PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	2/25/2020	**To:**	2/27/2020
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections LLC.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	315-730-
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	513-609-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	San Antonio
Field Office Director:	Daniel Bible
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	1777 NE Loop 410, Suite 1500 San Antonio, Texas 78217
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Karnes County Family Residential Center (KCFRC)		
Physical address:	409 FM 1144 Karnes City, Texas 78118		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	830-254-2000		
Facility type:	IGSA		
PREA Incorporation Date:	10/9/2014		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	830-254-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	830-254-

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	08/14/2019
Notes:	

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of Karnes County Family Resident Center (KCFRC) was conducted on February 25-27, 2020, by U.S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA Auditor, Thomas Eisenschmidt for Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Assistant Program Manager, (b) (6), (b) (7)(E) 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 Office of Professional Responsibility (OPR)/External Reviews and Analysis Unit (ERAU) section during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. The KCFRC is privately owned by the GEO Group and operates under contract with the DHS, Immigration and Customs Enforcement (ICE), Office of Enforcement and Removal Operations (ERO). The facility processes family residents who are pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at KCFRC are from Guatemala, Honduras, and El Salvador. This was the second DHS PREA audit for KCFRC and included a review of the 12-month audit period from 2/25/2019 through 2/27/2020. KCFRC is located in Karnes City, Texas.

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

(b) (6), (b) (7)(C) – Facility Administrator
(b) (6), (b) (7)(C) – Chief of Intake
(b) (6), (b) (7)(C) – Supervisory Detention and Deportation Officer (SDDO), ICE
(b) (6), (b) (7)(C) – Health Services Administrator
(b) (6), (b) (7)(C) – Chief of Resident Advisors
(b) (6), (b) (7)(C) – Mental Health Caseworker
(b) (6), (b) (7)(C) – Program Manager, Licensed Child Care Administrator
(b) (6), (b) (7)(C) – Assistant Facility Administrator
(b) (6), (b) (7)(C) – PSA Compliance Administrator
(b) (6), (b) (7)(C) Inspections and Compliance Specialist, ICE/OPR/ERAU

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

The audit began with a tour of the KCFRC intake area. The assigned intake staff walked the Auditor through the resident intake process upon their arrival. (b) (7)(E) [redacted] There is a shower room in the intake area allowing residents to shower one at a time and monitored by the same gender staff as the resident using it. All residents remain in this intake area until assessed by the medical staff. While in the area residents view three videos: Orientation, PREA, and Know Your Rights, in (Spanish, English and close captioned), and are provided the Karnes County Family Residential Center Handbook and the ICE Sexual Abuse and Assault Awareness pamphlet available in Spanish and English as well. The Auditor continued the tour visiting all areas residents have access to include their living areas (166 five person suites) the medical services department (with 11 rooms), recreation, chapel, education classrooms, food service, court rooms, the visiting area, and facility support areas.

KCFRC has had three different missions over the last 12 months. KCFRC held adult female residents only until October 2019 when the facility maintained male resident's head of household with male children until February. In February of this year the residents still included male head of households with male children but now includes male and female adult's head of households with their male and female children as well. Adult males accompany the family until 9:00 pm each evening and then retire to separate quarters away from the rest of the family. Assignment to one of the 166 suites is based on the vulnerability assessment conducted by medical and the ICE Juvenile Family Residential Management Unit (JFRMU) scale. The JFRMU scale is used to take into consideration the age and gender of the children prior to considering suite assignments. During the tour of these suites the Auditor observed cross gender announcements being made prior to the employee entering the suite allowing the residents to shower, dress, and use the toilet facilities without exposing themselves to employees of the opposite gender. Signage was observed by the Auditor in each suite and inside the waiting rooms in the intake area cells providing residents with PREA educational information, the facility zero tolerance policy, methods for reporting sexual misconduct, and contact information for the victim advocate services (The Rape Crisis Center). The information was predominantly in Spanish and English with reporting information on ICE Zero tolerance posters in Arabic, Farsi, French, Hindi, Korean, Romanian, Simplified Chinese, Tagalog, and Urdu. The resident reporting hotline was tested and checked from two different locations and was found to be operational. The PREA audit notices were also observed in multiple locations throughout the tour to include the resident suites, medical unit, and visitation, and at the entrance to the facility. The average stay for residents at KCFRC is 8.5 days. (b) (7)(E) [redacted]. There are no cameras located in any of the suites.

KCFRC has a fully functioning medical unit with 11 rooms. The unit is staffed with 57 GEO medical/mental health personnel and operates 24 hours a day seven days a week. The medical staff, by policy, are prohibited from performing any forensic examinations. KCFRC has a Memorandum of Understanding (MOU) with Methodist Specialty and Transplant Hospital in San Antonio signed in 2014 with no sunset date for healthcare services. The hospital agrees to provide a Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE) to any KCFRC resident victim of sexual abuse.

During the course of the site visit, the Auditor conducted informal interviews with staff and residents, questioning them on their knowledge of PREA. At the conclusion of the tour, the Auditor was provided with staff and resident rosters and randomly selected from each for formal interviews. Twelve random staff (including line-staff and first-line supervisors) and specialized staff were interviewed. Those specialized staff included: the Facility Administrator, PSA Compliance Manager, Human Resources, Training Supervisor, intake staff (2), Case Manager, Administrative Investigator, Grievance Coordinator, Classification Supervisor, medical staff, and mental health staff. A total of 23 random residents were interviewed. All 23 residents interviewed were limited English proficient (LEP) and required the use of a language line through Language Services Associates (LSA) provided by Creative Corrections. The resident interviews included 2 adult females, 18 adult males, and 3 male juveniles. There were no lesbian, gay, bi-sexual, transgender, intersex (LGBTI), victims or residents available for interview at the time of the site visit. There were 668 residents present at the time of the visit, 357 adults and 301 children.

There was one allegation of sexual abuse reported during the audit period. The allegation was made against a KCFRC staff member. The administrative investigative outcome was found to substantiate the allegation. The PAQ indicated the allegation was referred to outside law enforcement (Sheriff's Office) for investigation. The case did not result in any criminal charges. Upon review of the investigation file for the audit period, ICE was notified of the allegation with referral to OPR.

On February 27, 2020 an exit briefing was held in the staff conference room. The Team Lead opened the briefing and then turned it over to the Auditor.

In attendance were:

(b) (6), (b) (7)(C) - Inspections and Compliance Specialist, ICE/OPR/ERAU
(b) (6), (b) (7)(C) – SDDO, ICE
(b) (6), (b) (7)(C) – SDDO, ICE
(b) (6), (b) (7)(C) –Supervisor, ICE, JFRMU
(b) (6), (b) (7)(C) – Assistant Field Office Director (AFOD), ICE
(b) (6), (b) (7)(C) – Contracting Officers Representative (COR), ICE
(b) (6), (b) (7)(C) – Assistant COR, ICE
(b) (6), (b) (7)(C) – PSA Compliance Administrator
(b) (6), (b) (7)(C) – Human Resources Manager
(b) (6), (b) (7)(C) - Program Manager, Licensed Child Care Administrator
(b) (6), (b) (7)(C) - Assistant Facility Administrator
(b) (6), (b) (7)(C) – Facility Administrator
(b) (6), (b) (7)(C) – Chief of Intake

The Auditor spoke briefly about his observations. He informed those present of his preliminary findings. Residents interviewed had a good understanding of PREA and knew what mechanisms were in place to report incidents of sexual misconduct if needed. It was clear to the Auditor, staff at KCFRC view PREA seriously and have fostered a culture to better prevent, detect, and respond to sexual misconduct.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 3

§115.17 Hiring and promotion decisions
§115.31 Staff training
§115.35 Specialized training: Medical and Mental Health Care

Number of Standards Met: 37

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.13 Detainee supervision and monitoring
§115.14 Juvenile and family detainees
§115.15 Limits to cross-gender viewing and searches
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.32 Other training
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.43 Protective custody
§115.51 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
§115.71 Criminal and Administrative Investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of audits.

Number of Standards Not Met: 0

Number of Standards Not Applicable: 1

§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)(d) The Auditor determined compliance to this subpart of this standard based on review of the GEO policy 2.1.1 (Sexual Abuse / Assault Prevention and Intervention Programs) requiring KCFRC mandate zero tolerance towards all forms of sexual abuse and assault and outlining GEO's approach to preventing, detecting, and responding to such conduct. ICE shall review and approve this policy and any subsequent changes. KCFRC provides training to all staff, volunteers and contractors, defines for everyone prohibited acts, details hiring practices, and provides vulnerability assessments and critical roles for investigators, medical staff and volunteer staff to ensure the facility provides a sexually safe environment for residents and staff. The policy was approved by signature of the AFOD. The interview with the PSA Compliance Manager verified she is the point of contact for the agency PREA Coordinator and she has sufficient time and authority to oversee efforts for the facility to comply with the GEO zero tolerance policy.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) The Auditor determined compliance to these subparts of this standard based on review of policy 2.1.1 requiring KCFRC ensures that it maintains sufficient supervision of residents, including through appropriate staffing levels and video monitoring, to protect residents against sexual abuse and review those guidelines at least annually. The policy further requires the "Annual PREA Facility Assessment" (Attachment B of this policy), be utilized for this review and submitted to the local PSA Compliance Manager and Corporate PREA Coordinator annually as determined by GEO's U.S. Corrections and Detention Division. As noted earlier, KCFRC is privately owned by the GEO Group and operates under contract with the DHS, ICE, and ERO. According to the Facility Administrator, staffing levels for the supervision of the residents, at KCFRC are established prior to the contract being agreed to and are based on direct supervision with consideration given to video monitoring equipment present and operational; generally accepted detention/correctional practices; any judicial findings of inadequacy; the physical plant; resident population; any findings of incidents of sexual abuse; any recommendations of sexual abuse incident reviews; and any other relevant factors. The Auditor reviewed the one sexual abuse case reported during the auditing period, and the case findings could not be considered during this specific facility assessment annual review as the case was closed after the annual review date. The Auditor reviewed the incident review for the one completed investigation conducted and there with no recommendations made by the team. The supervision requirements include a daytime ratio of one staff member for every 16 residents and nighttime (10:00 pm till 6:00 am) ratio of one staff member for every 40 residents. The PSA Compliance Manager provided the Auditor a copy of the KCFRC supervision guidelines. She indicated she is part of the committee that reviews annually these guidelines taking into account the items as outlined in subpart (c). She also indicated the last review was conducted in September 2019 The Facility Administrator confirmed KCFRC never closes any supervision positions. During the tour and during the three-day site visit it appeared to the Auditor that staff supervision of residents was adequate.

(d) The Auditor determined compliance to this subpart of this standard based on review of policy 2.1.1 requiring KCFRC department heads, facility management staff and supervisors conduct and document frequent unannounced security inspections within their respective area, no less than once per week for all shifts to identify and deter sexual abuse of residents. These inspections are documented in the park logbooks and must state that the inspection is unannounced. Such policy and practice shall be implemented no less than once per week for all shifts. Watch Commanders from each shift confirmed they are required on each shift to visit each area of the facility residents may be to deter sexual abuse. The Auditor found supervisor signatures in random park logbooks checked indicating PREA rounds were conducted on all shifts.

§115.14 - Juvenile and family detainees.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of this standard based on review of policy 2.1.1 requiring juveniles be housed in the least restrictive setting appropriate to the juvenile's age and special needs, provided that such setting is consistent with the need to protect the juvenile's well-being and that of others, as well as with any other laws, regulations, or legal requirements. KCFRC does not accept any unaccompanied minors. The Facility Administrator confirmed ICE is responsible to determine the existence of a family unit for detention purposes and obtain reliable evidence of a family relationship. She also indicated all juveniles at KCFRC are to be housed with the mother/father head of household following the approved JFRMU housing classification scale and provided there are no safety or security concerns with the arrangements. She also stated that juveniles must be in the company of one of the parents at all times. The housing both the resident and juvenile are placed in are referred to as a suite and are much like a motel room. The facility reported one sexual abuse incident during the previous year, and upon review of the case file the Auditor determined the investigation was completed in accordance with the standards requirements.

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

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

Notes:

(b)(c)(d) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 detailing searches are necessary to ensure the safety of staff, civilians, and residents; to detect and secure evidence of criminal activity; and to promote security, safety, and related interest at KCFRC. This policy further states cross-gender pat-down searches of male residents not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Policy indicates that KCFRC does not permit cross-gender pat-down searches of female residents, absent exigent circumstances, and all cross-gender pat-down searches be documented in the Cross-Gender Pat Search Log. Random staff (male and female) interviews confirmed their awareness of the GEO policy. They indicated the information on searching is provided to them in policy 2.1.1 and in annual PREA refresher training. The PAQ and PSA Compliance Manager confirmed KCFRC had no instances for cross-gender pat-searches. The Facility Administrator informed the Auditor that pat-searches are not conducted at KCFRC. Interviews with

residents indicated that they were never pat searched at KCFRC. Random staff confirmed they received search training but searching beyond the use of a metal detecting hand wand is prohibited.

(e)(f) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring searches of residents may be necessary to ensure the safety of staff, civilians, and residents; to detect and secure evidence of criminal activity; and to promote security, safety, and related interest at KCFRC. The policy further states cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of staff safety, or when performed by medical practitioners. Even though searching of residents is detailed in policy 2.1.1, strip searches or body cavity searches, according to the Facility Administrator, are not conducted at KCFRC. This was confirmed by the PSA Compliance Manager as well.

(g)(h) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring all employees of the opposite gender announce their presence when entering the suite areas or any areas where residents are likely to be showering, performing bodily functions, or changing clothes. Residents shall be allowed to shower, perform bodily functions and change clothes without being viewed by staff, except in exigent circumstances or when such viewing is incidental to routine suite checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Random staff interviewed confirmed their requirement to announce their presence every time they enter suites as both males and females occupy them prior to entering, The random residents confirmed they had privacy while showering, performing bodily functions, and changing clothes and indicated staff announce prior to entering any area the residents may be performing any of those tasks. During the tour of KCFRC, the Auditor observed staff of the opposite gender announce their presence in areas residents may be showering, performing bodily functions, and changing clothes.

(i)(j) The Auditor based compliance on theses subparts of the standard after review of policy 2.1.1 requiring all security staff be trained in the proper procedures for cross-gender pat-down searches and searches of transgender and intersex residents. These pat searches must be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. The policy further requires staff at KCFRC not search or physically examine a resident for the sole purposes of determining the resident's genital characteristics. If the resident's gender is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all residents must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner. The Auditor reviewed the training curriculum security staff receives outlining the requirements of subpart (i). Interviews with random security staff confirmed their knowledge of the prohibition of searching transgender or intersex residents to determine their genital status and their responsibility to perform all pat-down searches in a professional and respectful manner. Also noted earlier, the Facility Administrator informed the Auditor that pat searches are not conducted at KCFRC.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC to take appropriate steps to ensure that residents with disabilities (including, for example, residents 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 agency's and facility's efforts to prevent, detect, and respond to sexual abuse. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Each resident arriving at KCFRC is provided the Karnes County Family Residential Center Handbook; ICE Sexual Abuse and Assault Awareness pamphlet; and view the three PREA videos (Orientation, PREA, and Know Your Rights). These documents are provided in English and Spanish only. The intake staff (2) interviewed confirmed residents receive a brief orientation about facility rules and sexual safety while in the intake area. If the residents speak a language other than English or Spanish staff utilize the language line (Language Line Service) for interpretive services to provide this initial sexual safety information and then documents that use of the interpretive services. The staff also indicated residents they encounter that may be hearing impaired or deaf would require staff to utilize the text telephone (TTY) and a tablet with a communication application for the deaf. When they encounter residents who are blind or with limited sight the resident is provided individualized attention by staff which may include reading the information to him or her. In cases where the resident has low intellect or limited reading skills, depending on the degree of limitation, would be referred initially to a supervisor or the medical/ mental health department to provide the necessary orientation information. There were no residents with disabilities, at the time of the visit, only LEP residents. Random resident interviews confirmed information on the facility's sexual abuse safety is provided to them upon arrival. During these interviews, the Auditor was informed by three residents, they never received this information. The Auditor reviewed their files and found signed documentation indicating each had received the required information. The Auditor reviewed seven resident files. In each of these files the orientations for these residents with the interpreter's reference number noted on each orientation form if the language was other than English or Spanish.

(c) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring in matters relating to allegations of sexual abuse, KCFRC shall provide in person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another resident, unless the resident expresses a preference for another resident to provide interpretation, and the agency determines that such interpretation is appropriate and consistent with DHS policy. Any use of these interpreters under these type circumstances shall be justified and fully documented in the written investigative report. The provision of interpreter services by minors, alleged abusers, residents who witnessed the alleged abuse and residents who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse. The KCFRC Investigator is Spanish speaking and the one allegation made during the previous 12 months was by a Spanish speaking resident requiring no use of the facility interpretive services. The interview with the Facility Administrator, PSA Compliance Manager, and Investigator confirmed the policy interpretive requirement. Random staff interviews confirmed their understanding of who can and cannot provide interpreter services during matters relating to sexual abuse. There was no resident present at the facility who filed a sexual abuse allegation for the Auditor to interview.

§115.17 - Hiring and promotion decisions.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(e)(f) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 prohibiting KCFRC from hiring or promoting anyone who may have contact with residents, and will not enlist the services of any contractor or volunteer who may have contact with residents, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42

U.S.C. 1997); who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. Review of Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0, requiring anyone entering into or remaining in government service, employee or contractor undergo a thorough background examination for suitability and retention. The ICE Personnel Security Unit (PSU) Chief (b) (6), (b) (7)(C) detailed candidate suitability, for the Auditor, indicating all applicants are obligated to disclose any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. Each applicant is questioned directly about any such previous misconduct both during their background check and during the job interview process and a positive response to any of those specific questions are grounds for unsuitability including material omissions or making false or misleading statements in the application. The HR Manager confirmed that during the application process GEO makes its best efforts to contact all prior institutional employers of an applicant for employment to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse, and unless prohibited by law, the facility would provide information on substantiated allegations of sexual abuse involving former employees upon request from an institutional employer for which the employee has applied to work seeking new employment. The Auditor reviewed ten personnel files (contractor/ and staff) and found background checks completed prior to the staff/contractor employment start date and were approved by ICE for hire. Each KCFRC prospective employee must also receive approval from the Texas Department of Child Protective Services as well prior to starting work.

(c)(d) The Auditor based compliance on these subparts of the standard after review of Federal Statute 731.105 requiring reinvestigations be conducted on all staff and contractors having resident contact every 5 years. The PSU Chief confirmed that ICE conducts these background checks on contractors and employees. The Auditor did a random check on ten employees (six- GEO and four-ICE) at KCFRC. Each of their backgrounds were current and up to date. The Facility Administrator and PSA Compliance Manager confirmed each staff member and contractor receives an annual background check through the Karnes County Sherriff annually. The facility exceeds the standard requirement of a background check to be conducted every five years.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) These subparts of the standard are not applicable as KCFRC has not made any upgrades to the facility and technologies since their previous audit in 2017.

§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) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1, requiring all GEO Facilities responsible for investigating allegations of sexual abuse are required to follow uniform evidence protocols that maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developmentally appropriate for juveniles where applicable and developed in coordination with the DHS. PREA allegations may also be investigated through OPR or Office of Inspector General (OIG). Agency policy 11062.2 outlines the agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS OIG, OPR, or local law enforcement agency, the case would be referred to ERO for assignment and completion of an administrative investigation. Interviews with both the Facility Administrator and PSA Compliance Manager confirmed the protocols for investigations outlined in policy 2.1.1 were approved by both ICE and the Texas Department of Child Protective Services.

(b) The Auditor based compliance on this subpart of the standard through review of the MOU with the Rape Crisis Center. This MOU was initiated in 2018 and automatically renews annually. The Auditor spoke with a representative from the Center who indicated an MOU existed with her agency and KCFRC to provide a 24-hour hotline, crisis , and advocacy for current or former victims of sexual violence. She also indicated her agency has a working relationship with Methodist Specialty and Transplant Hospital (KCFRC uses for healthcare services) providing an on-site trained advocate for any victim of sexual assault during a forensic examination. The Auditor observed the contact information available for the Rape Crisis Center in each suite at KCFRC. The PSA Compliance Manager confirmed either she or the Investigator provides this information to the alleged victim within an hour of the allegation being made. The provided information is contained within the investigative file and was present in the one investigative case file the Auditor reviewed.

(c)(d) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC offer all residents who experience sexual abuse access to forensic medical examinations (whether on-site or at an outside facility) with the victim's consent and without cost to the resident and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor also reviewed the MOU with Methodist Specialty and Transplant Hospital in San Antonio signed in 2014 with no sunset date. The hospital agrees to provide a SANE or SAFE to any KCFRC resident victim of sexual abuse. As noted in (b) above the victim would be provided advocacy services during the forensic examine through the Rape Crisis Center. The interview with the HSA confirmed residents are not charged for any service at KCFRC.

(e) The Auditor based compliance on this subpart of the standard after review of the MOU between the Karnes County Sheriff and KCFRC and the interview with the Sheriff. His interview indicated that he is contacted upon every allegation of sexual abuse and would conduct the criminal investigation if it was determined the incident was criminal in nature. He also confirmed that although not specifically stated in the MOU his office would comply with subparts (a) through (d) of the standard. The upgraded MOU will address the specific language requirements of the standard. The Auditor observed the Sheriff was contacted and responded to the one allegation made during the last 12 months. There were no criminal charges made in response to the allegation.

§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)(c)(d)(e)(f) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring an administrative investigation will begin within 24 hours of notifying ICE of a sexual abuse allegation except for allegations where the facility has been advised a criminal investigation is pending by either local law enforcement or ICE OPR or DHS OIG. The policy further requires allegations of sexual abuse that involve potentially criminal behavior or that include penetration or touching, of the genitalia, anus, groin, breast, inner thigh, or buttocks either directly or through the clothing, shall be referred to outside law enforcement agencies. KCFRC will document all referrals. All investigations are to be reported to the 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 resident 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 resident on resident 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 ERO AIU would assign an administrative investigation to be completed by an ERO Fact Finder or to the AFOD who then would assign to a manager for management inquiry (case summary) completion. All investigations are closed with a report of investigation. The agency's policy 11062.2 outlines the evidence and investigation protocols. The agency conducted one investigation. The Facility Administrator and PSA Compliance Manager confirmed the notification requirements of their policy and this standard and indicated the GEO Corporate Office staff and ERO PREA Field Coordinator are immediately notified. They also indicated the ERO PREA Field Coordinator makes all the required notifications to the ICE individuals as required by policy. The interview with the acting ERO PREA Field Coordinator confirmed this during his interview as well. The one investigative file demonstrated the notifications were made to these individuals as well. The Investigator at KCFRC confirmed all administrative investigations are conducted by trained investigators and all documentation of these investigations are maintained for as long as the alleged abuser is incarcerated or employed by GEO, plus five years as required by policy. The investigative case file review of the only administrative investigation conducted within the last 12 months was conducted by a trained investigator. The protocols for ICE investigations and GEO investigations are found on their respective web pages (www.ICE.gov/prea) and (www.geogroup.com/PREA).

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring PREA training on GEO's Sexual Abuse and Assault Prevention and Intervention Program be included in initial and annual refresher training for all employees, volunteers, and contract personnel, addressing the training topics required by the standard. This policy also requires KCFRC maintain written documentation verifying employee, volunteer, and contractor training. The policy requires the training include definitions and examples of prohibited and illegal sexual behavior; ICE and GEO's zero-tolerance policies for all forms of sexual abuse; how to fulfill their responsibilities under the agency sexual abuse and assault prevention, detection, and response policies and procedures, to include procedures for reporting knowledge or suspicions of sexual abuse; the right of residents and staff to be free from sexual abuse and from retaliation for reporting sexual abuse; an understanding that sexual abuse or assault is never an acceptable consequence of detention; recognition of situations where sexual abuse or assault may occur; recognition of the physical, behavioral, and emotional signs of sexual abuse or assault and methods to prevent and respond to such occurrences; how to detect and respond to signs of threatened and actual sexual abuse; the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the resident-victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition, and appropriate response to allegations or suspicions of sexual assault involving residents with mental or physical disabilities; understanding of how to report knowledge or suspicion of sexual abuse or assault and make intervention referrals to the facility's program; understanding of documentation and referral procedures of all allegations or suspicion of sexual assault; how to avoid inappropriate relationships with residents; and how to communicate effectively and professionally with residents, including LGBTI or gender nonconforming residents. The policy further requires the employee's documentation of training through signature on the PREA Basic Training Acknowledgment Form (Attachment F) that they understand the training they have received. This form is also used to document pre-service and annual in-service SAAPI training. The Auditor reviewed five random employee training files, each containing signed Attachment F acknowledgements. GEO staff (12) and ICE staff (2) interviews confirmed each had received PREA annual training and refresher training. The Auditor indicated the facility exceeds the standard as the requirement in refresher every two years and KCFRC requires annual refresher. The Auditor based compliance on this subpart of the standard after the interview with the KCFRC training staff person confirmed the training curriculum meets the required elements outlined in subpart (a) of the standard. The random staff interviews also detailed the training content and the annual refresher training requirements.

§115.32 - Other training.

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

Notes:

(a)(b)(c) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring all contractors and volunteers receive training on GEO's Sexually Abusive Behavior Prevention and Intervention Program to include their responsibilities under GEO's Sexual Abuse and Assault prevention, detection, and response policies and procedures. All contractors receive the same classroom training and refresher training that staff receive. KCFRC currently has two contractors. The level and type of training provided to volunteers is based on the services they provide and the level of contact they have with residents. However, every volunteer who has contact with residents shall be notified of GEO's and the facility's zero-tolerance policies regarding sexual abuse and informed how to report such incidents. KCFRC only has two volunteers and they receive training from the Chaplain on their responsibilities under the agency's and facility sexual abuse policy to include definitions of prohibited acts, communication with LGBTI groups, means of reporting, and ensuring the nearest security staff person is notified if a resident alleges sexual abuse to them. The Auditor reviewed the signed written confirmation of the contractors and volunteers indicating they received and understood this training. There were no volunteers or contractors available at KCFRC for the Auditor to interview during the site visit.

§115.33 - Detainee education.

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

Notes:

(a)(b)(c)(e) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring during the intake process, KCFRC ensure that the resident orientation program notifies and informs residents about GEO's zero tolerance policy regarding all forms of sexual abuse and assault and includes instruction on prevention and intervention strategies; definitions and examples of resident-on-resident sexual abuse, employee-on-resident sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse, to any employee, including an employee other than immediate point-of-contact line officer (i.e. the PSA Compliance Manager or mental health staff), the DHS OIG, and the JIC; information about

self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the resident's immigration proceedings; and the right of a resident who has been subjected to sexual abuse to receive treatment and counseling. The policy further requires this information be available in formats accessible to all residents, including those who are LEP, deaf, visually impaired or other disability, as well as to residents who have limited reading skills. As noted in standard 115.16, intake staff confirmed each resident arriving at KCFRC receives the Karnes County Family Residential Center Handbook; ICE Sexual Abuse and Assault Awareness pamphlet; and view the three PREA videos (Orientation, PREA, and Know Your Rights). All of these pieces of information are in English and Spanish. The interviews with the two intake staff, the one Classification staff, and the one Case Manager detailed the resident orientation process at KCFRC. Residents on the day of their arrival who do not speak English or Spanish receive a short orientation about the facility rules including how to report allegations of sexual abuse using the interpretive language line. All residents by policy receive an in-depth orientation within seven days of their arrival. This in-depth orientation details the Karnes County Family Residential Center Handbook through the Case manager. The orientation is documented for every resident and is presented utilizing the language line for those needing it. Information provided residents includes information on filing grievances; reporting sexual abuse and misconduct; contact information for the DHS OIG, DHS JIC, and Rape Crisis Center; zero tolerance information; definitions of prohibited sexual acts; avoiding sexual abuse and assault situations; reporting information including confidentially and anonymously; and medical and mental health care for victims. The Auditor reviewed seven resident files. In each of these files the orientations for these residents were conducted within two days of their arrival with the interpreter's reference number noted on each orientation form if the language was other than English or Spanish.

(d) The Auditor based compliance on this subpart of the standard after observing the ICE prescribed sexual assault awareness posters, in Spanish and English, throughout KCFRC, including within each resident suite with the name of the PSA Compliance Manager. Also observed by the Auditor was contact information for the Rape Crisis Center. This information is also available in the Karnes County Family Residential Center Handbook.

(f) The Auditor based compliance on this subpart of the standard after reviewing reporting information for residents in the Karnes County Family Residential Center Handbook as noted in (a) above and also confirmed with the random resident interviews (23) where the residents were aware of at least one means to report sexual abuse if they needed to for themselves or someone else.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring facility investigators be trained in conducting investigations on sexual abuse and effective cross-agency coordination. All investigations into alleged sexual abuse must be conducted by qualified investigators. The policy further requires these investigators receive this specialized training in addition to the general training mandated for all employees. KCFRC has eight trained investigators. The facility currently only uses one primary investigator. She confirmed for the Auditor the investigator training she received was through GEO. Documentation of her successful completion of this training is provided in her training records. The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b) KCFRC does not utilize the ICE Health Service Corps. (IHSC/USPHS) for healthcare services. Health care services are provided by contract facility staff through Wellpath.

(c) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 indicating facility medical staff shall not participate in sexual assault forensic medical examinations or evidence gathering. Forensic examinations shall be performed by a trained SANE or SAFE. Policy 2.11 further requires medical and mental health care practitioners receive specialized training in addition to the general training mandated for all employees. This specialized training (Medical Specialized Training) includes detecting signs of sexual abuse and assault; preserving physical evidence of sexual abuse; responding professionally to victims of sexual abuse and proper reporting of allegations or suspicions of sexual abuse and assault. The Auditor interviewed both the Health Services Administrator (HSA) and a mental health practitioner and both informed the Auditor all KCFRC medical/mental health staff (full and part time) receive this training annually and all are current with the training. A sampling of medical practitioner training files (10) were examined and found to be complete and reflective of the standard training requirements. The policy indicates all medical and mental health staff shall complete the specialized training annually. KCFRC exceeds the standards requirement for specialized training in requiring staff to complete the training on an annual basis. KCFRC has a Memorandum of Understanding (MOU) with Methodist Specialty and Transplant Hospital in San Antonio to perform SAFE or SANE examinations for residents at KCFRC. As noted earlier this policy (2.1.1) was approved by the AFOD.

§115.41 - Assessment for risk of victimization and abusiveness.

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

Notes:

(a)(b)(c)(d) The Auditor based compliance on these subparts of the standard after review of policy 2.1.5 (Admission and Release) requiring all mothers/fathers and children be screened upon arrival at the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior. Also, policy 2.1.1 requires residents be assessed during intake within twelve (12) hours of arrival to identify those likely to be sexual aggressors or sexual abuse victims and house residents to prevent sexual abuse, taking necessary steps to mitigate any such danger. The policy requires KCRFC utilize attachment C (GEO PREA Risk Assessment Tool) when conducting this vulnerability assessment. The attachment utilizes the following criteria to assess residents for risk and sexual victimization: whether the resident has a mental, physical, or developmental disability; the age of the resident; the physical build and appearance of the resident; whether the resident has previously been detained; the nature of the resident's criminal history; whether the resident has any convictions for sex offenses against an adult or child; whether the resident has self-identified as LBGTI or

gender nonconforming; whether the resident has self-identified as having previously experienced sexual victimization; and the resident own concerns about his or her physical safety. The initial risk assessment is performed by the medical staff typically within the first hour of the resident's arrival but not beyond 12 hours of arrival. The HSA confirmed her staff conducts each assessment prior to the resident being assigned a suite, utilizing attachment C with the document becoming part of the resident's medical record. The Auditor viewed ten medical records and found completed risk assessments conducted utilizing attachment C. All of these assessments were conducted within 12 hours of arrival.

(e) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring medical/mental health staff reassess each resident's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment under the guidance of the PSA Compliance Manager, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization utilizing the GEO PREA Vulnerability Reassessment Questionnaire (Attachment D) to conduct the reassessment. During the review of the ten medical records, the Auditor found one resident who was at KCFRC for four months. The resident's second assessment was conducted on the 67th day.

(f) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 prohibiting residents from being disciplined for refusing to answer, or for not disclosing complete information in response to questions asked in subpart (c). Interviews with the HSA and PSA Compliance Manager confirmed residents are not disciplined for refusing to answer any of the questions on attachment C or D. Both also indicated they were not aware of any resident refusing to answer any of the questions in the last 12 months. The Auditor was able further to corroborate this practice through observation of the intake procedures.

(g) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC implement appropriate controls on the dissemination of responses to questions asked related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by employees or other residents. The HSA confirmed appropriate controls are placed on all resident information including risk assessments. As previously noted, these documents are maintained in the medical record which is under double lock and key.

§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) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC use the information from the risk assessment to determine assignment of each resident to housing, recreation and other activities, and voluntary work in order to keep potential victims away from potential abusers. The PSA Compliance Manager or designee will maintain an "at risk log" of potential victims and potential abusers determined from the Initial Risk Screening Assessment. The "at risk log" will be maintained in the mental health department and kept current with housing locations. Housing assignments at KCFRC are also governed by policy 2.1.5 (Resident Admission and Release) requiring classification will use the ICE JFRMU Grouping Criteria in conjunction with Texas Department of Family Protective Services (TDFPS) housing requirements with each new arrival for identification and classification and housing of each family. Housing classification will only be completed by the Intake Supervisor or designee. ICE will provide only the information needed for classification-processing. Under no circumstances will non-ICE personnel have access to the parent or child's file. According to the Classification Supervisor interview each family is assessed separately for housing based on the risk assessment and the housing assignment classifications being comprised of five groups of families: group 1 includes parents whose children are 0-6 years of age without regard to the child's gender; group 2 includes parents whose children are 7-10 years of age; group 3 includes parents whose children are 11 to 13 years old; group 4 includes parents whose children are 14 to 17 years old; group 5 includes parents whose children span multiple age groupings (ex. group1 and group 2). The Classification Supervisor informed the Auditor that residents with any history of abuse are not placed at KCFRC by ICE. This restriction was also confirmed by the Facility Administrator.

(b)(c) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC when making assessments and housing decisions for transgender and intersex residents, the facility consider the resident's gender self-identification and an assessment of the effects of placement on the residents' health and safety. A medical or mental health practitioner shall be consulted as soon as practicable on these assessment and placement decisions which shall not be based solely on the identity documents or physical anatomy of the resident with serious consideration given to the individual's own views with respect to his/her own safety. The policy further indicates transgender and intersex residents may be housed in medical for up to 72 hours (excluding weekends, holidays and emergencies) until the appropriate housing determination is made by the GEO Transgender Care Committee (TCC). The Facility Administrator confirmed these requirements in the policy but also stated KCFRC has never had transgender or intersex residents placed at the facility. She also stated that because each suite has its own private bathroom, they would be placed in a suite with only family members, and there would be no concerns about showering arrangements if the facility ever receives a transgender or intersex resident.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 stating KCFRC will assign residents vulnerable to sexual abuse or assault to administrative observation for their protection until an alternative means of separation from likely abusers can be arranged, and such an assignment shall be made for the least amount of time practicable, and when no other viable housing option exists, as a last resort. Such assignment shall not exceed a period of 30 days. It should be noted, as indicated in the facility PAQ and interviews with the Facility Administrator and PSA Compliance Manager, KCFRC does not have a dedicated administrative segregation unit. If an administrative observation is used to protect vulnerable residents, the resident shall have access to programs, visitation, counsel and other services available to the general population to the maximum extent practicable. Any restriction imposed will be documented along with the justification for the restriction. The policy further requires the Chief of Resident Advisors conduct a review within 72 hours of the resident's placement in administrative observation to determine whether observation is still warranted. The Chief of Resident Advisors shall conduct, at a minimum, an identical review after the resident has spent 7 days in administrative observation, and every week thereafter for the first 30 days, and every 10 days thereafter utilizing the "Sexual Assault/Abuse Available Alternatives Assessment" form to document the assessment. All completed forms shall be reviewed and signed by the Facility Administrator or designee upon completion. The Facility Administrator and/or designee shall notify the ICE AFOD immediately who will then notify the appropriate ICE Field Office Director (FOD) or designee no later than 72 hours after the initial placement into observation whenever a resident has been placed in administrative observation on the basis of a vulnerability to sexual abuse or assault. The Facility Administrator, PSA Compliance Manager, and the Chief of Resident Advisors each indicated that if a resident was assaulted the abuser would be removed from the area, placed in one of the intake waiting rooms awaiting removal by ICE.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC provide multiple ways for residents to privately report sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The policy further requires KCFRC provide contact information to residents for relevant consular officials, the DHS OIG or, as appropriate, another designated office, to confidentially and, if desired, anonymously reports these incidents. These contact numbers are to be posted next to every resident telephone. The Auditor observed contact information for each consulate, in Spanish and English, next to the telephone in each of the resident suites. The ICE zero tolerance posters, in Spanish and English, were observed throughout the facility and in each of the suites as well. These posters provide information about the name of the facility PSA Compliance Manager with reporting contact information advising residents that reports can be made confidentially and anonymously. As noted earlier in the report, residents are provided an initial orientation upon arrival on how to report allegations of sexual abuse and an in-depth orientation based on the Karnes County Family Residential Center Handbook within their first week. The handbook outlines reporting options to the DHS OIG, the facility PSA Compliance Manager by dialing 9 on the phone, calling the Rape Crisis Center, filing a grievance, and contacting the FOD. The Auditor randomly interviewed 33 residents, and all could at least provide one means of reporting sexual abuse if it became necessary. The 1 allegation made during the previous 12 months was by the alleged victim to a Resident Advisor. The Auditor checked the resident reporting telephone line and found it operational without the use of the resident PIN or providing identifiable information prior to use.

(c) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC employees accept reports of sexual assault made verbally, in writing, anonymously, and from third parties and employees promptly document any verbal reports. The investigative case file review, on the 1 allegation reported in the last 12 months, demonstrated a verbal report made by the resident to a staff member was documented in writing. The random staff interviews confirmed staff is to accept and report allegations of sexual abuse regardless of how it was made. They also indicated verbal reports from residents, or third parties must be documented in writing to their supervisors.

§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)(e) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC allow residents to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging a complaint and not impose a time limit for filing. The policy details for residents the procedures for identifying and handling time-sensitive grievances that involve an immediate threat to a resident's health, safety, or welfare related to sexual abuse. The Karnes County Family Residential Center Handbook outlines this process for filing a sexual assault allegation. The grievance staff interview confirmed any grievance alleging sexual assault is considered an emergency resident grievance with no time limit on filing. Her office issues a decision on the grievance within 5 days of receipt and responds to an appeal of the grievance decision within 30 days. All grievances related to sexual abuse and the facility's decisions with respect to such grievances are reported to the appropriate FOD at the end of the grievance process via email. She further stated that she would bring any medical emergencies to the immediate attention of proper medical personnel for further assessment when necessary. The PAQ and the PSA Compliance Manager confirmed that the grievance process was not utilized at KCFRC by any residents to allege sexual abuse during the last 12 months.

(f) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 stating in order to prepare a grievance a resident may obtain assistance from another resident, their assigned resident advisor or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties. Random staff interviewed were aware a resident may obtain assistance from another resident, their assigned resident advisor or other facility staff, family members, or legal representatives. Most of the residents, over half of the 30 interviewed, were aware they could file a grievance alleging sexual assault.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to most appropriately address victim's needs. It further requires information about the local organization that provides residents who have been victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available) is posted in all living areas. The PSA Compliance Manager confirmed that calls to the Rape Crisis Center are not monitored by the facility and residents are informed of this in the facility handbook. Residents contacting the Rape Crisis are notified on the phone, to the extent the call is monitored. They do not enter a personal identification number (pin) to access this Center or for any reporting. She also stated that the Rape Crisis Center does not accept allegations of sexual abuse but will provide the resident information on how to report. As noted in standard 115.21, KCFRC has an MOU with the Rape Crisis Center. This MOU was initiated in 2018 and automatically renews annually. The Auditor spoke with a representative from the Center who indicated an MOU existed with her agency and KCFRC to provide a 24-hour hotline, crisis intervention, and advocacy for current or former victims of sexual violence. She also indicated her agency has a working relationship with Methodist Specialty and Transplant Hospital (KCFRC uses for healthcare services) providing an on-site trained advocate for any victim of sexual assault forensic examination. The Auditor observed the contact information available for the Rape Crisis Center in each suite at KCFRC. The Auditor verified that the phone contact was confidential while at the facility. The facility's Investigator and PSA Compliance Manager confirmed that the Investigator or PSA Compliance Manager provides each resident alleged victim of sexual abuse contact information for this Center within the first hour after the notification is made. The investigative file review indicated the resident was provided this advocate information.

§115.54 - Third-party reporting.

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

Notes:

The Auditor based compliance on this standard after review of policy 2.1.1 requiring GEO's third-party reporting procedures be posted throughout the facility. This includes posting on its public website the methods of receiving third-party reports of sexual abuse or assault on behalf of residents. The policy further requires third-party reporting posters be posted in all public areas in English and Spanish to include lobby, visitation, and staff break areas within the facility. During the three-day site visit, the Auditor observed third-party reporting posters in Spanish and English, throughout the facility to

include their lobby and visitation area. The GEO web page www.geogroup.com/PREA and ICE website https://www.ice.gov have reporting information on behalf of a resident as well. Random residents interviewed were aware that family members and friends could report sexual abuse on their behalf. The PAQ and the PSA Compliance Manager confirmed the one reported sexual abuse allegation was made verbally to a staff member and not through third- party reporting.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC staff immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or assault that occurred in any facility; any retaliation against residents or employees who reported such an incident or participated in an investigation about such incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. The policy further requires to help protect the safety of the victim or prevent further victimization of other residents or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions. Documentation provided to the Auditor confirmed the policy was reviewed and approved by the AFOD. Interviews with the Facility Administrator, the PSA Compliance Manager, and the Chief of Resident Advisors confirmed the staff reporting requirements and indicated they are provided to everyone in policy and included in the pre-service and annual refresher training. The PSA Compliance Manager also confirmed staff, by policy, may report sexual abuse outside their chain of command to the Chief of Resident Advisors or directly to Corporate through the hotline. Interviews with the 12 random security staff confirmed they were aware that they could go outside their chain of command to report allegations of sexual abuse and apart from reporting to designated supervisors or officials, employees shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary.

(d) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring allegations of sexual abuse in which the alleged victim is under the age of 18 or considered a vulnerable adult under State or local vulnerable person's statute, the facility shall report to designated State or local services. The interview with the Facility Administrator, HSA, and PSA Compliance Manager confirmed if KCFRC ever encountered an incident of sexual abuse of a vulnerable adult or child, KCFRC would notify TDFPS and the local Sheriff. There were no reported sexual abuse incidents at KCFRC involving a juvenile or vulnerable adult during the previous 12 months.

§115.62 - Protection duties.

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

Notes:

The Auditor based compliance on this standard after review of policy 2.1.1 requiring anytime a staff member has reasonable belief that a resident is subject to substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the resident. The Facility Administrator, PSA Compliance Manager, and random staff interviews confirmed in any situation involving a resident at substantial risk of imminent sexual abuse each would take immediate action to protect the resident. The PAQ and Facility Administrator confirmed KCFRC had no residents at substantial risk of imminent sexual abuse within the last 12 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) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 stating that in the event that a resident alleges that sexual abuse occurred while confined at another facility, the facility shall document those allegations and the Facility Administrator or Assistant Facility Administrator shall contact the Facility Administrator or designee where the abuse is alleged to have occurred and notify the ICE Field Office as soon as possible, but no later than 72 hours after receiving the notification. The facility shall maintain documentation that it has provided such notification and all actions taken regarding the incident. Copies of this documentation shall be forwarded to the PSA Compliance Manager and Corporate PREA Coordinator. Any facility that receives notification of alleged abuse is required to ensure that the allegation is investigated in accordance with PREA standards and reported to the appropriate ICE FOD. The Facility Administrator, PSA Compliance Manager, and the PAQ each indicated KCFRC has had no incidents of sexual abuse reported to them having occurred at another facility.

§115.64 - Responder duties.

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

Notes:

(a) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring all staff upon learning of an allegation that a resident was sexually abused, or if the employee sees abuse, the first security staff member to respond to the report shall separate the alleged victim and abuser; immediately notify the on-duty security supervisor and remain on the scene until relieved by responding personnel; preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; if the sexual abuse occurred within 96 hours the alleged victim and abuser shall be separated to ensure that they do not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating until the forensic examination can be performed. A security staff member of the same sex shall be placed outside the area where the resident is secured for direct observation to ensure these actions are not performed. The investigative case file review confirmed that a security staff was who the initial allegation was made to. The file also reflected the staff member followed the required protocols as required by the situation and outlined in policy. The random staff interviews confirmed their knowledge of their responsibilities as outlined in policy and required by the standard.

(b) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring whenever the first responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence; remain with the alleged victim, and notify security staff. The Auditor confirmed this practice during interviews with two non-security staff members. Each confirmed they would secure the alleged victim and immediately call for a security staff person.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC develop written plans to coordinate the actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to incidents of sexual abuse. The Facility Administrator confirmed KCFRC utilizes policy 2.1.1 to coordinate the actions taken by first responders, medical and mental health practitioners, investigators, and facility leadership in response to any incidents of sexual abuse since the policy details the responsibility for each of those disciplines. The Auditor reviewed the one completed investigation file for the last 12 months. The file contents documented the multidisciplinary and coordinated responses by staff members at KCFRC.

(c)(d) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring if any victim of sexual abuse is transferred between DHS Immigration Detention Facilities the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical and/or social services. The policy further requires if the victim of sexual abuse is transferred to a non-DHS Facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical and/or social services, unless the victim requests otherwise. Interviews with the Facility Administrator and PSA Compliance Manager confirmed that KCFRC has had no instances of any transfer of sexual abuse victims between DHS or non-DHS facilities within the previous 12 months. Both indicated that if and when they have one, the proper notifications would be made as required by policy. The HSA confirmed prior to a victim of sexual assault being transferred she would contact the receiving facility and provide both medical and mental health information as necessary.

§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:

The Auditor based compliance on this standard after review of policy 2.1.1 requiring any employees, contractors and volunteers suspected of perpetrating sexual abuse be removed from all duties requiring resident contact pending the outcome of an investigation. Separation orders requiring "no contact" shall be documented by the facility management via email or memorandum within 24 hours of the reported allegation. The email or memorandum shall be printed and maintained as part of the related investigation file. The interviews conducted with the Facility Administrator and PSA Compliance Manager indicated all staff, contractors, or volunteers being investigated for sexual abuse allegations or any other serious misconduct involving a resident are prohibited from having contact with residents until the completion of the investigation. As previously noted, KCFRC had an allegation made against a staff member. The Facility Administrator indicated the staff member was removed from resident contact upon the allegation and for the duration of the investigation. The review of the investigative file confirmed the written notice of removal from resident contact and was dated on the day the allegation was made.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring employees, contractors, volunteers, and residents from retaliating against any person, including a resident, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. KCFRC has designated the PSA Compliance Manager to monitor resident retaliation. She confirmed with the Auditor that retaliation monitoring begins the day the allegation is made and continues for a period of 90 days and could continue as long as monitoring for retaliation is required and or needed. She indicated all retaliation monitoring is documented on attachment B of this policy, "Protection from Retaliation Log". She also stated her monitoring would include the review of resident disciplinary reports and/or housing or program changes. The HR staff person is responsible for monitoring employee retaliation. She stated her monitoring begins on the day of the allegation as well and continues for at least 90 days and may continue longer if needed. She also stated her monitoring would include negative performance reviews, time off refusals or reassignment requests of staff. The interviews with the PSA Compliance Manager and HR confirmed KCFRC has had no reported instances of alleged retaliation occurring during the previous 12 months. The one investigative file documented retaliation monitoring for the individual who reported the allegation and continued for 90 days.

§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)(d) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC take care to place resident victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible (e.g. protective custody), subject to the requirements of 115.43. Resident victims shall not be held for longer than five (5) days in any type of administrative observation, except in unusual circumstances or at the request of the resident. It should be noted, as indicated in the facility PAQ and interviews with the Facility Administrator and PSA Compliance Manager, KCFRC does not have a dedicated administrative segregation unit The policy further requires any resident victim who is in protective custody after having been subjected to sexual abuse not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the resident as a result of the sexual abuse. KCFRC is also required to notify the ICE COR whenever a resident victim has been held in administrative observation for 72 hours. The Facility Administrator and PSA Compliance Manager confirmed if the alleged victim is placed in any type of administrative observation that prior to being placed back in his/her suite a reassessment would be conducted by mental health using the PREA Vulnerability Reassessment form (Attachment C). The review of the investigative file confirmed all notifications being made as required by the standard.

§115.71 - Criminal and administrative investigations.

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

Notes:

(a)(b)(c)(e)(f) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring when the facility conducts its own investigations into allegations of sexual abuse, it shall do so promptly, thoroughly, and objectively for all allegations. The policy further requires an administrative investigation be completed by trained investigators for all allegations of sexual abuse at GEO facilities, regardless of whether a criminal investigation is completed. The facility's investigator confirmed she conducts an administrative investigation on every allegation of sexual abuse within 24 hours of the allegation being made after consultation with the appropriate investigative offices within DHS and the local Sheriff's office. She also stated that she cooperates with whichever outside agency is conducting the criminal investigation and her protocols and determinations for administrative investigations are based on direct and circumstantial evidence; available physical DNA evidence; available electronic monitoring data; interviews notes from alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints; and reports of sexual abuse or assault involving the suspected perpetrator. She stated she assesses the credibility of any alleged victim, suspect, or witness, based on evidence without regard

to their status as a resident, employee, or contractor without requiring any resident who alleged sexual abuse or assault to submit to a polygraph. As noted earlier, policy 2.1.1 was approved by the AFOD and it contains KCFRC investigative policy. The facility's investigator indicated that KCFRC policy and practice requires the investigation continue regardless of the departure of the alleged abuser or victim from the control or employment. The review of the one allegation investigation confirmed the element requirements of the policy and standard were followed.

§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:

The Auditor based compliance on the standard after review of policy 2.1.1 requiring when an administrative investigation is undertaken, the facility shall impose no standard higher than a preponderance of the evidence in determining whether the allegation of sexual abuse and assault is substantiated. The facility's investigator confirmed the evidence standard she utilizes when determining a sexual abuse case is the preponderance of evidence. A review of the one completed investigative file, appeared that a preponderance of the evidence was the standard applied in determining the investigation outcome.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor based compliance on the standard after review of policy 2.1.1 requiring KCFRC at the conclusion of every investigation conducted by the facility investigator, inform the resident of the investigation outcome (substantiated, unsubstantiated or unfounded) through the "Notification of Outcome of Allegation" form. The Auditor found this form unsigned in the one completed investigative file, as the resident had left the facility prior to the investigation being completed. Information provided through ERAU, showed the resident was transferred September 24, 2019 and notification was made by ICE to the resident on October 10, 2019.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring staff be subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies. Interviews with the Facility Administrator and PSA Compliance Manager confirmed ICE and JFRMU reviewed and approved KCFRC's policies and procedures regarding disciplinary and adverse actions for violating these policies against sexual abuse. They also confirmed removal from their position and from the Federal service is the presumptive disciplinary sanction for all staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a resident by a staff member, contractor, or volunteer. The HR staff person also described this presumptive action and stated that in the one allegation at KCFRC involving an employee the staff member was terminated as a result of their actions.

(c)(d) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring all removals or resignations in lieu of removal for violations of the agency and/or facility sexual abuse policies be reported to appropriate law enforcement agencies, unless the activity was clearly not criminal and licensing bodies to the extent known. The Facility Administrator confirmed that her office is required to make these notifications when and if it ever became necessary. She stated all allegations are immediately reported to the Sheriff regardless if the staff member resigned or not. The one incident reported at KCFRC during the last 12 months was reported to the Sheriff and involved no licensed staff member.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring any contractor or volunteer who has engaged in sexual abuse be prohibited from contact with residents. KCFRC shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. Such incidents shall also be reported to law enforcement agencies, unless the activity was clearly not criminal. This policy further requires contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring resident contact pending the outcome of an investigation. The Facility Administrator stated allegations made against any contractor or volunteer would require their removal from any resident contact until the conclusion of the investigation. She also confirmed She would consider whether to prohibit any further contact with residents if they had not engaged in sexual abuse but had violated other provisions within these standards. Any volunteer or contractor actually found to have committed sexual abuse would be reported to law enforcement and licensing bodies. There were no reported incidents requiring the removal of a contractor or volunteer within the last 12 months.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC subject a resident to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the resident engaged in sexual abuse. Any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the resident to conform to rules and regulations in the future. During the previous 12 months there were no resident on resident allegations reported.

(c)(d) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 and interviews with the Facility Administrator, PSA Compliance Manager, and the Chief of Resident Advisors. Each of them confirmed the disciplinary process, as required by policy, allows for progressive levels of reviews, appeals, procedures, and documentation procedures. They also confirmed that by policy the KCFRC disciplinary process would consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The facility has had no substantiated allegations of sexual abuse by a resident within the last 12 months.

(e) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring a resident not be disciplined for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. The PSA Compliance Manager, PAQ, and the Facility Administrator confirmed there were no sexual abuse allegations involving a resident and staff where the staff member did not consent to such conduct.

(f) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring a resident making 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. The Chief of Resident Advisors confirmed no resident at KCFRC have ever been disciplined for filing any allegation of sexual abuse, nor would he or she, if it was done in good faith based upon a reasonable belief.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring during intake a PREA Risk Assessment (pursuant to § 115.41) is completed on all residents. If it is found that during this process if a resident is identified as having had prior sexual victimization or perpetrated sexual abuse, intake staff shall, as appropriate, ensure that the resident is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When the referral for medical follow-up is initiated, the resident shall receive a health evaluation no later than two working days from the date of assessment from a qualified medical staff member. When a resident is referred to mental health staff for a follow up evaluation, the resident shall receive the evaluation from the mental health Case Worker within 72 hours of the referral being initiated. As previously noted, the risk assessment is performed by medical staff and becomes part of the resident's medical record. The HSA confirmed when a follow-up is initiated, the resident receives a health evaluation typically the same or next day no later than two working days from the date of the assessment. When a referral for mental health is initiated, the resident receives a mental health evaluation no later than 72 hours after the referral. As noted earlier, residents with a history of abusive behavior are not allowed to be placed at KCFRC. There was one allegation of sexual abuse made during the previous 12 months. The review of the administrative investigative file indicated the resident was seen by medical on the day the allegation was made. The medical file was not available for review by the Auditor as it was no longer at the facility; therefore, the Auditor relied on the investigative file to support compliance.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring all victims of sexual abuse in custody shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by medical and mental health practitioners. This access includes offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The HSA confirmed KCFRC offers all residents who experience sexual abuse the services noted above and access to forensic medical examinations with the victim's consent and without cost to the resident and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The review of the one investigative file confirmed the resident was seen by medical staff and mental health staff.

§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) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring KCFRC offer medical and mental health evaluations (and treatment where appropriate) to all victims of sexual abuse while in GEO custody. The evaluation and treatment should include follow-up services, treatment plans, and when necessary referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The policy further requires these services be provided in a manner that is consistent with the level of care the individual would receive in the community. The HSA confirmed each alleged resident victim of sexual abuse would be offered evaluation and continued treatment services offered through their medical and mental health departments, consistent with the community level of care at no cost to the resident. She also stated that female resident victims of vaginal penetration, by a male abuser, would be provided a pregnancy test and all lawful pregnancy-related medical services when and where applicable. The medical record for the one allegation made during the previous 12 months was no longer at the facility. The Auditor did review in the investigative file where the resident was seen by medical on the day of the allegation.

(d)(e)(f) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring 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. The interview with the HSA confirmed that her medical and mental health departments provide on-site crisis intervention services, including emergency contraception, pregnancy testing, sexually transmitted infections and other infectious diseases testing, and prophylactic treatment to all victims if necessary.

(g) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC attempt to conduct a mental health evaluation on all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by mental health practitioners. The interview with the Facility Administrator and HSA confirmed this policy requirement. The Facility Administrator stated known abusers would not continue to be held at the facility as the design and mission does not allow for this type of resident.

§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) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation. Such review shall occur within 30 days of the conclusion of the investigation. The "DHS Sexual Abuse or Assault Incident Review" form of the team's findings shall be completed and submitted to the local PSA Compliance Manager, agency PSA Coordinator, and Corporate (GEO) PREA Coordinator no later than 30 working days after the review via the GEO PREA Database. The facility shall implement the recommendations for improvement or document its reasons for not doing so. The Auditor reviewed and found the incident review in the one completed investigation conducted during the previous 12 months was completed 6 days after the conclusion of the investigation with no recommendations made by the team.

(b) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1, interviews with the Facility Administrator and PSA Compliance Manager, and the review of the completed incident review all confirming the team looks at race; ethnicity; gender identity; lesbian; gay; bisexual; transgender or intersex identification; status; or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.

(c) The Auditor based compliance on this subpart of the standard after review of policy 2.1.1 requiring KCFRC conduct an annual review of the all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the Facility Administrator, FOD or his/her designee, and Corporate PREA Coordinator upon completion. The PSA Compliance Manager provided the Auditor with the annual review and noted it was completed in November 2019.

§115.87 - Data collection.

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

Notes:

(a) The Auditor based compliance on these subparts of the standard after review of policy 2.1.1 requiring all case records associated with claims of sexual abuse shall be maintained in appropriate files in accordance with Residential Standards and retained in accordance with established schedules. Particularly applicable to the storage, confidentiality and release of case records are the Confidentiality and Release of Medical Records section in the policy of Medical Care and the requirements in the policy on Residential Files, especially in regard to the Privacy Act of 1974. The PSA Compliance Manager confirmed data collected is securely maintained in her office, under double lock and key, with access to only staff requiring a need to review. She indicated the records are retained for at least five years after the date of the initial collection unless federal, state or local law requires otherwise.

§115.201 - Scope of audits.

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

Notes:

(d) The Auditor was allowed access to the entire facility and able to question staff and residents about sexual safety during the site visit.
(e) The Auditor was able to revisit areas of the facility and to view all relevant documentation as requested.
(i) Formal interviews with staff, contractors, and residents were conducted in a private confidential setting.
(j) Audit notices were posted and observed throughout the facility in English and Spanish. The Auditor received no staff or resident correspondence.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	3
Number of standards met:	37
Number of standards not met:	0
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 4/26/2020

Auditor's Signature & Date

(b) (6), (b) (7)(C) 4/26/2020

Assistant PREA Program Manager's Signature & Date

(b) (6), (b) (7)(C) 4/27/2020

PREA Program Manager's Signature & Date