training/information provided to staff who are required to use the new procedure and shall be completed through staff signatures.

On 05/08/2020, the facility submitted its second response to the CAP. The facility added a question to the ICE Intake Questionnaire that requires intake staff to ask if the detainee received and is in possession of the ICE National Detention Handbook. If the detainee does not have one upon arrival, the facility will issue the detainee one. The facility also now has an electronic copy of the ICE National Detainee Handbook in 11 different languages and the Sexual Abuse and Assault Prevention and Intervention (SAAPI) pamphlet in English and Spanish. The facility also provided documentation: (1) completed detainee intake screening forms demonstrating the intake procedure, and (2) signed staff acknowledgments regarding their understanding of the new processes. The facility complies with this section of the standard in all material ways.

§115. 17 - Hiring and promotion decisions

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

Notes:

(a)(b) Policy A-017- Hiring and Promotion and ICE Directives 6-7.0 and 6.8.0 outlines how the facility and agency, to the extent permitted by law, refuse to hire or promote anyone who may have contact with detainees and decline to enlist the services of any contractor or volunteer who may have contact with detainees, who has been found to have engaged, been convicted of engaging, or civilly or administratively adjudicated to have engaged in sexual abuse as defined in the standard. New hires and staff awaiting promotions are required to complete the HCDC A-017a Self-Declaration of Sexual Abuse/Sexual Harassment form. The individual will respond directly to questions about previous misconduct as required per the standard and as verification of the employee's fulfillment of his/her continuing affirmative duty to disclose any sexual misconduct. The form is retained in the employee's personnel file. The Auditor was able to confirm the above mentioned through the review of six randomly selected staff personnel files. The policy further indicates every effort is to be made to contact all prior institutional employers for information on sexual abuse incidents before hiring. The interview with the facility Human Resource Manager confirmed all the elements outlined in the standard are performed.

(c)(d) Policy A-017 and ICE Directives 6-7.0 and 6.8.0 requires the facility and agency to conduct criminal background checks on all staff and contractors who may have contact with detainees before being allowed entrance into the facility. It further requires a background recheck to be conducted every five years on all employees and contractors. The Human Resource Manager stated the HCDC Training Officer completes all staff and contractor background checks. The Auditor requested completed background record checks for six randomly selected HCDC employees and was provided the documentation for the six staff to include their five-year background rechecks but was unable to provide background record checks for the two contractors and one volunteer. The Auditor also received completed background record checks through ICE's Personnel Security Unit (PSU) Unit Chief for eight ICE employees, which confirmed that the employee background checks were performed before them reporting to duty. Documentation reviewed by the Auditor also confirmed the due dates for the five-year background rechecks. There was one staff person identified as requiring a five-year background recheck per the standards' requirement and is currently in the reinvestigation background check process. The Auditor determined the provided background check information was compliant with the standard in all material ways.

While on-site, the Auditor requested a current list of all volunteers and contractors who may have contact with detainees to randomly select sampling to confirm appropriate background checks have been completed and are documented. The Auditor also requested background check documentation for two contractors and one volunteer the Auditor interviewed while on-site, a medical and mental health contractor,

and the facility volunteer chaplain. The Auditor was not provided with background checks for either contractor. The PSA Compliance Manager stated the facility could not locate the volunteer chaplain's initial background check. While on-site, the facility was unable to provide the Auditor with an active list of all volunteers and contractors who were authorized to enter the facility who may have contact with immigration facility detainees. During the out brief on the first day, the Auditor was advised he would receive a list of all contractors and volunteers before his last day on-site. The Auditor was not provided with a list while on-site and subsequently gave the facility an additional week to provide it. On 12/26/2019, approximately two weeks from the last day on-site, the PSA Compliance Manager advised she would not be forwarding the Auditor a list of contractors and volunteers because the list contained personal telephone numbers and addresses. Therefore, the Auditor was unable to determine if the appropriate background checks are being completed per the standard's requirement.

Does not meet: 115.17(a,d): Although not a standard requirement, it is essential for the facility to maintain an active list of contractors and volunteers who have contact with detainees; however, the facility was not able to provide the Auditor with one. Thus, the Auditor was unable to determine if contractors and volunteers who have contact with detainees have received a background check per the standard's requirement. As mentioned, although the list is not a requirement of the standards, it is part of the DHS PREA Audit process and was requested as part of the initial document request by ERAU on 9/30/19, specifically requested on 11/15/19 as it was not provided as part of the initial document request and again by the Auditor while on-site, and is the only method to allow for the Auditor to select an unbiased sample of files to review to confirm compliance. The facility must provide a current list of contractors and volunteers. Further, the facility must provide a sampling selected by the Auditor, of background check documentation for contractors and volunteers who have provided services in the last 12 months to determine whether proper screening for criminal conduct was conducted in accordance with the standard's requirement.

Corrective Action Taken: On 04/16/2020, the Auditor received the facility's CAP response with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's initial CAP response, which stated, "*The facility does conduct background checks on all volunteers and contractors before they enter the facility. The background documents show home addresses, date of birth, and license numbers. These documents were shown to the Auditor on-site. However, as this is NOT a required standard, the facility cannot be found in non-compliance."* The Auditor disputes the facility comments "*that these documents were shown to the Auditor while on-site."* As noted earlier, the facility did not provide the Auditor a list of contractors or volunteers to randomly select from to verify background checks are completed in accordance with the standard requirement. The Auditor's response to the facility was "Standard 115.17 is a requirement of the facility to achieve PREA compliance." The Auditor was not provided with any background check documentation and the list of contractors or volunteers while on-site. The Auditor referred the facility to review PREA Regulation: 115.17(a) An agency or facility shall not hire or promote anyone who may have contact with detainees, and shall not enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 USC 1997); who has been convicted of engaging or attempting to engage in a sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. 115.17(d) The agency or facility shall also perform a background investigation before enlisting the services of any contractor who may have contact with detainees. Upon request by the agency, the facility shall submit for the agency's approval written documentation showing the detailed elements of the facility's background check for each contractor and the facility's conclusions." The facility must provide a sampling of background check documentation for contractors and volunteers who have provided services in the last 12 months to determine whether proper criminal conduct screening was conducted.

On 05/08/2020, the auditor received the facility's second response to the CAP with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's second CAP response, which was identical to the first CAP response. "*The facility does conduct background checks on all volunteers and contractors before they enter the facility. The background documents show home addresses, date of birth, and license numbers. These documents were shown to the Auditor on-site. However, as this is NOT a required standard, the facility cannot be found in non-compliance." On 5/20/20,* the Auditor provided the same response as he did for the facility's initial request to comply with the standard.

On 07/02/2020, the facility submitted its third response to the CAP and supporting documentation of the facility contractor and volunteer list. The Auditor did not concur with the facility's third CAP response, *"Attached is the list of volunteers and contractors even though this is **NOT** required by the standard."* It should be noted that on 12/26/2019, the PSA Compliance Manager advised the AFOD the list of volunteers and contractors had cell phone & home phone numbers on it and would not be submitting it. The facility was also requested to provide a sampling of background check documentation for contractors and volunteers who have provided services in the last 12 months to determine whether proper criminal conduct screening was conducted. The Auditors response is noted, "Full compliance with the standard is contingent upon the following request. The Auditor has randomly selected five names from the facility provided contractor and volunteer list and requests to receive supporting documentation of background checks for contractors and volunteers who have provided services in the last 12 months to determine whether proper screening for criminal conduct was conducted. Please note the Auditor does not need to see any (PII), e.g., SSN's, home addresses, phone numbers. If required, this information can be redacted by the facility."

On 07/13/2020, the Auditor received the facility's fourth response to the CAP along with supporting documentation. The Auditor was provided with completed background check information for the five randomly selected names from the facility contractor and volunteer list provided to the Auditor on 07/02/2020. The facility is compliant with the standard in all material ways.

§115. 32 - Other training
Outcome: Does not Meet Standard
Notes:

(a)(b)(c) Policy A-033 outlines how the facility shall train all volunteers and contractors who may have contact with immigration detainees to be able to fulfill their responsibilities and includes each element of the standard. Submitted with the facility PAQ was the HCDC PREA training curriculum utilized for training volunteers and contractors who are required to receive training prior to providing services to the facility. In review of the training curriculum, the Auditor determined all the required elements of standard are covered. The curriculum meets the level and type of training required for volunteers and contractors who may have contact with detainees. Also submitted with the facility PAQ was supporting documentation of completed training for volunteers and contractors, i.e., signed acknowledgments of training received and training session sign in sheets. It should be noted HCDC mandates that all contractors and volunteers receive annual refresher training, such as handouts/brochures related to the agency's zero tolerance policy on sexual misconduct. The Auditor interviewed the facility's Assistant Training Officer while on-site and conducted a phone call interview with the facility Chaplain, both who stated they assist in conducting volunteer and contractor training. While on-site the facility was unable to provide the Auditor with an active list of all volunteers and contractors who were authorized to enter the facility who may have contact with immigration facility detainees. During the out brief on the first day, the Auditor was advised he would receive a list of all contractors and volunteers before his last day on-site. The Auditor was not provided with a list while on-site and subsequently gave the facility an additional week to provide it. Approximately two weeks from the last day on-site, the PSA Compliance Manager advised she would not be forwarding the Auditor a list of all active contractors and volunteers because the list contained personal telephone numbers and addresses. Therefore, the Auditor was unable to randomly select a sampling of contractors and volunteers to determine whether or not all volunteers and contractors receive the required training in accordance with the standard.

Does not meet: 115.32(c) - Although not a standard requirement, it is essential for the facility to maintain an active list of contractors and volunteers who have contact with detainees; however, the facility was not able to provide the Auditor with one. Thus, the Auditor was unable to determine if contractors and volunteers who have contact with detainees have received the required training on their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures. As mentioned, although the list is not a requirement of the standards, it is part of the DHS PREA Audit process, was requested as part of the initial document request by ERAU on 9/30/19, specifically requested on 11/15/19 as it was not provided as part of the initial document request and again by the Auditor while on-site, and is the only method to allow for the Auditor to select an unbiased sample of files to review to confirm compliance. The facility must provide a sampling of contractor and volunteer training records related to required training on their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention, and response policies and procedures.

Corrective Action Taken:
On 04/16/2020, the Auditor received the facility CAP response with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's initial CAP response, which stated, "*This is NOT a standard requirement and as such, the facility cannot be found in non-compliance."* The Auditor's response to the facility is, "Standard 115.32(c) is a requirement of the facility to achieve PREA compliance. Please refer to PREA Regulation: 115.32(c). Each facility shall receive and maintain written confirmation that volunteers and other contractors who have contact with immigration facility detainees have completed the training. The facility must provide a sampling of contractor and volunteer training records related to required training on their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention, and response policies and procedures."

On 05/08/2020, the auditor received the facility's second response to the CAP with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's second CAP response, which was identical to the first CAP response, *"This is NOT a standard requirement, and as such, the facility cannot be found in non-compliance."* The Auditor provided the same response as he did for the facility's initial request to comply with the standard.

On 07/02/2020, the facility submitted its third response to the CAP and supporting documentation of a facility contractor and a volunteer list. The Auditor did not concur with the facility's third CAP response, *"Attached is the list of volunteers and contractors even though this is **NOT** required by the standard.*" As requested, the Auditor did not receive a sampling of contractor and volunteer training records related to the required training on their responsibilities under the agency's and facility's sexual abuse prevention and response policies and procedures. On 07/07/2020, The Auditor randomly selected five names from the provided contractor/volunteer list and requested the background check information for each.

On 07/13/2020, the auditor received the facility's fourth response to the CAP along with no supporting documentation. The Auditor did not concur with the facility's fourth CAP response, which stated, *"Due to the constraints of COVID-19, we have not had the requested training.* The Auditor's response noted, "The Auditor is not requesting that in-person training be conducted during the current pandemic, rather, that they provide evidence of training that should have already occurred (required by 115.32) for these individuals as the start date/work performed date/ or background investigation date, documented in the spreadsheet they provided for all 5 contractors/volunteers the auditor selected, was before COVID-19 existed in 2019. Full compliance with the standard is contingent upon the following request. As provided to the facility on 7/7/2020, the Auditor has randomly selected five names from the facility provided contractor and volunteer list and requests to receive supporting documentation of training related to their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention, and response policies, and procedures.*"*

On 08/13/2020, the Auditor received from the ICE Team Lead, (b) (6), (b) (7)(C), additional information provided by the facility and supporting documentation regarding the deficient standard. The facility stated, "*The Attached is the documentation for two of the individuals on the list selected by the PREA Auditor. One Volunteer never came to the facility after having her ID made so there was no reason for her to receive training. The facility could not locate documentation for two volunteers."* The Auditor reviewed and accepted the submitted documents of completed training for two of the five randomly selected volunteers and contractors. Per the facility's response, one of the volunteers never came to the facility; therefore, the training was not needed. The standard remained non-compliant as the facility did not provide completed training documentation for two of the five selected employees.

08/24/2020, the Auditor received from ICE Team Lead, (b) (6), (b) (7)(C), additional supporting documentation provided by the facility regarding the deficient standard. The document was an email correspondence from the facility PSA Compliance Manager to the AFOD, indicating the completion of training for the two volunteers that they initially could not provide completed training for. The email body contained responses from the two volunteers, (b) (6), (b) (7)(C) "*I have read Prea, and I understand it. I will abide by it.*" (b) (6), (b) (7)(C) "*I have read the PREA documents and will abide by the rules.*" The submitted documentation (email) did not provide the Auditor with the training curriculum and/or material the volunteers acknowledged reviewing to determine if the training and information received is compliant with the standard.

On 08/27/2020, a conference call was conducted with HCDC staff, ICE staff (ERAU and ERO), the contract ICE PREA Program Manager, and the PREA Auditor to discuss the pending CAP items and possible solutions the facility could employ to achieve compliance as the end of the regulatory 180-day CAP period was September 13, 2020. In regards to standard 115.32(c), the facility was advised it remains non-compliant**.** The following information was provided to those in attendance and discussed during the call. 115.32 (c) – July 7, 2020: The Auditor randomly selected five names from the facility provided contractor and volunteer list and requested to receive supporting documentation of training related to their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention, and response policies, and procedures (pending). The facility responded that due to COVID-19, the facility had not conducted the requested training. The facility was advised the Auditor was not asking that in-person training be completed during the current pandemic, rather, that they provide evidence of training that should have already occurred and (required by 115.32) for these individuals as the start date/work performed date/ or background investigation date, documented in the spreadsheet they provided for all five contractors/volunteers the Auditor selected, which was in 2019 before the issue of COVID-19 existed.

During the conference call, it was brought to the Auditor's attention for the first time by HCDC that due to the separation of the individual responsible for training at HCDC months ago, many records related to the PREA training of volunteers and contractors could not be located and hence why compliance cannot be demonstrated. As such, the Auditor agreed to a new remedial measure as the HCDC Facility Administrator stated there had been no new volunteers or contractors at the facility since the PREA Audit in December. It should be noted, the Auditor discussed this with HCDC during the conference call and additionally provided a written summary of the call to them on Aug 31 with his recommendations. HCDC was required to provide evidence that they have retrained everyone on the July 2, 2020 "HCDC Volunteer and Contractor List" that is still an active contractor or volunteer (or who will be once the pandemic winds down). The facility was required to also provide training through a PowerPoint (PPT) presentation in an email, virtual training, or other documentation that clearly shows volunteers and contractors have read and acknowledged the training provided. Furthermore, the method selected for providing training must be clearly identified and provided to ERAU through ERO. For instance, if the training was provided through a PPT, volunteers and contractors could state in the body of their email response: "I have received, read, understand, and acknowledged my responsibilities covered in the subject training provided, to include the facility's zero-tolerance policy;" the name of the document they're acknowledging should be in the subject line of the email sent to them.

On 09/11/2020, the Auditor received the facility's response and supporting documentation regarding the deficient standard. The facility stated, "*Standard 115.32(c) Providing evidence for PREA training for everyone on the July 2, 2020, HCDC Volunteer List, which includes contractors. There are 40 names on the list. The contractors (Medical) are noted in blue. CJM is Christian Jail Ministries. The individuals with VOL or OAP in front of their names are no longer with the facility. There are also two (2) Medical personnel who are no longer employed by Well Path. They are* (b) (6), (b) (7)(C) *CJM volunteers were sent an email with the PREA training slides attached. They were asked to reply back indicating they had received, read and understood. Only two responded. Those that did not and are still associated with CJM will not be allowed into the facility until they have received the required training. The emails from Chaplain* (b) (6), (b) (7)(C) *noting those who are no longer volunteers, is also attached.*"

On 9/12/2020, the Auditor reviewed the submitted documentation, and the following was concluded.

- The PSA Compliance Manager stated, The CJM volunteers were sent an email with the PREA training slides attached. They were asked to reply back indicating they had received, read and understood. Only two responded. The Auditor was not provided with evidence of the "two" volunteers who responded, indicating they have read, understand, and acknowledged their responsibilities covered in the subject training provided, to include the facility's zero-tolerance policy. Later the same day, the Auditor was provided with additional documentation - an email confirming training received and acknowledged by (b) (6), (b) (7)(C) - Musician/Chaplain).

Based on the lack of documentation provided, the Auditor has determined that 115.32(c) remains non-compliant.

§115. 33 - Detainee education

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

Notes:

(a)(b)(e)(f) Policy A-033 indicates how the facility provides detainees with PREA education upon intake to ensure they are informed about the facility's zero-tolerance policy for all forms of sexual abuse. The Auditor was provided with a tour of the detainee intake orientation process which occurs upon arrival and does not exceed 12 hours. In review of the facility's detainee handbook, which provides detainees with the required PREA orientation information, the Auditor determined that all six elements of the standard are covered per the standards requirements. The intake officer stated during the intake process, detainees who are determined to be LEP or who may have a disability, i.e., hearing impaired, deaf, and blind, etc. will receive interpretive services or medical and/or mental health assistance throughout the process. Detainees further receive additional PREA education during the orientation process, which takes place each Thursday. Detainees are shown the facility's PREA educational video and are required to watch the video within seven days of arrival at the facility. The video is

closed-captioned and available in the two predominant languages used by detainees, English and Spanish. The Auditor had the opportunity to sit in on the PREA orientation phase. Not only was the PREA educational video played, but staff who were giving orientation instruction also communicated to the detainees both in English and Spanish regarding the agency and facility's zero-tolerance policy. The Auditor also observed in the intake holding cell areas DHS posted signage, "ICE Zero Tolerance," to include the ICE Sexual Assault Awareness Information pamphlets. The Auditor was advised by numerous staff and detainees that the ICE National Detainee handbook is not provided by the facility upon intake, as it is delivered to detainees while they are at the Baltimore Field Office Hold Room. The AFOD confirmed this during the audit out brief and stated documentation is maintained regarding the distribution of the ICE National Detainee Handbook to the detainee. It should be noted, Intake staff indicated they do not normally have copies of the ICE National Detainee Handbook located at the facility. The Auditor was not provided with any documentation that confirms detainees are offered or have received a copy of the ICE National Detainee Handbook. Furthermore, HCDC intake process does not include a process for confirming that detainees received a handbook from the Baltimore Field Office Hold Room and still have the handbook in their possession upon arrival to the facility. Therefore, the Auditor could not verify whether all detainees are receiving a copy of the ICE National Detainee handbook either at the Baltimore Field Hold Room or upon intake at the facility. The ICE National Detainee Handbook ensures the detainee is receiving meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees who are limited in their ability to speak or understand English (i.e. limited English proficiency).The Handbook also provides detainees with information on the agency and facility's zero-tolerance policy for sexual abuse and how to report incidents of sexual abuse which provides information for detainees on the prevention and reporting of sexual abuse and assault, as well as, information on detainee rights and responsibilities, available programs and services, facility rules, and methods to report problems and file complaints with ICE and DHS. The Auditor was also advised detainee handbooks are available on the facility kiosk and would provide the Auditor a screenshot of the handbooks; however, the Auditor was not provided with evidence the information is available to detainees on the kiosk. While on-site, the Auditor interviewed 20 detainees and most recalled receiving the required PREA information in a format they could understand upon intake or there shortly after through the use of interpretive services.

(d) The Auditor observed numerous PREA related informational signage throughout the facility to include in all detainee dorms: the DHS-prescribed sexual assault awareness notice; the name of the PSA Compliance Manager; and contact information for the local rape crisis center (HopeWorks), that can assist detainees who have been victims of sexual abuse.

(c)The Auditor randomly selected ten detainees for file review in order to confirm they had received the required PREA information upon intake, and the facility could only provide five of the chosen randomly detainee intake forms indicating they received the facility intake orientation, which also includes the required PREA information. Only three of the submitted intake forms included the detainee's signature acknowledging receipt. Therefore, the Auditor could not verify that all detainees are participating in the intake orientation process and receiving the required detainee education per the standards requirement.

Does not meet: 115.33(b)(c)(f) Each facility shall provide the detainee notification, orientation, and instruction in formats accessible to all detainees, including those who are LEP, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The facility could not provide the Auditor with documentation that all detainees are offered and/or receive the ICE National Detainee Handbook upon intake to the facility. The agency and facility must take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for detainees limited in their ability to speak or understand English (i.e., limited English proficiency). The facility must demonstrate detainees are receiving PREA education and the proper procedures for how documentation of detainee education participation during the intake process orientation is documented. The facility must ensure information about reporting sexual abuse shall be included in the agency ICE National Detainee Handbook made available to all immigration detention facility detainees.

Corrective Action Taken:
On 04/16/2020, the Auditor received the facility's response and supporting documentation to remedy the deficient standard. The facility stated, "*Documentation is attached showing ICE detainees receive the Detainee Handbook before arriving to the facility. Documentation is also attached showing signatures of staff who have attended training on ICE Detainee Handbook. Also attached is the page of the training which tells staff ICE detainees receive the handbook before arriving to the facility."* The Auditor did not concur with the initially submitted documentation. The facility only provided documentation that detainees receive the ICE National Detainee Handbook & the Sexual Assault Awareness Pamphlet while at the ICE Baltimore Field Office Hold Room. HCDC did not demonstrate and document a process for confirming that detainees received a handbook from the Baltimore Field Office Hold Room and still have the handbook in their possession upon arrival/intake to the facility. The facility also did not specify if a detainee does not have the handbook, if they are provided one by the facility. The facility must also provide documentation of training/information provided to staff required to use the new procedure and shall be completed through staff signatures. The facility must also provide a sampling of ten completed detainee intake orientation forms containing detainee signatures acknowledging the education received.

On 05/08/2020, the auditor received the facility's second response to the CAP with supporting documentation to remedy the deficient standard. The facility stated, "(b) *The facility has added a question to the ICE Intake Questionnaire that requires Intake staff to ask if the detainee received and is in possession of the National Detention Handbook. If the detainee does not, one will be issued to him. Documentation attached showing procedure and staff acknowledgment. (c) The facility has added a question to the ICE Intake Questionnaire that requires Intake staff to ask if the detainee received and is in possession of the National Detention Handbook. If the detainee does not, one will be issued to him. Documentation attached showing procedure and staff acknowledgment. Orientation documentation previously submitted"* The Auditor reviewed and accepted the facility's corrective action plan and supporting documentation. Standard 115.33 is now compliant in all material ways.

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

Notes:

(e) Although interviews with detainees confirmed receiving a risk screening upon intake, they do not recall being followed-up with or reassessed with similar questions at a later time. The interview with the PSA Compliance Manager confirmed reassessments would only be completed at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. Interview with the Classification Supervisor corroborated the aforementioned. During the review of ten detainee assessments for risk of victimization and abusiveness, the Auditor confirmed the proper procedures are being followed per the standard in all material ways, except for subpart 115.41(e). Reassessments within 60 to 90 days from the date of initial assessment are not completed per the standards requirement, thus making it non-compliant.

Does Not Meet: 115.41(e) - The facility must develop procedures for reassessing each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization.

Corrective Action Taken:
On 04/16/2020, the Auditor received the facility CAP response with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's initial CAP response, which stated, "*The facility has not implemented this as of yet. Our target implementation date is June 1, 2020."* The Auditors response was as follows: The Auditor will require the facility to provide supporting evidence to substantiate compliance with standard 115.41(e). The facility must provide documentation of the procedure by a sampling of no less than ten completed initial risk screening and a detainee's reassessments. The facility must also provide documentation of training/information provided to staff assigned to complete such reassessments. This shall be achieved through staff signatures acknowledging such information/training was received."

On 05/08/2020, the facility submitted its second response to the CAP with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's initial CAP response, which stated, *"The facility does not classify ICE detainees. This is done by ICE officials. They conduct the reclasses at 60, 90 & 120 intervals."* The Auditor's response was identical to the first CAP response, adding that the "facility" shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. The Auditor will require the facility to provide supporting evidence to substantiate compliance with standard 115.41(e). The facility must provide documentation of the procedure by a sampling of no less than ten completed initial risk screenings and the detainee's reassessments. The facility must also provide documentation of training/information provided to staff assigned to complete such reassessments. This shall be achieved through staff signatures acknowledging such information/training was received.

On 07/02/2020, the facility submitted its third response to the CAP and supporting documentation of the facility's PREA Risk Assessment form. The Auditor did not concur with the facility's third CAP response, which stated: "*Attached is the form which will be used to reassess each detainee between 60 + 90 days from the date of initial intake."* The Auditor received and accepted the facility's PREA Risk Assessment form to conduct 60-90 reassessments. However full compliance was contingent upon the facility providing the requested supporting evidence to substantiate compliance with standard 115.41(e). The facility must provide documentation of the procedure through a sampling of no less than ten completed initial risk screenings and reassessments of detainees. The facility must also provide documentation of training/information provided to staff assigned to complete such reassessments. This shall be achieved through staff signatures acknowledging such information/training was received.

On 8/18/2020, the Auditor received additional information from the facility via email from the ICE Team Lead, (b) (6), (b) (7)(C). In the body of the email, the following was noted, "*Please see the attached document that was sent out on July 20, 2020. We are required by the Maryland Commission on Correctional Standards (MCCS), Adult Detention Center (ADC) to maintain a record of all Policies and Procedures and Post Orders reviewed by staff. Note: Each month an email audit is conducted to ensure we're in compliance."* The submitted attachment was a blank copy of the facility's Risk Assessment form, previously reviewed and accepted by the Auditor. The Auditor did not concur with the submitted documentation to demonstrate compliance with the standard. As previously requested, numerous times, supporting evidence to substantiate compliance with standard 115.41(e) was contingent upon the facility providing documentation of the procedure through a sampling of no less than ten completed initial risk screening and reassessments of a detainee. The facility must also provide documentation of training/information provided to staff assigned to complete such reassessments. This shall be achieved through staff signatures acknowledging such information/training was received.

On 08/27/2020, a conference call was conducted with HCDC staff, ICE staff (ERAU and ERO), the contract ICE PREA Program Manager, and the PREA Auditor to discuss the pending CAP items and possible solutions the facility could employ to achieve compliance as the end of the regulatory 180-day CAP period is September 13, 2020. In regards to standard 115.41(e), the facility was reminded it remained non-compliant**.** The following information was provided to those in attendance and discussed during the call. The Auditor received and accepted the facility's PREA Risk Assessment form to conduct 60-90 reassessments. However, the Auditor would continue to require the facility to provide supporting evidence to substantiate compliance with standard 115.41(e). The facility must provide documentation of the procedure through a sampling of no less than ten completed initial risk screenings and reassessments of detainees. The facility must also provide documentation of training/information provided to staff assigned to complete such reassessments. This shall be achieved through staff signatures acknowledging such information/training was received.

Also on 08/27/2020, the Auditor received ten detainee PREA risk assessments. The form for reassessment approved by the Auditor (A-033b) during the CAP period had an option to select the reason for screening as *Intake at CBF*, *Intake at Commitment*, and *Reassessment*. All of the documentation submitted noted the reason for screening as *Intake at Commitment,* none with *Reassessment* selected. The Auditor was unable to determine the reassessment process from the forms provided and requested written clarification. A second page is

attached to each *Intake at Commitment* assessment form that starts with "Counselor Review of Criminal History." So the Auditor could understand the reassessment process, the facility was asked to explain how a reassessment is completed per the requirements of the standard. The Auditor advised the process should be outlined in an email or acknowledgment form bulleted with staff responsibilities (what questions they're asking/what forms they're using, etc. The Auditor also requested documentation of classification staff responsible for conducting reassessments, in either an email or a signed acknowledgment form, indicating they have reviewed and understand their responsibilities for completing the newly implemented 60-90 reassessment procedures. The facility was also requested to provide the initial and reassessment for ten detainees demonstrating reassessments were completed within 60-90 days.

Upon reviewing the initial ten intake risk assessments provided, five of them did not contain the staff person's name who conducted the initial assessment and/or the date the assessment was completed. For instance, the assessment of one detainee (pg. 17 of PDF provided to ICE) appeared to be missing an initial review date and the name of the staff person who conducted the initial assessment as it appeared on other assessments; however, the second page of the form listed a Counselor Review Date of January 24, 2020, which, if that was the initial assessment date, still reflected that the reassessment was not conducted within 60-90 days per the standard requirement as it appeared the reassessment occurred on August 20, 2020. The Auditor understands the reassessment review process has recently been implemented, and the facility is now utilizing an electronic method for completing risk assessments. Nonetheless, it is imperative to capture the name of the staff person and date of the initial risk assessment to determine that a reassessment is being conducted within the standard's 60-90-day requirement.

On 09/11/2020, the Auditor received the facility's response, which stated "*Standard 115-41(e) 60-90-day reassessments. Attached is documentation supporting compliance with this standard. The first page of the attachment is a list of all ICE detainees at the facility on the date of the reassessments. The second and third pages indicate the procedures for the reassessment process and the questions that will be asked by Classification Staff."*

On 9/12/2020, the Auditor reviewed the submitted documentation, and the following was concluded.

- The Auditor was not provided with documentation of classification staff responsible for conducting reassessments, in either an email or a signed acknowledgment form, indicating they have reviewed and understand their responsibilities for completing the newly implemented 60-90 reassessment procedures.
- The Auditor requested ten detainee's "initial and 60-90 reassessments" to demonstrate reassessments are completed within the required time frames. Of the ten reassessments provided, four were indicated as being completed within the 60-90-day requirement. However, upon reviewing the documentation, the Auditor was not supplied with the initial assessment for two of the four; therefore, the Auditor was unable to ascertain if they were completed per the standard's requirements. The other six reassessments were completed outside of the 60-90 day requirement.

Based on the lack of documentation provided, the Auditor has determined that 115.41(e) remains non-compliant.

§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:

(c) Although interviews conducted with the Facility Director and PSA Compliance Manager, who is also responsible for conducting all PREA related investigations, indicated the facility had developed written procedures for administrative investigations, Policy A-033 section J - Investigation Requirements, was submitted with the facility PAQ as supporting documentation. In a review of the policy, the Auditor could not locate the facility written procedures incorporating each element required for administrative investigations per the standard.

Does not meet:
115.71(c) – The facility will need to amend their current Policy (A-033 section J - Investigation Requirements) and ensure that written procedures for administrative investigations include "each" provision delineated within the standard.

Corrective Action Taken:
On 04/16/2020, the Auditor received the facility CAP response with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's initial CAP response, which stated, *"The facility's policy has not been amended at this time. Target implementation date to include training is June 1, 2020."* The Auditor responded as follows: the facility must provide supporting evidence to substantiate compliance with standard 115.71(c). The facility must provide the amended policy. The facility must also provide documentation of training/information provided to staff required to use the new policy/procedures. This shall be completed through staff signatures acknowledging such information/training was received.

On 05/08/2020, the facility submitted its second response to the CAP with no supporting documentation to remedy the deficient standard. The Auditor did not concur with the facility's second CAP response, which stated, "*Policy stands as written."* The Auditor responded as follows: the facility must provide supporting evidence to substantiate compliance with standard 115.71(c). The facility must provide the amended policy. The facility must also provide documentation of training/information provided to staff required to use the new policy/procedures. This shall be completed through staff signatures acknowledging such information/training was received.

On 07/02/2020, the facility submitted its third response to the CAP and supporting documentation. The Auditor did not concur with the facility's third CAP response, which stated: *"Language has been added to the policy that meets the standard. Again, due to COVID-19 the*

facility has not conducted the requested training." In reviewing the submitted documentation, the Auditor advised the facility that the amended policy did not contain "all" the required elements delineated within standard 115.71(c). Please refer to standard 115.71(c), which outlines all the necessary elements of the standard. The facility must provide the amended policy (containing "all" the elements noted within the standard). The facility must also provide documentation of training/information provided to staff required to use the new policy/procedures. This shall be completed through staff signatures acknowledging such information/training was received.

On 07/13/2020, the facility submitted its fourth response to the CAP along with no supporting documentation. The Auditor did not concur with the facility's fourth CAP response which was the same response as the third CAP submittal; *"Language has been added to the policy that meets the standard. Again, due to COVID-19 the facility has not conducted the requested training."* In a review of the submitted documentation, the amended policy did not contain "all" the required elements delineated within standard 115.71(c). Please refer to standard 115.71(c), which outlines all the elements required of the standard. The facility must provide the amended policy (containing "all" the elements noted within the standard). The facility must also provide documentation of training/information provided to staff required to use the new policy/procedures. This shall be completed through staff signatures acknowledging such information/training was received.

On 08/27/2020, a conference call was conducted to discuss the pending CAP items with HCDC as the end of the regulatory 180-day CAP period was September 13, 2020. In regards to standard 115.71(c), the facility was advised it remained non-compliant**.** The following information was provided to those in attendance and discussed during the call. 115.71 (c): The provided amended policy does not contain "all" the required elements delineated within standard 115.71(c). The facility must also provide documentation of training/information provided to staff needed to use the new policy/procedures. This shall be completed through staff signatures acknowledging such information/training was received. The facility responded that due to COVID-19, the facility had not conducted the requested training. The Auditor does not require that in-person training be completed during the current pandemic; rather, that applicable staff signs an acknowledgment form or email that they have read the new policies/procedures (it should be obvious which policy updates and responsibilities they are acknowledging).

09/11/2020, The Auditor received the facility's response, stating*, "Standard 115-71(c) Criminal and administrative investigations. Attached is the amended policy, A-033, with all the required elements of the standard. The first page of the attachment clearly states the name of the policy and the signatures of all approving parties. The second page is shown because "Investigation Requirements" is the last line on the bottom of the page. The third page, all highlighted items are what has been added to the policy."*

On 9/12/2020, The Auditor reviewed and accepted the facility's submitted documentation, revised policy A-033, which now covers all elements in subpart (c). Also provided are relevant staff signatures acknowledging the policy updates and their responsibilities. Standard 115.71 is fully compliant in all material ways.

§115. 201 - Scope of audits
Outcome: Does not Meet Standard
Notes:

Standard 115.201(e) states the agency shall provide the Auditor with relevant documentation to complete a thorough audit of the facility.

115.201(e) – Does not meet:
During the regulatory 180-day CAP period, the facility did not provide the Auditor with all requested documentation to certify compliance with two of the seven deficient standards. The facility was given two additional weeks after their actual audit to provide relevant documentation before becoming part of the CAP. In addition to the Auditor's feedback in the ICE Corrective Action Plan Word document table, every time the facility provided feedback and documentation during the CAP period, the facility was also provided reminders of what was pending in great detail in an email on 7/15/2020, during the conference call on 8/27/2020, and the follow-up email on 8/31/2020, reiterating what the Auditor's expectations for what the facility needed to do to come into compliance before the 180-CAP deadline. The Auditor could not complete a comprehensive review of pertinent information to determine full compliance for standards 115.32 and 115.41.

Corrective action taken:
On 09/11/2020, two days before the regulatory 180-day CAP period ended, the Auditor received the facility's final response and submitted documentation to demonstrate compliance with the deficient standards. On 9/12/2020, the Auditor reviewed the submitted documentation, and the following was determined:

115.32 Other Training

- The PSA Compliance Manager stated, " Providing evidence for PREA training for everyone on the July 2, 2020 "HCDC Volunteer List which includes contractors. There are 40 names on the list. The contractors (Medical) are noted in blue. CJM is Christian Jail Ministries. The individuals with VOL or OAP in front of their names are no longer with the facility. There are also two (2) Medical personnel who are no longer employed by Well Path. They are (b) (6), (b) (7)(C) [redacted]. The CJM volunteers were sent an email with the PREA training slides attached. They were asked to reply back indicating they had received, read and understood. Only two responded. Those that did not and are still associated with CJM will **not** be allowed into the facility until they have received the required training. The emails from Chaplain (b) (6), (b) (7)(C) [redacted] noting those who are no longer volunteers is also attached." The Auditor was not provided with evidence of the "two" volunteers who responded, indicating they have read, understand, and acknowledged their responsibilities covered in the subject training provided, to include the facility's zero-tolerance policy.

115.41 Assessment or risk of victimization and abusiveness.

- The Auditor was not provided with documentation of classification staff responsible for conducting reassessments, in either an email or a signed acknowledgment form, indicating they have reviewed and understand their responsibilities for completing the newly implemented 60-90 reassessment procedures.
- The Auditor requested ten detainees "initial and 60-90 reassessments" to demonstrate reassessments are completed within the required time frames. Of the ten reassessments provided, four were indicated as being completed within the 60-90-day requirement. However, upon reviewing the documentation, the Auditor was not supplied with the initial assessment for two of the four; therefore, the Auditor was unable to ascertain if they were completed per the standard's requirements.

Based on the lack of documentation provided, the Auditor has determined that 115.32 and 115.41 remains non-compliant.

AUDITOR CERTIFICATION:

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

Mark Stegemoller October 22, 2020
Auditor's Signature & Date

(b) (6), (b) (7)(C) October 22, 2020
Program Manager's Signature & Date