PREA Audit: Subpart B
DHS Immigration Detention Facilities
PREA Audit Report

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Alberto Caton	**Organization:**	Creative Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Bakersfield ERO
ICE Field Office Director:	David W. Jennings
PREA Field Coordinator:	Juan Garcia
Field Office HQ physical address:	
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Bakersfield Hold Room		
Physical address:	800 Truxtun Ave. Bakersfield, CA		
Mailing address: *(if different from above)*			
Telephone number:	(661) 328-4500		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer (SDDO)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	Juan Garcia	**Title:**	SDDO
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)

AUDIT FINDINGS

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS:

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

On February 27, 2018, Alberto Caton, Certified PREA Auditor, representing Creative Corrections of Beaumont, TX conducted the first Prison Rape Elimination Act (PREA) audit of the Bakersfield Hold Room, located at 800 Truxtun Avenue, Bakersfield, CA 93301. This audit was conducted to determine the facility's level of compliance with the Department of Homeland Security's (DHS's) Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities. The audit period under review extends from February 1, 2017 to February 23, 2018.

The facility is operated by Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) and Group 4 Securicor (G4S) provides security services and transportation pursuant to a contract with the agency. The facility operates with (b) (7) sworn ICE employees (b) (7) line officers and (b) (7)(E) supervisors. Of the (b) (7) employees, (b) (7)(E) are male and (b) (7)(E) are female. In addition to the ICE employees, there are (b) (7) G4S uniformed employees, including (b) (7)(E) lieutenant and (b) (7)(E) sergeant, who manage custody operations at the facility; G4S staff consists of (b) (7) males and (b) (7)(E) females. There facility does not use volunteer services of any kind. (b) (7)(E)

The hold rooms are located in the Northwest corner of the first floor of a three-story building in a metropolitan area of the city; it was built in 2000 and the agency has occupied the site since 2001. There are seven hold rooms of different shapes and sizes inside a square area. The hold rooms surround the circular-shaped Processing Room where there is a "U-shaped" desk/counter in the middle. Two hold rooms, (5 & 6) are single occupancy and the others are multiple occupancy; Hold Room 4 is designated for female detainees and there is always a female G4S officer assigned to the Processing Room. There is a Control Room adjacent to Hold Room 4 and a sally port next to the Control Room provides access to the Processing Room. There is (b) (7)(E) G4S officer assigned to the Control Room where a large window provides a complete view of the Processing room. The facility does not hold juveniles or families and detainees are not held overnight; they are held for 12 hours or less and usually transported-out by 5:00 PM (b) (7)(E) There are no showers or detainee dining rooms; detainees are fed sack lunches in their assigned hold rooms. There is an eighth hold room outside the Processing Room, in front of the door to the Control Room; this room is normally used to facilitate detainee phone calls to their consulates and to hold females or to provide heightened security if needed.

Of 2,664 detainees booked in the last 12 months, there were 2,576 men, 88 women and none identified as transgender. The average daily population over the previous year is 11. The facility has (b) (7) video surveillance cameras, (b) (7)(E) . (b) (7)(E)

PRE-ONSITE PHASE

On February 6, 2018, External Audits and Review Unit Team Lead (b) (6), (b) (7)(C) provided an "Ops Plan/Agenda" for the audit; the plan lists specific information about the audit, the facility, its leadership and a proposed schedule of activities for the onsite audit. On February 10, 2018, (b) (6), (b) (7)(C) uploaded documents provided by headquarters to the SharePoint site to release them to the AUDITOR. The next day, (b) (6), (b) (7)(C) uploaded additional documents provided by the facility. Overall, the documents included the Pre-Audit Questionnaire (PAQ), a floor plan of the facility, applicable agency directives and procedures, a staffing plan/roster of officers, numerous PowerPoint presentations with applicable training curricula, detainee information posters and brochures, the agency's Sexual Abuse or Assault Incident Review Form, a disciplinary action matrix and other documents. On February 12, 2018, the AUDITOR initiated review of the PAQ and the documents received from headquarters and the field. The AUDITOR started completing the "Pre-Audit" portion of the audit compliance tool based upon review of the PAQ and aforementioned documents. On February 18, 2018, after completing the Pre-Audit portion of the tool, the AUDITOR provided an "Issue Log" to (b) (6), (b) (7)(C) requesting clarification and documentation related to specific standard provisions.

The AUDITOR requested contact information for community-based agencies that would provide services to victims of sexual abuse at the facility and (b) (6), (b) (7)(C) indicated that the information would be provided onsite. The AUDITOR conducted a search online and found the "Alliance Against Family Violence and Sexual Assault," a local community-based advocacy agency. On February 22, 2018, the AUDITOR conducted a telephone interview with a representative of this agency and she stated that her agency provides services to detainees at Mesa Verde, an ICE detention facility in the area, but she has never had any contact with staff or detainees at the Bakersfield Hold Room.

On February 21, 2018, the AUDITOR visited the ICE ERO website at https://www.ice.gov/contact/deteniton-information-line and verified that there is a link to the ICE Detention Reporting and Information Line flyer; the flyer provides a toll-free number and information for stakeholders who wish to report sexual abuse of detainees in ICE custody. The AUDITOR called the number, spoke with a representative who verified that detainees and third parties can report a case of sexual abuse of detainees in ICE custody by calling that number.

ONSITE PHASE

On February 27, 2018, the AUDITOR arrived at the facility and was escorted to an office designated for the audit (b) (6), (b) (7)(C) arrived shortly thereafter. Following greetings and introductions, (b) (6), (b) (7)(C) started the entry briefing meeting with Assistant Field Office Director (AFOD) (b) (6), (b) (7)(C) Supervising Detention and Deportation Officer (SDDO) (b) (6), (b) (7)(C), and the AUDITOR in attendance. Staff provided the Issue Log with responses to questions from the AUDITOR and reported that the audit notice was posted in all detainee access areas on February 6, 2018, three weeks before the onsite audit. The AUDITOR explained the onsite audit process, the post-audit phase and requested to start the site inspection. All aforementioned individuals participated in the site inspection. The inspection started at the receiving and processing area. Upon entering the area, staff pointed out the Video Conferencing Room, two detainee visiting rooms, office space to be designated for audit interviews, Holding Room #8, and the Control Room. There is (b) (7)(E) G4S officer assigned to the Control Room. The AUDITOR asked the officer about his duties and the video surveillance system (b) (7)(E) The Control officer

stated that there is always a minimum of (b) (7)(E) officers assigned to the Processing room (b) (7)(E) of which is a female and that hold rooms are checked (b) (7)(E)

The group left the Control Room and proceeded through the sally port into the Processing Room and out to the vehicle sally port. This is a large uncovered area surrounded by high walls where vehicles transporting detainees enter the facility; there are two large roll-up doors where vehicles enter and there was a bus on the far side that creates a potential blind spot. (b) (7)(E). Members of the tour were just in time to observe as two detainees were being removed from a transport vehicle; the AUDITOR observed the process, including the pat-down search of the new arrivals. The tour followed the transport officers and detainees into the Processing Room where the AUDITOR observed as the officers conducted pat-down searches and provided instructions to the detainees in Spanish. The searches and interaction with the detainees were very professional and the AUDITOR did not observe any inappropriate maneuvers. The AUDITOR asked impromptu questions and (b) (7)(E) officer (b) (7)(E)

Staff reiterated that juveniles and families are not brought to the facility and that strip, body cavity and cross-gender searches are never done; staff further explained that a transgender detainee would be allowed to choose the gender of the officer who would perform the pat-down search. The AUDITOR asked questions about the intake process and permission to review four unattended detainee files sitting on the counter in the middle of the room while detainees were being processed. The AUDITOR asked who has access to detainee files and a G4S supervisor stated that both ERO and G4S staff review these files. Staff explained that ICE officers conduct an assessment when they interview detainees on site where they are arrested and information, such as criminal history, is already known when the detainee arrives. The assessment information is provided to the facility and the ICE officer enters it into the Risk Classification System after transporting the detainee to the facility. The AUDITOR asked to inspect all hold rooms to identify camera placements, telephones, PREA posters (English and Spanish), and audit notices (English and Spanish); the AUDITOR verified that all of the aforementioned is present in each hold room. The AUDITOR entered unoccupied hold rooms (b) (7)(E) The AUDITOR also noted that staff were diligent about announcing the presence of people of the opposite gender before and after opening hold room doors.

The AUDITOR asked about accommodations for detainees with communication disabilities and limited English proficiency (LEP) and staff explained that there are several employees who are fluent in Spanish, PREA posters provide information in Spanish and the agency's telephone interpreter services are used if necessary to communicate with a detainee. The AUDITOR noted that some employees communicated in Spanish with detainees. The AUDITOR asked about sign language interpreter services and staff indicated that it could be obtained through the local court interpreter services, video conferencing or a local service provider. The AUDITOR asked about testing the phones in the hold rooms and a supervisor explained that the phones in the hold rooms have not been operational for two weeks because the carrier went out of business; she stated that all detainees are allowed phone calls at the counter upon arrival and there is a form the detainee signs documenting that the phone call was placed or declined. The AUDITOR reviewed another four detainee files in an adjacent office area with the supervisor and confirmed that the phone call slips were completed.

After completing the inspection, the supervisor escorted the AUDITOR to the office designated for interviews. The AUDITOR discussed the selection criteria with the supervisor based upon the detainees in custody at the facility; the AUDITOR interviewed detainees who were about to leave the facility, detainees who recently arrived, detainees who arrived from a state prison, detainees identified as LEP, and detainees arrested as part of the ongoing Fugitive Operations. The AUDITOR is fluent in Spanish and conducted detainee interviews in English and Spanish using the Detainee Interview Guide for Holding Facility. The supervisor escorted the detainee into the office and the AUDITOR read the "Introductory Script" to each detainee before conducting the interview in private. A total of six detainees appeared for interviews and two declined upon learning that the interviews were voluntary. The AUDITOR completed detainee interviews and departed the facility for a lunch break.

After the break, the supervisor provided a binder with documents requested for onsite review. The binder included documents already uploaded to the SharePoint site, as well as training records for ICE and G4S personnel and detainee risk screening documents. The detainees screening documents included a blank copy of the ICE Custody Classification Worksheet and a few printouts submitted as evidence of completed detainee risk screening required under 115.141(c). It was necessary for staff to explain to the AUDITOR how the printouts demonstrate that risk screening was completed. The documents included a screenshot of the agency's computerized Risk Classification Assessment (RCA) system showing risk screening for one detainee and printouts of 12 detainee-risk-screenings with dates ranging from February 6, 2017 to July 28, 2017; the printouts show the date and other information presented as evidence that screening was done, but not the actual risk screening information or detainee identification. The AUDITOR asked to view the computerized RCA system to review actual detainee screenings for the audit period, but the request was not granted.

The training records included certificates of completion for all ICE and G4S employees reflecting that ICE employees completed the online PREA Training and that G4S employees completed the PREA Training for Contractors. The supervisor reported that ICE employees did not receive the training on conducting pat-down searches of transgender and intersex detainees required under Standard 115.115(f), and that the training is being developed.

The AUDITOR requested access to personnel files for ICE and G4S employees to verify background investigation clearances and compliance with all requirements under Standard 115.117 – Hiring and Promotions. The AFOD explained that the Human Resources Office was closed because the employee who runs the office went home sick for the day and would not be back the next day either. He also indicated that he was not sure files for G4S employees were available at the facility and he did not know where they are kept. (b) (6), (b) (7)(C) suggested contacting (b) (6), (b) (7)(C), the designee listed on the PAQ for Hiring and Promotions. The AUDITOR summarized the activities for the day, discussed activities planned for the next day and departed the facility for the day.

On February 28, 2018, the AUDITOR returned to the facility to continue the audit. The AUDITOR used a list of ICE and G4S employees to identify staff to be interviewed. The supervisor escorted the AUDITOR to the private interview room and called upon staff designees to report to the room for interviews. The AUDITOR read the introductory script to each employee designee before proceeding with the interview; a total of (b) (7) employees were interviewed. Since the facility does not house juveniles or families, there was no designee to be interviewed on those topics. All but (b) (7)(E) staff designees listed in the Designee Interview Guides for Subpart B were interviewed. The AUDITOR completed the remaining (b) (7)(E) designee interviews after the onsite audit. The AUDITOR also interviewed three G4S contract employees, including supervisors.

After completing onsite staff interviews, the AUDITOR prepared for the exit briefing. (b) (6), (b) (7)(C) invited two members of the facility leadership to the meeting and made a few opening statements before turning it over to the AUDITOR. Present were AFOD (b) (6), (b) (7)(C) and the facility's PSA Compliance Manager, SDDO Juan Garcia; SDDO (b) (6), (b) (7)(C) had already left for the day. The AUDITOR provided preliminary audit findings for each applicable standard and discussed the remaining steps in the audit process. There was extensive discussion about reviewing personnel files,

establishing a service agreement with Alliance Against Family Violence and Sexual Assault, and developing a data collection system. The AUDITOR was allowed to keep the binder overnight between Day 1 and Day 2 but was not allowed to keep the binder for further review during the post-audit phase. (b) (6), (b) (7)(C) concluded the meeting and the AUDITOR departed the facility.

POST ONSITE PHASE
After completing the onsite audit, the AUDITOR organized completed questionnaires for staff, contractor and detainee interviews, site inspection notes and documentation received during the onsite audit. The AUDITOR conducted telephone interviews with all remaining designees; namely, for Hiring and Promotions, Evidence Protocol and Forensic Medical Examinations and Employee, Contractor and Volunteer Training, as well as missing interviews for Access to Emergency Medical Services and Random Sample of Staff and Contractors. The AUDITOR established contact with the Chief and Deputy Chief of the agency's Personnel Security Unit (PSU) and identified a method of obtaining employee and contractor background investigation clearance information not obtained at the facility due to the HR Office being closed. The AUDITOR provided a list with randomly selected employee and contractor names to the Chief and the PSU verified background clearance information for all selected employees and contractors. The AUDITOR completed the Audit Narrative and Description of Facility Characteristics before moving-on to compliance determination for each standard. Upon completing the compliance determinations for the standards, the AUDITOR prepared the Summary of Overall Findings on the next page. For the compliance determination of standard provisions, AUDITOR used a template to ensure all relevant information is documented for each standard. The template provides the following information:

- POLICIES AND OTHER DOCUMENTS REVIEWED
- PEOPLE INTERVIEWED
- SITE INSPECTION OBSERVATIONS
- A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS
- RECOMMENDED CORRECTIVE ACTIONS

The AUDITOR completed a final review of the audit report and submitted it according to established protocol.

SUMMARY OF OVERALL 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.

On February 27 – 28, 2018, a Prison Rape Elimination Act audit of the Bakersfield Hold Room, in Bakersfield, CA was conducted to determine the facility's compliance with Subpart B of the Department of Homeland Security's (DHS's) Standards to Prevent, Detect and Respond to Sexual Abuse and Assault in Confinement Facilities. The audit reveals that the facility is partially in compliance with the standards. Of the 31 standards listed in the DHS Holding Facilities Auditor Assessment Tool, the facility met 22, did not meet 8 and one did not apply. The facility met 73% of the 30 standards that apply. Below is a summary of the standards exceeded, standards met, standards not met, and standards that did not apply.

******STANDARDS EXCEEDED******

- **None**

******STANDARDS MET******

PREVENTION PLANNING

- **§115.111 – Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator**
- **§115.117 – Hiring and promotion decisions**
- **§115.118 – Upgrades to facilities and technologies**

RESPONSIVE PLANNING

- **§115.122 – Policies to ensure investigation of allegations and appropriate agency oversight**

TRAINING AND EDUCATION

- **§115.131 – Employee, contractor, and volunteer training**
- **§115.132 – Notification to detainees of the agency's zero-tolerance policy**
- **§115.134 – Specialized training: Investigations**

REPORTING

- **§115.154 – Third-party reporting**

OFFICIAL RESPONSE FOLLOWING A DETAINEE REPORT

- **§115.161 – Staff reporting duties**
- **§115.162 – Agency protection duties**
- **§115.163 – Reporting to other confinement facilities**
- **§115.165 – Coordinated response**
- **§115.166 – Protection of detainees from contact with alleged abusers**
- **§115.167 – Agency protection against retaliation**

INVESTIGATIONS

- **§115.171 – Criminal and administrative investigations**
- **§115.172 – Evidentiary standards for administrative investigations**

DISCIPLINE

- **§115.176 – Disciplinary sanctions for staff**
- **§115.177 – Corrective action for contractors and volunteers**

MEDICAL AND MENTAL CARE

- **§115.182 – Access to emergency medical services**

DATA COLLECTION AND REVIEW

- **§115.186 – Sexual abuse incident reviews**
- **§115.187 – Data collection**

ADDITIONAL PROVISIONS IN AGENCY POLICY

- **§115.193 – Audits of standards**

******STANDARDS NOT MET******

PREVENTION PLANNING

- **§115.113 – Detainee supervision and monitoring**
- **§115.115 – Limits to cross-gender viewing and searches**
- **§115.116 – Accommodating detainees with disabilities and detainees who are limited English proficient**

RESPONSIVE PLANNING

- **§115.121 – Evidence protocol and forensic medical examinations**

ASSESSMENT FOR RISK OF SEXUAL VICTIMIZATIONAND ABUSIVENESS

- **§115.141 – Assessment for risk of victimization and abusiveness**

REPORTING

- **§115.151 – Detainee reporting**

OFFICIAL RESPONSE FOLLOWING A DETAINEE REPORT

- **§115.164 – Responder duties**

ADDITIONAL PROVISIONS IN AGENCY POLICY

- **§115.201 – Scope of Audits**

******STANDARDS NOT APPLICABLE******

PREVENTION PLANNING

- **§115.114 – Juveniles and family detainees**

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	0
Number of standards met:	22
Number of standards not met:	8
Number of standards N/A:	1

The submission of this interim audit report triggers the start of the corrective action period which shall not exceed 180 days; therefore, the corrective action period expires on September 18, 2018. The agency and the facility shall work together on the development of a corrective action plan to achieve compliance. The AUDITOR will take the necessary steps to verify implementation of all corrective measures. After the corrective action plan is approved, the AUDITOR will issue a final audit report with a determination of the facility's compliance with regard to standards that required a corrective action.

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.

§115.111 – 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:

POLICIES AND OTHER DOCUMENTS REVIEWED
- Pre-Audit Questionnaire (PAQ)
- Directive 11062.2: Sexual Abuse and Assault Prevention and Intervention

PEOPLE INTERVIEWED
- None required

SITE REVIEW OBSERVATIONS
- Zero-Tolerance Poster on the wall in the Processing Room and all hold rooms

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.111(a)
The standard requires a written zero tolerance policy that mandates zero tolerance toward all forms of sexual abuse and outlines the agency's approach to preventing, detecting and responding to such conduct. Directive 11062.2, Item 2. Policy specifies the agency's zero tolerance policy and lists several strategies for effective safeguards against sexual abuse, including: detainee screening, staff training, detainee education, response and intervention, medical and mental health care, investigation, etc. The Zero-Tolerance poster does not list the strategies, but it informs readers that the agency has a zero-tolerance policy and how to report sexual abuse.

The directive and the Zero-Tolerance poster support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.111(a) – No corrective action required

§115.113 – Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11087.1: Operations of ERO Holding Facilities
- Staffing Plan

PEOPLE INTERVIEWED
- Designee on Detainee Supervision and Monitoring

SITE INSPECTION OBSERVATIONS
- Control Room
- Video surveillance cameras
- Group 4 Securicor (G4S) uniform personnel onsite
- Processing Room

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.113(a)
The directive specifies that the Field Office Director (FOD) shall ensure that each holding facility maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse and assault. The facility provided a staffing plan/roster with names of deportation officers and G4S personnel and no other information. The DESIGNEE stated that the facility uses surveillance cameras and staff conduct security checks of the hold rooms every (b) (7)(E). The AUDITOR identified hold rooms where the complete interior is not visible through the window in the door (b) (7)(E). The DESIGNEE stated that staff would open the door if necessary to get a complete view of the interior of the room (b) (7)(E) She explained that the facility is staffed based upon the activities scheduled for the day; she does not know the staff-to-detainee ratio, but there are always at least (b) (7)(E) G4S officers assigned to the Processing Room. The AUDITOR toured the Control Room, which is always staffed by (b) (7)(E) officer; there is a complete view of the Processing Room (b) (7)(E). There were several G4S officers and Immigration and Customs

Enforcement (ICE) officers on the floor of the Processing Room during the tour. There was a lot of activity and interaction between officers and detainees; this required frequent opening and closing of hold room doors.

The directive specifies the requirement of the standard provision; however, it is not clear how the staffing plan demonstrates appropriate staffing levels without including important considerations such as: the physical lay-out of the facility, design capacity, composition of the population, number of staff assigned, work schedules, number and location of video cameras, identified blind spots, etc. The DESIGNEE explained clearly how the facility maintains adequate levels of supervision from day-to-day and the AUDITOR's observations during the tour reflect that there was adequate staffing at that time. In fact, the frequent opening of hold room doors and the high level of staff and detainee interaction would tend to limit opportunities for sexual abuse.

115.113(b)
The policy lists supervision guidelines, e.g.: accounting for detainees continuously, monitoring for apparent mental health or physical conditions, regular visual monitoring via video camera, hold room checks (b) (7)(E) and logging those checks and noting any important observations. The policy reflects that Enforcement and Removal Operations (ERO) Headquarters (HQ) is responsible for Annual Reviews; however, one was not provided. The DESIGNEE stated that the facility uses detainee guidelines from HQ and that mandatory Performance and Learning Management System (PALMS) training include this subject. She was not sure about annual reviews of the guidelines or who conducts those reviews.

Neither the agency nor the facility has provided any evidence to show that annual reviews of detainee supervision guidelines have been done; therefore, there is no evidence that supports a compliance determination.

115.113(c)
The directive requires the FOD to ensure each holding facility maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees from sexual abuse. It further requires the FOD to take into consideration the physical layout of each holding facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in agency custody. The DESIGNEE explained how she takes three of the six factors prescribed by the standards into consideration and indicated that some of the other factors would not be decided at her level.

The two-page document provided as a staffing plan sorts deportation officers into (b) (7)(E) teams, such as detention, non-detention, fugitive operations, etc. and includes their seniority number. The second page lists G4S officers and (b) (7)(E) work schedules each with a specific task such as picking-up detainees at certain locations or making a removal run to Mexico. The document does not explain how any of the six considerations prescribed by the standard are taken into account when determining adequate levels of detainee supervision and the need for video monitoring. The agency/facility could consider consulting a document created by the Moss Group, titled "Developing and Implementing a PREA-Compliant Staffing Plan," visit https://www.prearesourcecenter.org/sites/default/files/library/staffingplanfinalwbjalogosubmt.pdf

RECOMMENDED CORRECTIVE ACTIONS

115.113(a) – No corrective action required

115.113(b) – The FOD should develop a protocol for conducting and documenting annual reviews of detainee supervision guidelines to ensure the facility's supervision needs are met, the protocol should specify who is involved in the review, a time of the year when the review is to be done, and specific topics to be included in the review. If the FOD conducted these reviews, documentation of the reviews should be provided to the AUDITOR to show compliance with the standard provision.

115.113(c) – The facility should develop a staffing plan that includes the considerations prescribed by the standard provision. The staffing plan should explain how each of the six factors prescribed by the standard provision are taken into consideration in determining adequate levels of supervision and the need for video monitoring.

§115.114 – Juvenile and family detainees.
Outcome: Not Applicable (provide explanation in notes)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ

PEOPLE INTERVIEWED
- None required

SITE INSPECTION OBSERVATIONS
- Inspection tour
- Statements from staff

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.114(a)
The PAQ indicates that the facility does not detain juveniles of families. During the tour, staff asserted that the facility does not detain or hold juveniles or families and the AUDITOR did not see any juveniles or families at the facility.

115.114(b)
During the tour, staff asserted that the facility does not detain or hold juveniles or families and the AUDITOR did not see any juveniles or families at the facility.

RECOMMENDED CORRECTIVE ACTION

115.114(a) – No corrective action required.

115.114(b) – No corrective action required.

AUDITOR RECOMMENDATION: If not yet in place, the FOD should consider issuing a policy document specifying that the facility shall not detain or hold juveniles or families.

§115.115 – Limits to cross-gender viewing and searches.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11087.1

PEOPLE INTERVIEWED
- Designee on Viewing and Searching Detainees by Staff of the Opposite Gender
- Sample of Staff, Including Line Staff and First-Line Supervisors

SITE INSPECTION OBSERVATIONS
- New detainee searches

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.115(b)
The questionnaire reflects that there were zero strip, cross-gender and body cavity searches at the facility during the 12-month audit period. The directive calls for pat-down searches to be conducted by an officer of the same gender as the detainee when operationally feasible. The policy also requires documentation of all strip and visual body cavity searches, limits cross-gender strip and body cavity searches to exigent circumstances only (including consideration for officer safety) and forbids law enforcement personnel from conducting visual body cavity searches of minors; if necessary, only a medical practitioner may conduct such search. The interviews of line staff and supervisors revealed that they have never conducted or witnessed a cross-gender strip or body cavity search and reaffirmed that the facility does not hold or accept juveniles and families. The DESIGNEE stated that cross-gender strip and body searches are not allowed. During the tour, the AUDITOR observed as two new arrivals were processed and the officers performed pat-down searches only.

The directive, the statement from the designee, the line staff and the AUDITOR's observations support a determination that cross-gender strip or visual body cavity searches are not done at the facility and that the facility does not hold juveniles or families.

115.115(c)
The PAQ specifies that there is a process in place to document all strip searches and visual body cavity searches. The directive requires all strip and visual body cavity searches to be documented. The DESIGNEE stated that cross-gender strip and body searches are not allowed. The interviews of line staff and supervisors revealed that they have not witnessed or conducted any cross-gender strip or visual body cavity searches. During the tour, the AUDITOR observed as two new arrivals were processed and the officers performed pat-down searches only.

The directive, the statement from the DESIGNEE, the line staff and the AUDITOR's observations support a determination that cross-gender strip or visual body cavity searches are not done at the facility and that a search of this type would be documented if it were necessary.

115.115(d)
The directive requires the FOD to ensure that detainees are permitted to shower (where showers are available), perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances. This subsection of the policy also requires the FOD to ensure personnel of the opposite gender announce their presence when entering an area where detainees are likely to be showering, performing bodily function, or changing clothes. The interviews of line staff and supervisors revealed that there are no showers at the facility; that a female officer is always assigned to the Processing Room and if there is a male present, she would announce his presence before and after opening the door to the female hold room. One interviewee stated that staff process only one gender at a time to avoid having both male and female detainees in the Processing Room at the same time. (b) (7)(E) One interviewee reported that he has not observed any detainees of the opposite gender performing bodily functions or changing clothing. During the tour, the AUDITOR viewed the surveillance monitor (b) (7)(E) The AUDITOR also heard several announcements that staff of the opposite gender was present before doors to hold rooms were opened.

The directive, the interviews with the DESIGNEE and line staff and the AUDITOR's observations support a determination that the facility implemented procedures to ensure detainees are able to perform bodily functions without staff of the opposite gender seeing them. Detainees are not able to take showers because the facility does not have showers.

115.115(e)
The PAQ reflects that the facility refrains from searching detainees for the sole purpose of determining their gender. The directive requires the FOD to ensure ERO personnel do not search or physically examine a detainee for the sole purpose of determining gender. It provides that if unknown, the detainee's gender may be determined during conversations with the detainee, by reviewing medical records (if available), or, if necessary, learning such information as part of a broader medical examination conducted in private, by a medical practitioner. The interviews of line staff and supervisors revealed that they have not conducted or witnessed a search or physical examination done solely to determine a detainee's gender. The DESIGNEE stated that staff would rely on information received from the sending facility or from the streets, but strip searches are not done.

The directive and the interviews with the DESIGNEE and line staff support a determination that the facility does not search detainees or physically examine them solely to determine gender.

115.115(f)
The PAQ reflects that pat-down searches are 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 directive states that pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and ICE policy, including consideration of officer safety. The interviews of line staff indicate that they received training on conducting pat-down searches, that cross-gender searches are not done absent exigent circumstances; the officers even described how they were trained to conduct these searches. One interviewee explained that the officer always informs the detainee what the search involves before placing hands on them to make sure there are no surprises; another officer described how he was trained to use the back of the hands, to not touch inner thighs and stated that a transgender detainee would be asked to specify the gender of the employee he or she would choose to conduct the pat-down search. The DESIGNEE stated that training on conducting searches and being professional is done during the morning muster and he explained how officers are taught to conduct a pat-down search in a respectful and professional manner. The AUDITOR observed the search of the two new arrivals and did not see any disrespectful or unprofessional maneuvers. During the review of training records at the end of Day 1, the SDDO reported that ICE personnel had not been trained on the on proper pat-down search procedures including cross-gender searches and searches of transgender and intersex detainees and that the training was being developed.

The directive, the interview with the DESIGNEE and line staff, and the AUDITOR's observations support a determination that searches are 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 standard requires training for law enforcement staff on proper pat-down search procedures including cross-gender searches and searches of transgender and intersex detainees. While the interviews support a determination of compliance, the information the SDDO provided relative to ICE staff not receiving the training required under the standard provision does not.

RECOMMEDED CORRECTIVE ACTIONS

115.115(b) – No corrective action required.

115.115(c) – No corrective action required.

115.115(d) – No corrective action required.

115.115(e) – No corrective action required.

115.115(f) – The facility shall provide training to all law enforcement staff on the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees. The facility should be ready to provide training records to prove compliance.

§115.116 – Accommodating detainees with disabilities and detainees who are limited English proficient.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- Directive 11087.1
- ERO Holding Facility Procedures (poster)
- ERO Language Services (poster)
- Zero-tolerance poster

PEOPLE INTERVIEWED
- Designee on Accommodating detainees with disabilities and detainees who are limited English proficient
- Random Sample of Staff and Contractors
- Detainees with Limited English Proficiency (LEP)

SITE INSPECTION OBSERVATIONS
- ICE Officers interviewing two new arrivals
- Zero-tolerance Posters in Spanish and large print
- Audit Notice in Spanish and large print

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.116(a)
The PAQ reflects that detainees with disabilities (including deaf or hard of hearing, blind or low vision, as well as intellectual, psychiatric and speech disabilities) are accommodated to ensure equal opportunity to participate and benefit from the agency's efforts to prevent, detect and respond to sexual abuse. The directive requires the FOD to take appropriate steps to ensure detainees with disabilities have an equal opportunity to participate in and benefit from processes and procedure when placed in a holding facility. The ERO Holding Facility Procedures includes the requirements of the directive, the Language Services poster provide instructions for obtaining translation or interpreter services and the Zero-tolerance posters are written in large print text. The DESIGNEE explained that detainees with communication disabilities are informed about PREA via the posters on the doors; the AUDITOR asked about sign language interpreter services and the DESIGNEE stated that it would be provided if needed, though he did not articulate how he would go about obtaining such service. With regard to a detainee who is illiterate or unable to read due to a disability, he stated that the information would be read to the detainee and explained that staff would identify illiteracy while serving

documents to the detainee. The DESIGNEE confirmed that there is no affirmative effort to determine whether a detainee needs an accommodation to read and understand the posted information. The random staff and contractor interviews revealed that there are poster boards with information on sexual abuse and how to report in the Processing Room and in each hold room and that Braille would be used if necessary to accommodate a detainee with blindness; there are no assistive devices at the facility for accommodating detainees with blindness or low vision, but the information would be read to the detainee if necessary. One interviewee stated that once he had to communicate with a detainee with schizophrenia and staff just asked the normal questions; however, if necessary, the detainee would be referred to mental health professionals. He explained that information about a disability would be recorded on the medical sheet which is transported with the detainee. One officer stated that a sign language interpreter would be provided if necessary to communicate with a detainee with hearing impairment. Another interviewee stated that hand signs were used a few weeks ago to communicate with a detainee who is deaf with no-speech, that there are no devices at the facility to assist with communicating with a detainee with a communication disability and the facility does not use audio or video to communicate PREA information, only the PREA posters. The officer indicated that he would notify his supervisor if he believes it is necessary to relay information about a detainee's disability to other staff. During interviews, one detainee told the AUDITOR he did not see well out of one eye, but he was still able to read. The facility did not identify any detainees with communication disabilities to be interviewed. During the tour the AUDITOR noted that the Zero-tolerance poster and the audit notice had large print text.

While the directive and tour observations tend to support a determination of compliance, the fact that detainees with communication disabilities receive PREA information from posters on the doors and there is no evidence that staff take appropriate steps to ensure the information on the Zero-tolerance poster is communicated to them is troubling. The officer who indicated that he or she would read a document to a detainee with limited reading ability was referring to documents being served to the detainee, not to the PREA poster. When asked if any employee talked to them about sexual abuse prevention, a few detainees said "Yes at the sending facility;" none of them reported receiving that information from an employee at the audited facility. If detainees with communication disabilities do not know about the zero-tolerance policy and how to report, PREA would not work for them, as these are the cornerstones to a system where sexual abuse is reported and investigated. Both the standard provision and the directive require staff to take appropriate steps to ensure detainees with disabilities have an equal opportunity to participate and benefit from the agency's efforts to prevent, detect and respond to sexual abuse. To the extent the Zero-tolerance posters are a part of those efforts, if no appropriate steps are taken to ensure detainees with communication disabilities get the message in the posters, the facility is not complying with the mandate of either document. Relying on a detainee with an intellectual or communication disability to read and understand a poster in the hold room does not satisfy the intent of the standard, because the standard places the responsibility on the agency to take appropriate steps to ensure these detainees have an equal opportunity to benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse.

115.116(b)
The PAQ reflects that staff at the facility take reasonable steps to ensure detainees with LEP have meaningful access to all aspects of the agency's efforts to prevent, detect and respond to sexual abuse. The directive requires the FOD to take appropriate steps to ensure detainees with LEP have meaningful access consistent with DHS and ICE policy. The ERO Holding Facility Procedures require translation and interpreter services for detainees with LEP and the ERO Language Services Resource Flyer includes definitions and instructions for accessing translation and interpreter services through the ERO Language Access Resource Center as well as instructions for using Language Services translation or transcription services. In addition to Spanish, the poster tells detainees, in seven other languages, to report sexual assault and provides toll free phone numbers and the name and phone number of the PREA PSA Coordinator. The random staff and contractor interviews revealed that line staff communicate with detainees with LEP often, that there about ten officers who are fluent in Spanish and almost everyone speaks some Spanish and that staff try to identify the language and use Language Services if necessary. One interviewee stated that if he needed to communicate information from written material, he would read the material to the detainee through the interpreter if necessary. If another language is needed, Language Services is used; sometimes an appointment is necessary if there is not an interpreter for the detainee's language at that moment. The AUDITOR is fluent in Spanish and interviewed two detainees with LEP; both detainees indicated that there was no problem communicating with staff and they acknowledged seeing the PREA documents in Spanish. During the tour, the AUDITOR heard deportation officers communicating fluently in Spanish with the two new arrivals and there is a Spanish version of the zero-tolerance Poster and the audit notice in every hold room.

The documents reviewed, the interviews with line staff and detainees, and the observations during the tour support a determination of compliance. There are several officers who are fluent in Spanish; the two LEP detainees were able to communicate effectively with staff; the zero-tolerance poster and the audit notice were provided in Spanish and staff would use Language Services if another language is needed.

115.116(c)
The PAQ reflects that there is a process in place to provide in-person or telephonic interpretation services that enable effective, accurate and impartial interpretation by someone other than another detainee and the process prohibits minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser from serving as interpreters. Directive 11062.2 specifies the language of the standard verbatim. The DESIGNEE stated that an employee who speaks the detainee's language would be used and if there is not an employee who speaks the language, Language Services would be used. With regard to using another detainee, he stated only if the reporting detainee is comfortable with that and he would take into consideration the time available to obtain interpreter services. The AUDITOR asked if there are any detainees that would not be used, and he explained that criminal history, gang affiliation, culture, nationality and religion would be considered. The random staff and contractor interviews revealed that line staff would not use another detainee or a minor to interpret for a detainee about a sexual abuse allegation, in particular if it is a legal matter, if the detainee is a witness or has a close relationship to the reporting detainee (due to conflict of interest). There were no detainees who needed an interpreter to report sexual abuse for the AUDITOR to interview.

The policy supports a compliance determination; however, the interviews with the DESIGNEE and one of the random interviews suggests that additional training on using a detainee as an interpreter in matters relating to allegations of sexual abuse may be appropriate. The facility should provide additional training to staff about using detainees as interpreters in matters related to allegations of sexual abuse. This information is not included in the ERO Holding Facility Procedures.

RECOMMENDED CORRECTIVE ACTIONS

115.116(a) – If facility staff are not taking appropriate steps to ensure detainees with communication disabilities understand written information about the zero-tolerance policy and how to report sexual abuse, the facility should articulate specific steps for employees to take, e.g.: reading the zero-tolerance poster to the detainee with a communication disability as part of the intake process or just telling them about the zero-tolerance policy and how to report.

115.116(b) – No corrective action required.

115.116(c) – No corrective action required.

§115.117 – Hiring and promotion decisions.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Executive Order 10450 - Security Requirements for Government Employment
- United States Criminal Code
- Directive 6-7.0, ICE Personnel Security and Suitability Program
- Directive 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel
- PREA Questionnaire – DHS Employees
- PREA Questionnaire – Contractors
- Office of Personnel Management (OPM) regulations

PEOPLE INTERVIEWED
- None required

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.117(a)
ICE Directive 6-7.0 Personnel Security and Suitability Program includes a list of Personnel Security Investigations and a detailed description of each type. The list includes the National Agency Check (NAC) and the National Agency Check with Inquiries (NACI). The General Investigative Standards specifies that the minimum investigative standard at ICE is the NACI. The NACI includes checks with national and local law enforcement agencies, criminal history fingerprint files, Defense Clearance and Investigations Index, employment checks, personal references, and other sources, as necessary to cover specific areas of a subject's background. The NACI is thorough enough to identify any history of behaviors identified in the standard provision. The agency provided Executive Order 10450 - Security Requirements for Government Employment; this order includes a requirement to determine whether an employee or prospective employee's history includes any criminal, infamous, dishonest, immoral, or notoriously disgraceful conduct, habitual use of intoxicants to excess, drug addiction or sexual perversion. ICE Directive 6-8.0 on Suitability Screening Requirement for Contractor Personnel requires all contractor personnel to be evaluated for suitability for access to ICE facilities, sensitive information and IT resources prior to commencement of any work. The directive provides that the minimum investigation standard for ICE contractor personnel requiring unescorted facility access on a recurring basis will be the NACI. The AUDITOR was not able to review employee or contractor files onsite because the HR Office was closed. During the post audit phase, the AUDITOR learned that employee files at the facility do not include background clearance information and contractor personnel files are not kept at the facility. The AUDITOR established contact with the Chief and Deputy Chief of the agency's Personnel Security Unit (PSU); the Chief explained that background clearances in which prospective employees and contractors are required to complete an Electronic Questionnaire for Investigations Processing or e-QIP include verification that the prospective employee/contractor has not engaged in the sexual misconduct specified in this standard provision. The Chief indicated that he could verify background clearance dates for ICE employees and for contractors and requested a list of the names of the people to be checked. The AUDITOR randomly selected, from the list of facility employees and contractors, the names of (b) (7)(E) ICE employees, including a supervisor, and (b) (7)(E) G4S contract employees, including a supervisor, and provided that list to the Chief. The Deputy Chief later provided pre-employment background clearance dates for all employees and contractors selected, dates last investigations closed and confirmed that criminal check updates were completed for the promotions to supervisory ranks.

The directive and the information received from the PSU support a determination of compliance with the standard provision.

115.117(b)
The agency provided the PREA Questionnaire all prospective employees are required to complete as part of the application process. The Chief of PSU explained that prospective employees must complete security paperwork that addresses criminal conduct, including sexual misconduct, before assuming the duties of any position with the agency. The questionnaire includes the questions prescribed by the standard provision. The PREA Questionnaire for contractors has been in use for several years and the agency started using the questionnaire for employees in January 2018; according to the Chief, the background clearance process has always covered previous sexual misconduct for employee applicants.

The agency's personnel selection process already requires prospective employees and contractors to answer questions about previous sexual misconduct as part of the application process; therefore, it is not part of the interviews for hiring process. The PREA Questionnaires and the explanation from the Chief support a determination of compliance with the standard provision.

115.117(c)
Directive 6-7.0 requires all applicants for a position with ICE to undergo a pre-employment background investigation to determine their suitability for employment. The directive also requires a Single Scope Background Investigation Periodic Reinvestigation which covers five or ten years since the last investigation, depending on the employee's eligibility. The Chief and Deputy Chief verified that five-year background rechecks are done when due and identified, from the list of employees selected at random, the date each of them was cleared to enter on duty and the date the last investigation closed. In one case, an employee was initially cleared for duty in March 2013 and the reinvestigation was scheduled for February 2018 and is ongoing.

The directive and the reporting from the Chief and Deputy Chief support a determination of compliance with the standard provision.

115.117(d)
ICE Directive 6-8.0 requires all contractor personnel to be evaluated for suitability for access to ICE facilities, sensitive information and IT resources prior to commencement of any work. The directive provides that the minimum investigation standard for ICE contractor personnel requiring unescorted facility access on a recurring basis will be the NACI. The Chief and Deputy Chief verified that five-year background rechecks are done when due and identified, from the list of contract employees selected at random, the date each of them was cleared to enter on duty and the date the last investigation closed. None of the contract employees selected at random are due for their first five-year recheck.

The directive and the reporting from the Chief and Deputy Chief support a determination of compliance with the standard provision.

115.117(e)
The agency provided OPM regulations, which specifies that material, intentional false statements, or deception or fraud in examinations or appointment is considered a basis for finding a person unsuitable and taking a suitability action; also, Page 3 of the e-QIP includes a paragraph on "Penalties for False and Inaccurate Statements," that advises prospective and current employees and contractors completing the questionnaire of the penalties for knowingly falsifying or concealing a material fact. The paragraph states that Federal agencies generally fire, do not grant a security clearance, or disqualify individuals who have materially and deliberately falsified these forms, and this remains a part of the permanent record for future placements. United States Criminal Code (title 18, section 1001) provides that knowingly falsifying or concealing a material fact is a felony which may result in fines of up to $10,000, and/or 5 years imprisonment, or both.

The OPM regulations the United States Criminal Code and the e-QIP paragraph support a determination of compliance with the standard provision.

115.117(f)
The PAQ reflects that the agency provides information on substantiated allegations of sexual abuse involving a former employee upon request from an institutional employer for whom the employee has applied for work. The agency did not provide a policy document on this standard provision; the AUDITOR asked about a policy and the facility stated that it is an HR issue, not an operational issue. The AUDITOR contacted the Chief and he stated that release of employee misconduct information to a prospective institutional employer would go through the Chief of Investigative Operations. The AUDITOR contacted that chief and she acknowledged that the information would be released if the prospective employer provides a waiver signed by the employee; however, she believes the PSU would be responsible for that and she was not sure about an agency policy. The AUDITOR contacted the OPR PSA Coordinator and she stated that OPR has not receive any requests from prospective employers about substantiated allegations of sexual abuse involving a former employee and explained that in the event of such request is received, the OPR would coordinate with the Office of the Principal Legal Advisor and the Office of Human Capital in preparing a response to the prospective employer reflecting what is allowed under federal law. She pointed out that the standard does not require a written policy on this issue; thus, it is not referenced in the ICE SAAPI Directive or local OPR policies.

While the standard does not specifically require a written policy, the audit tool calls for reviewing policy regarding this issue. This is standard background investigation activity required under this standard and if there is no policy authorizing release of such information to a prospective institutional employer, it is not clear how designated staff would respond upon receiving such request. The difficulty in receiving a clear response from pertinent offices brings into question the agency's readiness to respond to an actual request from a prospective employer and points to the need for written policy on this matter. The response from the Chief of Investigative Operations supports a determination of compliance with the standard provision; however, THE AUDITOR RECOMMENDS THE AGENCY CONSIDER ISSUING A POLICY TO PROVIDE DIRECTION AND GUIDANCE TO ALL CONCERNED.

RECOMMENDED CORRECTIVE ACTIONS

115.117(a) – No corrective action required.

115.117(b) – No corrective action required.

115.117(c) – No corrective action required.

115.117(d) – No corrective action required.

115.117(e) – No corrective action required.

115.117(f) – No corrective action required.

§115.118 – Upgrades to facilities and technologies.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11087.1

PEOPLE INTERVIEWED
- Designee on Upgrades to the Holding Facility and its Technologies

SITE INSPECTION OBSERVATIONS
- Facility tour

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.118(a)
The PAQ reflects that the facility was acquired by the agency after the May 6, 2014 implementation date of the standards; however, staff clarified in the AUDITOR's Issue Log that the acquisition of the holding rooms pre-date the 2003 enactment of PREA. The PAQ also reflects that there has not been any substantial expansion or modification to the facility since May 6, 2014. The Directive specifies the language of the standard provision requiring the FOD to coordinate with the Office of Facilities Administration in considering the effect any new design, acquisition, expansion or modification would have on the agency's ability to protect detainees from sexual abuse. The DESIGNEE stated that the facility is not a new acquisition and has not been expanded or modified. During the tour of the facility, the AUDITOR did not identify any new construction or modification.

There is no evidence of any expansion or modification to the facility. The documents reviewed, the statement from the DESIGNEE and the tour of the facility support a determination of compliance.

115.118(b)
The PAQ reflects that the facility has not installed or updated its video monitoring system since May 6, 2014. Like Standard Provision (a) above, the Directive requires the FOD to coordinate with the Office of Facilities Administration in considering how any new or updated video monitoring system would enhance the agency's ability to protect detainees from sexual abuse. The DESIGNEE stated that there has not been any new or updated video monitoring or other electronic surveillance system and that the agency/facility is looking at upgrading to a digital camera system with increased storage capacity. During the tour, the AUDITOR did not identify any new surveillance system.

There is no evidence of any new or upgrades to the facility's video monitoring system. The documents reviewed, the statement from the DESIGNEE and the tour of the facility support a determination of compliance.

RECOMMENDED CORRECTIVE ACTIONS

115.118(a) – No corrective action required.

115.118(b) – No corrective action required.

§115.121 – Evidence protocols and forensic medical examinations.
Outcome: Does not Meet Standard (requires corrective action)

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- Directive 11087.1
- Directive 11062.2
- PowerPoint presentation on Introduction to Advanced Forensic Techniques in Crime Scene Investigation
- Email from the designee

PEOPLE INTERVIEWED
- Designee on Providing Forensic Medical Examinations

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.121(a)
Directive 11062.2 lists the agency's uniform protocols that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The agency provided a comprehensive and detailed 136-slide PowerPoint presentation titled "Introduction to Advanced Forensic Techniques in Crime Scene Investigation." This serves as the agency's uniform evidence protocol for responding to and investigating allegations of sexual assault. The facility does not house juveniles; therefore, the requirement for its protocols to be developmentally appropriate for juveniles is mute.

The review of the directive and the PowerPoint support a determination of compliance with the standard provision.

115.121(b)
Directive 11087.1 requires the FOD to coordinate with ERO Headquarters and the ICE PSA Coordinator to ensure that, to the extent available, a qualified member from a community-based organization, provide emotional support, crisis intervention, information and referrals to the victim. The PowerPoint presentation describes the uniform evidence protocol, which includes these services.

The review of the directive and the PowerPoint support a determination of compliance with the standard provision.

115.121(c)
The PAQ reflects that there is a process in place to ensure that where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the agency will arrange for or refer the alleged victim detainee to a medical facility to undergo a forensic medical examination, performed qualified medical personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE). The PowerPoint presentation describes the uniform evidence protocol and include a detailed protocol for sexual assault forensic examinations. The DESIGNEE stated that the holding facility coordinates with OPR; state and local law enforcement transports the detainee to a local hospital as part of their crime scene investigation and if they determine that a forensic medical examination is needed, they would ask for one. The cost of the examination would be borne by the responding agency pursuant to their agreement with the hospital, not by the detainee. She indicated that the protocol for obtaining detainee consent could vary between jurisdictions and she is not sure whether the hospital in Bakersfield uses a form for obtaining detainee consent in writing. To ensure the forensic examination is conducted by qualified medical personnel, including a

SAFE or SANE, the responding law enforcement agency transports the detainee to a community hospital that has a SANE or SAFE on staff, and the detainee is allowed to use available victim advocacy services at the hospital.

The PowerPoint and the interview with the designee support a determination of compliance with the standard provision.

115.121(d)
Directive 11062.2 includes a procedure on "Response and Health Care Services Following and Allegation;" this procedure includes a protocol for referring the victim to service providers including forensic examinations conducted by a SAFE or SANE, as well as coordination with victim advocates to accompany the victim during law enforcement investigations. The PowerPoint presentation includes a segment on offering advocacy services to the victim. The DESIGNEE stated that the detainee is allowed to use victim advocacy services to the extent available at the hospital used by the responding law enforcement agency.

The review of the directive, the PowerPoint presentation and the interview with the designee support a determination of compliance with the standard provision.

115.121(e)
Directive 11062.2 calls for cooperating with outside investigating agencies and endeavoring to remain informed about the progress of the investigation; it does not specifically require the agency to request that the investigating agency follow the requirements of 115.121(a) through (d). The DESIGNEE replied to an email from the AUDITOR asking whether the agency asks outside investigating agencies to follow the requirements of 115.121(a) through (d); she explained that OPR would defer to the state/local agency's evidence protocol for obtaining useable physical evidence using community resources and services to provide crisis intervention and counseling, requesting a forensic examination performed by a SANE or SAFE, and allowing the detainee-victim access to victim advocacy services if available at the hospital.

The directive does not include the requirement of the standard provision to request that an outside investigating agency follow the requirements of the standard and the DESIGNEE'S statement reflects that the practice is to defer to the investigating agency's protocol for obtaining evidence and allowing the detainee victim access to community resources and advocacy services. The standard provision specifically requires the agency to request that an outside investigating agency follow the DHS standards; while there is no mechanism to compel or to ensure that an outside investigating agency follow the standards, there is a requirement to request that they do.

RECOMMENDED CORRECTIVE ACTIONS

115.121(a) – No corrective action required.

115.121(b) – No corrective action required.

115.121(c) – No corrective action required.

115.121(d) – No corrective action required.

115.121(e) – The agency should issue a directive requiring appropriate components to request that outside investigating agencies follow the requirements of 115.121(a) through (d). It would be a good idea for each component to submit these requests in writing and request a written response from the investigating entity; these would allow the components to show compliance with the requirements of the standard provision.

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

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- Directive 6-1.0, dated 02/03/2005 - Functions of the Office of Professional Responsibility (OPR)
- Memorandum dated November 10, 2010, from Deputy Director Pena
- DHS Report of Investigation Continuation
- Immigration Options for Victims of Crimes brochure

PEOPLE INTERVIEWED
- Designee on Referring Sexual Abuse Allegations for Investigation

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.122(a)
The PAQ reflects that the agency established a protocol to ensure that each sexual abuse allegation is investigated. Directive 11062.2 specifies in great detail the agency's sexual abuse investigation protocol. The procedure specifies the responsibilities of the various investigative bodies. The DESIGNEE stated that all sexual abuse allegations are entered into the Sexual Abuse and Assault Prevention and Intervention (SAAPI) notification protocol via SharePoint and the OPR is notified via the ICE Significant Event Notification (SEN) Notification Database. He explained that he

conducts a preliminary investigation and forwards his report to OPR; however, if the allegations are criminal, the police and OPR would investigate them. The facility has not had any sexual abuse allegations for the AUDITOR to review.

The review of the Directive and the designee-interview support a determination of compliance. There has not been an allegation for the AUDITOR to review for compliance with the standard provision.

115.122(b)
The PAQ reflects that the agency's protocol is posted on the website, redacted as appropriate. The Directive specifies the responsibilities of the various managers, offices and investigative agencies. The Directive can be found on the agency's website at https://www.ice.gov/doclib/detention-reform/pdf/saapi2.pdf .

The review of the Directive supports a determination of compliance. There were no allegations of sexual abuse or referrals for the AUDITOR to review for compliance with the standard provision.

115.122(c)
The agency provided Directive 11062.2 and Memorandum dated November 10, 2010, from Deputy Director Pena. The memorandum provides guidelines to all ICE employees on directing complaints appropriately to the Joint Intake Center and the various investigative bodies.

The review of the Directive and the memorandum support a determination of compliance. There were no allegations of sexual abuse or completed investigations for the AUDITOR to review for compliance with the standard provision.

115.122(d)
Directive 11062.2 requires the OPR to submit briefings and provide information to ICE senior management including the PSA Coordinator as part of the investigation of allegations process.

The directive requires notification to the PSA Coordinator as part of the "Investigation of Allegations" process. The standard provision requires prompt notification to the PSA Coordinator; it is not clear whether notification as part of the investigation of allegations constitutes "prompt" notification. That said, it is not clear why the requirement to notify the PSA Coordinator was not included in Subsection 5.7 – Notification and Reporting Following an Allegation. The requirement of the directive supports a determination of compliance with the standard provision. THE AUDITOR RECOMMENDS THE AGENCY REVIEW THIS PROCEDURE TO ENSURE THESE NOTIFICATIONS ARE DONE "PROMPTLY."

115.122(e)
The agency provided Page 3 of the DHS Report of Investigation Continuation; this form requests U Visa information. Additionally, a brochure titled "Immigration Options for Victims of Crimes" provides information about the Violence Against Women Act, U Non-immigrant Status and T Non-immigrant Status. The Sexual Abuse/Assault Verification Checklist, calls for coordinating with appropriate ICE entities for a U nonimmigrant status visa. Directive 11062.2 requires coordination for U visa in criminal cases.

The review of the DHS Report of Investigation Continuation, the Immigration Options for Victims of Crimes and the Sexual Abuse/Assault Verification Checklist supports a determination of compliance with the standard because they provide timely access to information about the U nonimmigrant status.

RECOMMENDED CORRECTIVE ACTIONS

115.122(a) – No corrective action required.

115.122(b) – No corrective action required.

115.122(c) – No corrective action required.

115.122(d) – No corrective action required.

115.122(e) – No corrective action required.

§115.131 – Employee, contractor and volunteer training.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- PowerPoint Presentation (employees)
- PowerPoint Presentation (contractors)
- Certificates of completion (ICE employees)
- Certificates of completion (G4S officers)
- ICE Employee Training Records
- Examples of refresher information provided to Hold Rooms

PEOPLE INTERVIEWED
- ICE PSA Coordinator
- Designee on Contractor and Volunteer Training on Sexual Abuse
- Random Sample of Staff and Contractors

SITE INSPECTION OBSERVATIONS

- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.131(a)
The PAQ reflects that all employees and contractors have been trained to fulfill their duties under the standards and that the training included information on the eight topics prescribed under 115.131(a). Directive 11062.2 specifies the agency's policy that requires the training prescribed by the standard provision in addition to other relevant topics. The training is mandated for employees, contractors and volunteers. The agency submitted two PowerPoint presentations, one for employees and the other for contractors and volunteers. The AUDITOR reviewed both presentations and determined that all eight topics prescribed by the standard provision are covered in both presentations. The supervisor at the facility provided a binder with training records; the training records included certificates of completion for all ICE and G4S employees reflecting that ICE employees completed the online PREA Training and that G4S employees completed the PREA Training for Contractors. The DESIGNEE explained that G4S personnel received online training through PALMS and a PowerPoint presentation, verified that each of the eight topics prescribed by the standard provision was included in the training and provided explanations and/examples for each topic. The random staff/contractor interviews indicate that employees completed the online training and received a certificate of completion after passing an examination. Interviewees verified that all eight topics prescribed by the standard provision were included and provided explanations and/or examples for each. One interviewee added that he receives training on a regular basis during the morning briefings. The ICE PSA Coordinator stated that employees have been trained within two years of implementation, refresher information has been broadcasted to holding facilities and her office is working on getting an agency-wide refresher training out to the field. She provided Directive 11087.1 and a written broadcast sent to FODs Deputy FODs and AFODs on March 8, 2017, as samples of refresher information provided to holding facilities. The broadcast provides information on Enhanced Guidance – Significant Event Notification Reporting for Allegations of Sexual Assault or Abuse Incidents.

The review of the directive, the two PowerPoint presentations, the certificates of completion and the staff interviews support a determination of compliance with the standard provision.

115.131(b)
The PAQ reflects that all current employees and contractors received training and refresher information, as appropriate. Directive 11062.2 requires all employees to be trained by May 1, 2015 and biennial refresher training thereafter. The agency provided two spreadsheets, each with (b) (7)(E) of employee training records reflecting that the employees completed, started or had not started training on SAAPI. The records do not specify whether they are records for initial or for refresher training. The AUDITOR searched records for (b) (7) of the (b) (7) ICE employees at the facility and only one completed the training within the last two years; the others completed the training in 2013 or 2014. The AUDITOR notes that the agency/facility submitted these records as documents for this standard provision on refresher training. The random staff/contractor interviews revealed that line staff receives additional refresher training about sexual abuse annually through PALMS. One interviewee could not articulate the title of the course but asserted that it was a PREA course and he received that training most recently about three months ago.

The standard provision requires training within two years of the effective date of the standards and refresher information as appropriate. The Directive requires biennial refresher training, which appears to exceed the requirement of the standard provision. The examples of refresher information provided to holding facilities and the random sample of staff/contractor interviews support a determination of compliance with the standard provision.

115.131(c)
The PAQ reflects that Headquarters and the facility retain training records for at least five years. The certificates of completion are evidence that training records are retained, and the two spreadsheets include training dates that go back at least five years. If supervisors are providing refresher training regularly and not documenting it, the facility could develop some form of participant sign-in sheet to document the training and forward it to the custodian of employee training records.

The PAQ and review of training records support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.131(a) – No corrective action required.

115.131(b) – No corrective action required.

115.131(c) – No corrective action required.

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

POLICIES AND OTHER DOCUMENTS REVIEWED
- The PAQ
- The agency's zero-tolerance poster
- Sexual Assault Awareness Poster

PEOPLE INTERVIEWED
- Designee on Providing Information about the Zero-tolerance Policy to Detainees
- Random Sample of Staff and Contractors
- Random Sample of Detainees

SITE INSPECTION OBSERVATIONS
- Zero-tolerance posters on wall in hold rooms

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

The PAQ reflects that the agency's zero-tolerance policy is available to the public and key information about the policy is visible or continuously and readily available to detainees at the facility. The zero-tolerance poster includes key information about the policy and the Sexual Assault Awareness poster provides key information to detainees about sexual abuse, how to report and the expected response to reports of sexual assault. The DESIGNEE stated that the facility provides information about the zero-tolerance policy through the posters in the hold rooms; the detainee handbook is issued at processing facilities and there is no use of audio or video for this purpose at the facility. The random staff/contractor interviews revealed that the facility informs detainees about the zero-tolerance policy through the poster boards in the Processing Room and hold rooms, the posters are checked daily and replaced if necessary and no other written material is provided at this facility. Only one of the detainees interviewed stated that he saw the sexual abuse information poster on the wall; three said they received information at Taft (sending facility) and one said he did not focus on the documents on the wall. The information is posted in a language the detainees understand. During the inspection tour, the AUDITOR verified that the zero-tolerance posters were on the wall in every hold room. The facility does not issue the PREA information brochure to detainees and the AFOD agreed to post the Sexual Assault Awareness poster in all hold rooms after the AUDITOR asked about it during the post audit phase.

The documents reviewed, the interviews with staff and detainees, and the inspection tour support a determination of compliance with the standard provision. THE AUDITOR RECOMMENDS THE FACILITY ALERT ALL DETAINEES ABOUT THE TWO PREA POSTERS UPON ARRIVAL AND ENSURE THEY UNDERSTAND THE INFORMATION PROVIDED. This would ensure all detainees are informed about the zero-tolerance policy and how to report sexual abuse. The posters on the wall do not guarantee that all detainees will be informed because some detainees may not read information posted on the walls.

RECOMMENDED CORRECTIVE ACTIONS

115.132(a) – No corrective action required.

§115.134 – Specialized training: Investigations.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- Directive 11062.2
- Qualified Investigator Definition & Qualifications for FY 2016 – 2017
- Seven PowerPoint presentations
- Specialized Sexual Abuse and Assault Training for ERO Personnel (sign-in sheet Jan 9 – 10, 2017)
- Specialized Sexual Abuse and Assault Training for ERO Personnel (course schedule and description Jan 9 – 12, 2017)

PEOPLE INTERVIEWED
- None required

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.134(a)
Directive 11062.2 specifies the agency's policy that requires the specialized training prescribed by the standard provision for OPR Investigators. The directive calls for the training to cover interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The agency provided the matrix for Qualified Investigator Definition & Qualifications for FY 2016 – 2017, which lists the various types of investigators, a definition for "Qualified," scope/capabilities, qualifications, frequency of training, training format and duration of training. The course schedule and description reflect that the Specialized Sexual Abuse and Assault Training for ERO Personnel was a two-day course for OPR and ERO investigators that covered a variety of relevant topics, including Lessons learned through positive PREA outcomes, Legal issues, Trauma-informed interviewing, etc. The sign-in sheet reflects that there were approximately (b) (7)(attendees. The agency also provided approximately six PowerPoint presentations on specialized investigator training.

The directive, the review of the various training curricula and the training records identified above support a determination of compliance with the standard provision. The agency is serious about training for sexual abuse investigators; the curriculum is extensive and specialized training was provided as recently as January 2017 with (b) (7)(investigators in attendance.

115.134(b)
The sign-in sheets identified above is evidence that the agency maintains written documentation verifying specialized training provided to investigators.

The review of the sign-in sheets supports a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.134(a) – No corrective action required.

115.134(b) – No corrective action required.

§115.141 – Assessment for risk of victimization and abusiveness.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11087.1
- Custody Classification Worksheet
- Risk Classification Assessment (RCA) printout
- 12 Printouts

PEOPLE INTERVIEWED
- Designee on Detainee Risk Assessments
- Random Sample of Staff and Contractors
- Random Sample of Detainees

SITE INSPECTION OBSERVATIONS
- Impromptu questions of staff in Processing Room

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.141(a)
The PAQ reflects that before placing any detainees together, staff considers whether, based on the information before them, a detainee may be at a high risk of being sexually abused. Directive 11087.1 requires the FOD to ensure that before placing detainees together in a hold room, there shall be consideration of whether a detainee may be at a high risk of being sexually abused or assaulted, and, when appropriate, staff shall take necessary steps to mitigate any such danger to the detainee. The directive also calls for assessing detainees for risk of being sexually abuse or sexually abusive to other detainees in cases where detainees may be held overnight. The DESIGNEE stated that initially staff know where the detainee is coming from, sexual orientation criminal history, etc. He explained that staff conduct risk assessments to determine whether the detainees is vulnerable to sexual abuse or is likely to be abusive to other detainees and that detainees with victimization concerns are asked if they need protection; he added that the assessments are done upon arrival because staff need to identify potential victims and potential predators and ERO Officers enter information into RCA as soon as the detainee arrives at the facility, and the supervisor approves the entry. The information is obtained from the detainee, from agency records and from criminal records. The random sample of staff/contractor interviews revealed that criminal convictions, particularly sex crimes, are considered and a detainee is placed in a single cell if there are concerns about sexual safety. To identify safety concerns, officers conduct a search of relevant criminal history databases, and information from facilities where the detainee has been housed, as well as information in the paper file is considered before placing the detainee in a hold room with other detainees. Three detainees arrived from Taft and stated that they were asked risk screening questions there; the other three were picked-up as part of the ongoing Fugitive Operations and indicated that they were asked where they were from, their age, criminal history, etc. at the site where they were arrested. During the site inspection, the AUDITOR witnessed the interviews of two new arrivals; the ICE officers spoke to them in Spanish before they were assigned to a hold room. The AUDITOR asked about the risk screening process and staff explained that the arresting officers ask the relevant questions at the arresting site and the information is already known when the detainee arrives at the facility.

The review of the directive, the sample RCA printout, interviews of staff and detainees, and observations during the inspection tour support a determination of compliance with the standard provision.

115.141(b)
The PAQ reflects that detainees who may be held with other detainees are assessed for risk of sexual victimization and abusiveness and are asked about concerns for their physical safety. Directive 11087.1 requires the FOD to ensure that detainees who may be held overnight with other detainees are assessed to determine their risk of being sexually abused or sexually abusive, to include asking detainees about their concerns for their physical safety. Part 2. of the Custody Classification Worksheet includes an assessment of detainee vulnerability and other management concerns that may affect the custody decision. The DESIGNEE stated that risk assessments are done on a daily basis when detainees arrive at the facility because "we need to identify those who are potential victims and those who are potential predators," and detainees with victimization concerns are offered protection. The random staff/contractor interviews revealed that criminal convictions, particularly sex crimes, are considered and a detainee is placed in a single cell if there are concerns about sexual safety. To identify safety concerns, officers conduct a search of relevant criminal history databases and information from facilities where the detainee has been housed and information in the paper file is considered before placing the detainee in a hold room with other detainees. None of the detainees interviewed were identified as having victimization or abusiveness concerns and while some detainees were arrested during early hours of the morning as part of the ongoing Fugitive Operations, none of them were held overnight.

The review of the directive, the vulnerability assessment on the classification worksheet, and the random staff/contractor and detainee interviews support a finding of compliance with the standard provision.

115.141(c)
The PAQ reflects that assessments for risk of sexual victimization include all nine factors prescribed by the standard provision. Directive 11087.1 requires the FOD to ensure detainees are screened for risk of sexual victimization or abusiveness towards other detainees. The directive lists all nine criteria prescribed by the standard provision. Staff provided a blank copy of the ICE Custody Classification Worksheet; in addition to the nine considerations prescribed by the standard provision, the worksheet considers supervision history, security threat, history of violence and disciplinary history involving violent behavior in a facility. The DESIGNEE articulated a variety of actions the facility takes when considering each of the nine factors prescribed by the standard provision, including relying on the screening from Mesa Verde, using background check information, separating the detainee, interviewing the detainee, etc. The random staff/contractor interviews revealed that there is a classification worksheet that is used at processing facilities, but not at this facility because detainees are there for only a few hours during the day. The three detainees arrested during

the Fugitive Operations indicated that they were asked questions such as: age, marital status, how long in the country, country of origin, arrest history, etc.

While the directive and the classification worksheet appear to support a determination of compliance, some of the random staff/contractor and detainee interviews and the AUDITOR's interactions with staff do not. The AUDITOR asked several times for detainee screening records and the facility only provided a blank classification worksheet, an RCA printout with information for one detainee, and 12 printouts submitted as evidence that risk screening was done, though there was no detainee identifying information on those printouts. The only document the AUDITOR was allowed to keep is the blank worksheet. The interviews do not support a determination that the facility considers the nine factors prescribed by the standard provision when assessing a detainee's risk of sexual victimization. The three detainees who were arrested as part of the Fugitive Operations shared some of the questions asked of them at the time of their arrests, and most of those questions are not consistent with probing for information related to the nine consideration factors prescribed by the standard provision; additionally, the random staff/contractor interviews revealed that the classification worksheet is not used at the facility. If the facility is using the classification worksheet, all worksheets completed during the audit period must be produced for inspection. If detainee screening information is entered into the RCA system, staff should produce RCA printouts for the audit period showing that the screening was done consistently or allow the AUDITOR to view the RCA system. The AUDITOR recognizes that detainees are at the facility for a very short period and are not held overnight; however, neither the standards nor the directive include this an exception to the risk assessment required under 115.141(c). Staff may be considering some of the criteria prescribed, but if it is not documented and the facility is unable to show that the 115.141(c) criteria are considered when assessing every detainee's risk of sexual victimization, the facility's practice does not meet the requirement of the standard provision.

115.141(d)
The PAQ reflects that there is a process in place to provide heightened protection to detainees identified as being at high risk of victimization. Directive 11087.1 requires the FOD to ensure that detainees identified as being at high risk of victimization are provided with heightened protection, to include continuous direct sight and sound supervision, single-cell housing, or placement in a cell actively monitored on video by a staff member sufficiently proximate to intervene, unless no such option is determined to be feasible. The DESIGNEE acknowledged using all three methods listed in the interview protocol for providing heightened protection to a detainee who is at high risk of sexual victimization; he also added interviewing the detainee to determine the best facility for holding and referring to mental health professionals. He asserted that the facility has always been able to provide protection, including by using Hold Room #8, which is separated from all others and can be monitored directly from the Control Room. The random staff/contractor interviews revealed that a detainee at high risk of sexual victimization would be isolated immediately. The facility did not identify a detainee at risk of sexual victimization for the AUDITOR to interview.

The directive and interviews with staff support a determination of compliance; however, the standard provision is specific about identifying detainees at high risk of sexual victimization pursuant to the assessment under this section, meaning the risk assessment required under 115.141(c). Since the facility did not demonstrate that detainee assessments for risk of sexual victimization include the considerations prescribed under 115.141(c), a determination of compliance is not supported.

115.141(e)
The PAQ reflects that the facility implemented appropriate controls to prevent dissemination of sensitive detainee risk assessment information. Directive 11087.1 requires the FOD to implement appropriate controls on the dissemination of sensitive detainee screening information. The DESIGNEE stated that all information is treated as sensitive and G4S officers have access to the same detainee information as ICE Officers. The random staff/contractor interviews revealed that sensitive detainee risk screening information is shared only with those who need to know. During the inspection tour, the AUDITOR identified four uncontrolled detainee files on the counter in the Processing Room while detainees were out on the floor. The AUDITOR asked for permission and was allowed to view the content of all four files.

The directive and the interviews with staff tend to support a determination of compliance with the standard provision; however, no material evidence of the controls purported, in the PAQ, to have been implemented were provided to demonstrate compliance. Also, although not accessed by a detainee or any other unauthorized person, the four unsupervised files on the counter in the Control Room while detainees were present does not help to support the assertion that appropriate controls have been implemented. If the files were not in use, they could have been held in a location where they were out of sight, maybe under the counter.

RECOMMENDED CORRECTIVE ACTIONS

115.141(a) – No corrective action required.

115.141(b) – No corrective action required.

115.141(c) – If detainee assessments for risk of sexual victimization and abusiveness include consideration of the criteria prescribed in 115.141(c), the facility must find a way to demonstrate compliance. If the facility is not considering the criteria prescribe in 115.141(c), it must develop a methodology for considering that criteria when assessing a detainee's risk of sexual victimization. The facility shall ensure all applicable personnel is trained on the new screening methodology and provide the training records to demonstrate that training was provided. Additionally, the facility must be prepared to produce detainee screening records to demonstrate compliance with the standard provision.

115.141(d) – Upon implementing a methodology for assessing a detainee's risk of sexual victimization that includes consideration of the criteria prescribed in 115.141(c), any detainee identified as being at high risk of victimization would have been identified pursuant to the assessment under this section, thus bringing the facility into compliance with this standard provision.

115.141(e) – If the facility implemented appropriate controls to prevent dissemination of sensitive detainee screening information, it must provide material evidence of those controls. If appropriate controls have not been implemented, the facility shall implement such controls and provide material evidence of those controls, as well as records of training provided to applicable personnel.

§115.151 – Detainee reporting.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11087.1
- Zero-tolerance poster

PEOPLE INTERVIEWED
- Designee on Detainee Reporting of Sexual Abuse
- Random Sample of Staff and Contractors
- Random Sample of Detainees

SITE INSPECTION OBSERVATIONS
- Zero-tolerance posters

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.151(a)
The PAQ reflects that the facility provides detainees information about multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to sexual abuse. Directive 11087.1 requires the FOD to ensure detainees are provided instruction on how they can privately report incidents of sexual abuse or assault, retaliation for reporting sexual abuse or assault, or staff neglect or violation of responsibilities that may have contributed to such incident to ERO personnel. The Zero-Tolerance poster includes a toll-free number for reporting cases of sexual abuse or assault to the DHS Inspector General; the poster tells detainees that they can call anonymously. The DESIGNEE identified multiple ways for detainees to report sexual abuse, including verbally, in writing, anonymously, through a third party, using the hotline, etc. and stated that detainees are informed of methods of reporting sexual abuse verbally and through posters. The Random Sample of Staff and Contractors interviews revealed multiple ways for detainees to report sexual abuse, including verbally, in writing, asking to speak to a supervisor, calling the hotline, sending a note to staff, or calling the JIC or the facility's PSA Coordinator. Only one of six detainees interviewed reported seeing information about how to report sexual abuse and it was in a language he could understand. The others did not see any such information; one of them said he did not focus on any postings on the wall. During the site inspection, the AUDITOR identified the zero-tolerance poster in the Processing Room and in each of the eight hold rooms; the poster tells detainees to report sexual abuse to a staff person, an ICE official or to call the toll-free numbers on the poster which includes the ICE Detention Reporting and Information Line (DRIL Line) and the DHS Inspector General.

The directive, the interviews with staff and the AUDITOR's observations during the inspection tour support a determination of compliance. Detainees are provided multiple ways to report sexual abuse including by placing a call to the Inspector General.

115.151(b)
The PAQ reflects that detainees receive instructions on how to contact the Inspector General or other office to report sexual abuse confidentially or anonymously. Directive 11087.1 requires the FOD to ensure detainees are provided instructions on how to contact the DHS/OIG (or, as appropriate, another public or private entity which can receive, and immediately forward detainees reports of sexual abuse or assault to agency officials) to confidentially and, if desired, anonymously, report these incidents. The Zero-Tolerance poster only provides numbers for the ICE DRIL Line and the DHS OIG. Neither the designee nor the random staff/contractor interviews identified a way for detainees to report sexual abuse to a public or private entity or office that is not part of the agency.

While the directive supports a determination of compliance, the interviews and the zero-tolerance poster do not. The poster provides the number for the DHS Inspector General but does not identify that office as an entity that is not part of the agency. The requirement to have an outside agency is for the benefit of detainees, not the agency. If detainees see DHS Inspector General, they have no reason to believe it is not part of the agency. The agency must make the case to the detainees that they would be reporting to an entity that is not part of the agency, otherwise detainees would be justified if they fail to report for fear of retaliation. The AUDITOR identified the Alliance Against Family Violence and Sexual Assault as a private entity that is not part of the agency and could provide the service required by the standard provision. The AFOD stated that he would contact the Alliance Against Family Violence and Sexual Assault to make the necessary arrangements.

115.151(c)
The PAQ reflects that there is a process in place for staff to accept allegations made verbally, in writing, anonymously and from third parties and promptly document verbal allegations. Directive 11087.1 requires the FOD to ensure staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports. The random sample of staff/contractor interviews revealed that staff and contractors accept allegations made through any of the reporting methods and promptly document verbal allegations.

The directive and staff interviews support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.151(a) – No corrective action required.

115.151(b) – If not yet in place, the facility shall provide a way for detainees to report sexual abuse to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous upon request. The facility shall identify how it will informing detainees of this new reporting option.

115.151(c) – No corrective action required.

§115.154 – Third-party reporting.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- Directive 11087.1
- ICE website

PEOPLE INTERVIEWED
- None required

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.154
The PAQ reflects that the facility has a process in place for receiving third-party allegations of detainee sexual abuse and that the agency informs the public how to report sexual abuse on behalf of detainees. Neither Directive 11062.2 nor 11087.1 include a policy on receiving third-party reports of sexual abuse or telling the public how to report sexual abuse on behalf of a detainee. The AUDITOR verified that the agency's website at https://www.ice.gov/contact/deteniton-information-line includes a link to the ICE DRIL Line flyer; the flyer provides a toll-free number and information for stakeholders who wish to report sexual abuse of detainees in ICE custody. The AUDITOR called the number, spoke with a representative who verified that detainees and third parties can report a case of sexual abuse of detainees in ICE custody by calling that number.

Although the directives do not include a policy on receiving third-party reports of sexual abuse or telling the public how to report sexual abuse on behalf of a detainee, the agency's website and the call to the DRIL Line support a determination of compliance. The standard only requires the agency to establish a method, which is satisfied by the website; the standard does not require a policy.

RECOMMENDED CORRECTIVE ACTIONS

115.154 – No corrective action required.

§115.161 – Staff reporting duties.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- Deputy Director Memorandum dated November 10, 2010

PEOPLE INTERVIEWED
- Designee on Staff Reporting Duties
- Random Sample of Staff and Contractors

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.161(a)
The PAQ reflects that there is a process in place to ensure that staff report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding:
- An allegation of sexual abuse that occurred to any detainee
- Retaliation against detainees or staff who reported or participated in an investigation about a sexual abuse allegation; and
- Any staff neglect or violation of responsibilities that may have contributed to sexual abuse or retaliation

Directive 11062.2 requires all ICE employees to immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The November 10, 2010-Memorandum requires employees to report allegations of misconduct to the JIC, OPR or OIG and specifically includes "physical or sexual abuse of a detainee or anyone else" among examples of reportable misconduct. Interviews of the designee and the random sample of staff/contractors reveal that staff are aware of their obligation to immediately report allegations of sexual abuse of a detainee, retaliation and staff neglect that may have contributed to sexual abuse or retaliation. The DESIGNEE identified the JIC and the OIG as methods for staff to report misconduct outside of their chain of command. The facility did not have any sexual abuse allegations for the AUDITOR to review.

The directive, the Memorandum and staff interviews support a determination of compliance with the standard provision.

115.161(b)
The PAQ reflects that staff who become aware of an allegation of sexual abuse immediately follow the reporting requirements set forth in the agency's written policy. Directive 11062.2 requires all ICE employees to report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The November 10, 2010-Memorandum requires employees to report allegations of misconduct to the JIC, OPR or OIG and specifically includes "physical or sexual abuse of a detainee or anyone else" among examples of reportable misconduct. While the designee articulated the requirement to report sexual abuse to the JIC, the random sample of staff/contractor interviews reveal that staff may not be aware of their responsibility to report sexual abuse of a detainee directly to the JIC, OPR or OIG pursuant to the memorandum.

As it relates to reporting sexual abuse of a detainee, there are two agency policy documents with directions that could be confusing to some. The directive requires staff to report sexual abuse to their supervisor or a designated official; some employees believe their reporting responsibilities are satisfied by reporting the allegation to their supervisor. However, the Memorandum specifies that "Employees must report to the JIC, OPR, or OIG allegations of misconduct…" The memorandum requires employees to report serious misconduct to the JIC, OPR or OIG and provides examples of such serious misconduct; the memorandum then goes-on to address reporting of misconduct of a lesser nature that are appropriately reported to local management. With both policy documents in place, it is important for staff to understand these distinctions and recognize that in addition to reporting sexual abuse of a detainee to their supervisor, they must also report it to the JIC, OPR or OIG. The memorandum specifically requires employees to report these incidents; it does not specify whether the supervisor may report to the JIC, OPR or OIG on the employee's behalf. IF THE EXPECTATION IS FOR EMPLOYEES TO PERSONALLY REPORT THESE INCIDENTS AS SPECIFIED IN THE MEMORANDUM, THIS SHOULD BE REINFORCED DURING EMPLOYEE TRAINING OR IN WRITING.

115.161(c)
The PAQ reflects that apart from reporting, staff does refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions. Directive 11062.2 specifies that ICE employees shall not reveal any information related to a sexual abuse or assault allegation to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff, or to make medical treatment, investigation, law enforcement, or other security and management decisions. The DESIGNEE stated that due to privacy, staff know not to discuss allegations outside of the chain of command and people who need to know. The random sample of staff/contractor interviews reveal that staff are generally aware of their responsibility to limit information related to a sexual abuse report to those who need to know.

The directive and the staff interviews support a determination of compliance with the standard provision.

115.161(d)
The PAQ does not include a response for this standard provision. Directive 11062.2 requires consultation with the relevant Office of the Principal Legal Advisor (OPLA) or the Office of Chief Counsel (OCC) if the detainee is determined to be a vulnerable adult under State or local statute and requires staff to report the allegation to the designated State or local services agency as necessary under applicable mandatory reporting laws and document their efforts. The DESIGNEE did not identify this reporting requirement and the facility has not had any allegations of sexual abuse.

The directive and the staff interview support a determination of compliance. The facility could reinforce this reporting requirement during staff training.

RECOMMENDED CORRECTIVE ACTIONS

115.161(a) – No corrective action required.

115.161(b) – No corrective action required.

115.161(c) – No corrective action required.

115.161(d) – No corrective action required.

§115.162 – Agency protection duties.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2

PEOPLE INTERVIEWED
- Random Sample of Staff and Contractors

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.162

The PAQ reflects that there is a process in place to ensure employees take immediate action to protect a detainee when it is believed that a detainee is subject to a substantial risk of imminent sexual abuse. Directive 11062.2 requires an ICE employee to take immediate action to protect a detainee if the employee has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse or assault. The random sample of staff/contractor interviews reveal that staff would take immediate action to protect a detainee believed to be at substantial risk of imminent sexual abuse or assault; namely, staff would isolate the detainee. The facility did not have any sexual abuse investigations or allegations for the AUDITOR to review.

The directive and staff interviews support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.162 – No corrective action required.

§115.163 – Report to other confinement facilities.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2

PEOPLE INTERVIEWED
- Designee on Receiving Allegations from, and Reporting to, Other Confinement Facilities
-

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.163(a)
The PAQ reflects that there is a process in place to ensure notification of the appropriate office of the agency or administrator of the facility where the alleged abuse occurred, in cases where staff receive an allegation that a detainee was sexually abused at another facility. Directive 110.62.2 requires notification of the administrator of the facility where the assault is alleged to have occurred as soon as possible, but no later than 72 hours after receiving the notification. The DESIGNEE stated that it would be reported to the appropriate office of the agency or facility. The facility has not had any such allegation; therefore, there is no documentation of a notification to review for compliance.

The directive and the designee interview support a determination of compliance with the standard provision, though the designee could be more specific about notifying the administrator of the facility.

115.163(b)
The PAQ reflects that there is a process in place to ensure the notification takes place as soon as possible but no later than 72 hours after receiving the notification. The directive requires the same notification timeframe. The DESIGNEE stated as soon as possible but was not sure about the timeframe.

The directive and the designee interview support a determination of compliance with the standard provision. IF NOT YET IN PLACE, THE AUDITOR RECOMMENDS THAT THE AGENCY/FACILITY DEVELOP A TEMPLATE OR FORM LETTER FOR THIS TYPE OF NOTIFICATION; THIS COULD SERVE AS A JOB-AID FOR STAFF IN THE FIELD AND PROMOTE CONSISTENCY IN THE PRACTICE.

115.163(c)
The PAQ reflects that there is a process in place to ensure this notification is documented. Directive 11062.2 requires staff to document the notification as well as their efforts. The facility has not had any allegations of sexual abuse; therefore, there is no documentation to review for compliance with the standard provision.

The standard provision only requires documentation of such notifications. Since the standard provision does not specifically require a process, the audit determination cannot be based upon whether the facility has a process, but whether the facility documents such notifications. The directive supports a determination of compliance with the standard provision. THE AUDITOR RECOMMENDS THE FACILITY DEVELOP A FORM LETTER AND PROVIDE TRAINING TO APPLICABLE STAFF TO ENSURE THE A PROCEDURE IS INSTITUTIONALIZED.

115.163(d)
The PAQ reflects that there is a process in place to ensure the allegation is referred for investigation when the holding facility receives notification from another facility that a detainee was sexually abused while at the holding facility. Directive 11062.2 requires the special agent in charge to ensure notification to the appropriate law enforcement agency having jurisdiction over the investigation of the alleged sexual abuse or assault or notify them directly if necessary. The DESIGNEE stated that he would notify the FOD, the local Police Department, and the JIC and refer the allegation to investigators.

The directive and the designee interview support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.163(a) – No corrective action required.

115.163(b) – No corrective action required.

115.163(c) – No corrective action required.

115.163(d) – No corrective action required.

§115.164 – Responder duties.
Outcome: Does not Meet Standard (requires corrective action)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11087.1

PEOPLE INTERVIEWED
- Designee on First Responder Duties to a Sexual Abuse Allegation
- Random Sample of Staff and Contractors

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.164(a)
The PAQ reflects that there is a process in place to ensure that the first law enforcement officer to respond:

1. Separate the alleged victim and abuser;
2. Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence;
3. If the sexual abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
4. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

Directive 11087.1 specifies first responder duties and all four steps prescribe by the standard provision are included. When asked about the first responder steps, the DESIGNEE listed the first two and added interviewing the victim, calling for medical response, notifying the FOD and starting the investigation. The random sample of staff/contractor interviewees were only able to list the first two steps as well.

While the directive supports a determination of compliance with the standard provision, the staff interviews do not. The officers seem to remember the first two steps but had a difficult time with the last two. During the exit briefing, the OPR Team Lead provided a card with the four steps listed to the designee to make copies and distribute to law enforcement staff at the facility. This card could serve as a job-aid for officers serving as first responder to an actual case of sexual assault.

115.164(b)
The PAQ reflects that there is a process in place to ensure that non-sworn first responders request that the alleged victim not take any actions that could destroy physical evidence and then notify law enforcement staff. Directive 11087.1 specifies the language of the standard verbatim. The DESIGNEE identified only the second step and pointed out that only law enforcement staff at the facility has contact with detainees. The random sample of staff/contractor interviewees were about 50% correct.

The directive supports a determination of compliance with the standard provision. The AUDITOR recognizes that only law enforcement staff at the facility have contact with detainees; therefore, the applicability of this standard provision is not likely.

RECOMMENDED CORRECTIVE ACTIONS

115.164(a) – The facility should either provide additional training or issue a job-aid to all potential first responders to ensure staff are prepared to perform first responder duties in the event of an actual case of sexual abuse.

115.164(b) – No corrective action required.

§115.165 – Coordinated response.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11087.1

PEOPLE INTERVIEWED
- Designee on the Facility's Coordinated, Multidisciplinary Response to Sexual Abuse

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.165(a)
The PAQ reflects that there is a process in place to ensure the use of a coordinated, multidisciplinary team approach when responding to sexual abuse. Directive 11087.1 specifies the agency's written institutional plan for a coordinated, multidisciplinary team approach to responding to sexual abuse. The plan specifies responsibilities of the FOD, first responding officer, first responding staff member if not an officer, medical and mental health professionals, forensic medical examiners and sexual assault incident reviewers. When asked to describe communication and coordination methods among various staff first responders to an actual case of sexual assault, the DESIGNEE listed phone calls, verbal communication, emails and quick response.

The directive provides a detailed coordinated multidisciplinary institutional response plan that supports a determination of compliance with the standard provision; however, the staff interview suggests there could be additional training to ensure staff are prepared in the event of an actual case of sexual assault at the facility. The facility could consider disseminating the response plan among all staff who would be involved in a coordinated multidisciplinary response to ensure it is available for routine review. Supervisors could discuss the plan periodically with staff to ensure the plan remains fresh in everyone's memory.

115.165(b)
The PAQ reflects that there is a process in place to ensure staff informs the receiving facility of the incident and the victim's potential need for medical or social services, in the event the facility transfers a victim of sexual abuse to a DHS facility. Directive 11062.2 calls for the FOD to ensure that, as permitted by law, the receiving facility is informed of the incident and the victim's potential need for medical or mental health care or victim services (unless, in the case of transfer to a non-ICE facility, the victim requests otherwise). The DESIGNEE stated that he would provide the receiving facility information about the allegation and the victim's potential need for medical services and that information would be transmitted verbally and through the medical records. The facility has not had to transfer a victim to another facility; therefore, there is no documentation to review for compliance with the standard provision.

The directive and the staff interview support a determination of compliance with the standard provision.

115.165(c)
The PAQ reflects that there is a process in place to ensure staff informs the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise), in the event the facility transfers a victim of sexual abuse to a non-DHS facility. Directive 11062.2 calls for the FOD to ensure that, as permitted by law, the receiving facility is informed of the incident and the victim's potential need for medical or mental health care or victim services (unless, in the case of transfer to a non-ICE facility, the victim requests otherwise). The DESIGNEE was not sure about the requirement to inform a non-DHS receiving facility of the incident and the victim's potential need for medical or social services but is inclined to respect the victim's wishes.

The directive supports a determination of compliance with the standard provision; however, the staff interview suggests there could me additional training on the subject to ensure staff are prepared to respond according to the standard provision and agency policy.

RECOMMENDED CORRECTIVE ACTIONS

115.165(a) – No corrective action required.

115.165(b) – No corrective action required.

115.165(c) – No corrective action required.

§115.166 – Protection of detainees from contact with alleged abusers.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2

PEOPLE INTERVIEWED
- Designee on Protecting Detainees from Contact with Alleged Abusers

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.166
The PAQ reflects that there is a process in place to remove any employee or contractor alleged to have perpetrated sexual abuse from duties requiring detainee contact if agency management deems it appropriate. Directive 11062.2 requires the FOD to ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties involving detainee contact pending the outcome of an investigation. The DESIGNEE stated that the facility would remove an employee or contractor suspected of perpetrating sexual abuse from duties involving contact with detainees.

The directive and staff interview support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.166 – No corrective action required.

§115.167 – Agency protection against retaliation.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2

PEOPLE INTERVIEWED
- Designee on Preventing or Responding to Retaliation
- Random Sample of Staff and Contractors

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

The PAQ reflects that employees at the facility refrain from retaliation against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or participates in sexual activity as a result of force, coercion, threats, or fear of force.
Directive 11062.2 specifies that ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The DESIGNEE stated that a person who engages in retaliation would be removed from contact with detainees or from the facility pending investigation. The random sample of staff/contractor interviewees stated that they have not experienced retaliation, nor do they know of any case of retaliation.

The directive and staff interviews support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.167 – No corrective action required.

§115.171 – Criminal and administrative investigations.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- Qualified Investigator Definition & Qualifications for FY 2016-2017
- Ten PowerPoint presentations

PEOPLE INTERVIEWED
- Designee on Coordinating with Outside Investigators

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.171(a)
The directive list responsibilities for the FOD, including conducting a prompt, thorough, and objective investigations by qualified investigators; this establishes that the agency is responsible for investigating allegations of sexual abuse. The facility did not have any investigations or allegations of sexual abuse; therefore, there is no documentation for the AUDITOR to review for compliance with the standard provision.

The directive supports a determination of compliance with the standard provision.

115.171(b)
The directive calls for pursuing internal administrative investigations and disciplinary sanction in coordination with the assigned criminal investigative entity to ensure non-interference with criminal investigations. The facility did not have any investigations or allegations of sexual abuse; therefore, there is no documentation for the AUDITOR to review for compliance with the standard provision.

The directive supports a determination of compliance with the standard provision.

115.171(c)
The directive does not list the investigative procedures prescribed by the standard provision; however, the agency provided several PowerPoint presentations with detailed procedures for conducting administrative investigations. The training material provided includes all topics prescribed by the standard provision.

The training material support a determination of compliance with the standard provision.

115.171(d)
The directive specifies that administrative investigations shall not be terminated solely due to the departure of the alleged abuser or victim from employment or control of ICE. The facility did not have any investigations or allegations of sexual abuse; therefore, there is no documentation for the AUDITOR to review for compliance with the standard provision.

The directive supports a determination of compliance with the standard provision.

115.171(e)
The PAQ reflects that the facility cooperates with investigators and remains informed about the progress of the investigation when an outside agency investigates allegations of sexual abuse. The directive requires facilities to cooperate with outside investigators and endeavor to remain informed about the progress of the investigation. The DESIGNEE confirmed that the agency cooperates with outside investigators and stated that facilities should be able to provide documents, videos, statements, medical records, make employees and detainees available for interviews and designate a point of contact for the investigating agency.

The directive and the interview support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.171(a) – No corrective action required.

115.171(b) – No corrective action required.

115.171(c) – No corrective action required.

115.171(d) – No corrective action required.

115.171(e) – No corrective action required.

§115.172 – Evidentiary standard for administrative investigations.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2

PEOPLE INTERVIEWED
- None required

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

The PAQ reflects that for investigations into allegations of sexual abuse, the evidentiary standard for determining whether the allegations are substantiated is no higher than a preponderance of the evidence. Directive 11062.2 specifies that administrative investigations shall impose no standard higher than a preponderance of the evidence to substantiate and allegation of sexual abuse or assault. The facility did not have any investigations or allegations of sexual abuse; therefore, there is no documentation for the AUDITOR to review for compliance with the standard provision.

The directive supports a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.172 – No corrective action required.

§115.176 – Disciplinary sanctions for staff.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- Directive 11062.2
- ICE Table of Offenses and Penalties
- Responsive Actions to Disciplinary Sanctions for Staff Requirements

PEOPLE INTERVIEWED
- None required

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.176(a)
The agency provided the ICE Table of Offenses and Penalties; Rows B3 and B4 under Discriminatory Behavior appear to be the most relevant to substantiated allegations of sexual abuse or violating agency sexual abuse policies. The matrix reflects that penalties include removal from service. The facility did not have any allegations or violations of sexual abuse rules, policies or standards involving an employee; therefore, there is no documentation for the AUDITOR to review for compliance with the standard provision.

The matrix supports a determination of compliance with the standard provision.

115.176(c)
Directive 11062.2 requires OPR to report staff removals or resignations in lieu of removal for violating sexual abuse policy to law enforcement agencies, unless the activity was clearly not criminal. The Responsive Actions to Disciplinary Sanctions for Staff Requirements reiterates some of the policy specified in the directive relative to reporting removals or resignations in lieu of removal for violating sexual abuse policy to law enforcement agencies. The facility did not have any substantiated staff-on-detainee sexual abuse allegations, completed sexual abuse investigations or other relevant documentation to be reviewed for compliance with the standard provision.

The directive supports a determination of compliance with the standard provision.

115.176(d)
Directive 11062.2 requires OPR to make a reasonable effort to report staff removals or resignations in lieu of removal for violating sexual abuse policy to any relevant licensing bodies, to the extent known. According to OPR Responsive Actions to Disciplinary Sanctions for Staff Requirements, as of March 17, 2017, ICE OPR does not currently have an internal process in place for notifying licensing bodies of any criminal activity by ICE contractors or employees. ICE OPR is currently researching the parameters around such notifications and researching relevant positions and licensing bodies. Additionally, ICE OPR intends to engage ERO and the ICE Office of Acquisitions about ensuring facility contracts include language that enables the agency to easily identify personnel positions requiring licenses.

The directive and the Table of Offenses and Penalties tend to support a determination of compliance with the standard provision. The standard provision only requires reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known; the agency's efforts to identify personnel positions requiring licenses is a reasonable start to the process. The AUDITOR exhorts to agency to pursue this effort toward identifying positions requiring licenses to facility compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.176(a) – No corrective action required.

115.176(c) – No corrective action required.

115.176(d) – No corrective action required.

§115.177 – Corrective action for contractors and volunteers.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- ICE Responsive Actions to Disciplinary Sanctions for Staff Requirements

PEOPLE INTERVIEWED
- Designee on Corrective Action for Contractors and Volunteers

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.177(a)
The PAQ reflects that there are processes in place for the following:
- To consider whether to prohibit further contact with detainees by contractors who have not engaged in sexual abuse, but have violated other provisions within these standards, and
- To promptly report allegations of sexual abuse involving a contractor to the appropriate law enforcement agency, the JIC and other appropriate DHS investigative office according to DHS policy and procedures

Directive 11062.2 requires the FOD to notify appropriate law enforcement agencies, notify ERO's Assistant Director, Field Operations, notify ICE Joint Intake Center; when a non-ICE employee, contractor, or volunteer is alleged to be the perpetrator of the sexual abuse or assault, ensure that the facility administrator has also contacted the corporation or locality that operates the facility. The process for removing a contractor who is found to have engaged in criminal activity related to Directive 11062.2, is specified in the ICE Responsive Actions to Disciplinary Sanctions for Staff Requirements and calls for OPR PSU to coordinate the removal of that contractor with the Contracting Officer Representative (COR). When asked how the facility addresses allegations of sexual abuse involving a contractor, the DESIGNEE'S response was consistent with the requirements specified in the directive, including notifying appropriate law enforcement and the JIC. Although he was not sure about a process for reporting allegations to relevant licensing bodies, he indicated that it would be done. He asserted that the facility has not had any such incident and explained that G4S has their own process in place for dealing with investigation and employee discipline.

The directive and the designee interview support a determination of compliance with the standard provision.

115.177(b)
The PAQ reflects that there is a process in place to remove contractors suspected of perpetrating sexual abuse from all detainee-contact duties pending the outcome of an investigation, as appropriate. Directive 11062.2 requires the FOD to remove any employee, contractor or volunteer suspected of perpetrating sexual abuse or assault from all duties requiring detainee contact pending the outcome of an investigation. The DESIGNEE stated that the contractor would be removed from contact with detainees if suspected of perpetrating sexual abuse.

The directive and the designee interview support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.177(a) – No corrective action required.

115.177(b) – No corrective action required.

§115.182 – Access to emergency medical services.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2
- Directive 11087.1

PEOPLE INTERVIEWED
- Designee on Access to Emergency Medical Services for Detainee Victims of Sexual Abuse

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.182(a)
The PAQ reflects that there is a process in place to ensure victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. Directive 11087.1 requires the FOD to ensure that timely, unimpeded access to emergency medical and mental health treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care. The DESIGNEE stated that victims of sexual abuse are taken to the emergency room at the local community hospital where they would receive the treatment required under the standard. The facility did not have any sexual abuse allegations, completed sexual abuse investigations, and related medical records for the AUDITOR to review for compliance with the standard provision.

The directive and the designee interview support a determination of compliance with the standard provision.

115.182(b)
The PAQ reflects that there is a process in place to ensure emergency medical treatment services are provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Directive 11087.1 requires the FOD to coordinate with ERO HQ and the ICE PSA Coordinator in utilizing, to the extent available and appropriate, community resources and services that provide expertise and support in the areas of crisis intervention and counseling to address victims' needs. Directive 11062.2 states that such treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The DESIGNEE echoed the provisions of the directive as it relates to medical services free of charge to the victim and provided regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The directive and the designee interview support a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.182(a) – No corrective action required.

115.182(b) – No corrective action required.

§115.186 – Sexual abuse incident reviews.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Sexual Abuse or Assault Incident Review Form

PEOPLE INTERVIEWED
- None required

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

115.186(a)
The PAQ reflects that there are processes in place for the following:

- To conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse
- To prepare a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse if the allegation is determined to be founded
- To conduct the incident review within 30 days of the agency receiving the investigation results from the investigative authority
- To implement the recommendations for improvement, or document the reasons for not doing so in a written response when the written report recommends a change in policy or practice
- Forwarding the report and response is to the agency PSA Coordinator

The agency provided its "Sexual Abuse or Assault Incident Review Form." The form specifies the language of the standard provision and calls for the review team to identify the members of the team, provide details about the incident, information about the victim and perpetrator(s), detail about the investigation (criminal or administrative), incident review findings, including: group dynamics, staffing, physical plant, incident response, and any other general information. The form includes fields for the team to list any recommendations and for the facility to list any recommendations not implemented and why. The agency/facility did not provide any completed incident reviews and the facility has not had any sexual abuse investigations or allegations; therefore, there is no related documentation for the AUDITOR to review for compliance with the standard provision.

The Sexual Abuse or Assault Incident Review Form demonstrates that the agency/facility has the framework in place to conduct incident reviews and supports a determination of compliance with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.186(a) – No corrective action required.

§115.187 – Data collection.

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

Notes:

POLICIES AND OTHER DOCUMENTS REVIEWED
- PAQ
- Directive 11062.2

PEOPLE INTERVIEWED
- Designee on Case Records Associated with Sexual Abuse Allegations

SITE INSPECTION OBSERVATIONS
- None required

THE FOLLOWING IS A DESCRIPTION OF KEY EVIDENCE RELIED UPON IN ARRIVING AT THE COMPLIANCE DETERMINATION, AS WELL AS THE AUDITOR'S ANALYSIS, REASONING AND CONCLUSIONS

The PAQ reflects that the facility maintains, in a secure area, all agency case records associated with claims of sexual abuse, in accordance with these standards and applicable agency policies, and in accordance with established schedules. Directive 11062.2 calls for data collected to be securely retained in accordance with agency record retention policies and the agency protocol regarding investigation of allegations. The DESIGNEE stated that all case records related to sexual abuse allegations are maintained in a secure area in SAAPI SharePoint where only the SAAPI Coordinator has access to it. He was not able to specify whether records are maintained in accordance with DHS PREA and agency policies and established schedules.

Because the facility has not had any investigations or allegations of sexual abuse, there are no records to maintain. The AUDITOR recommended that the PSA Coordinator develop a form to be used for collecting all the data prescribed under 115.187(b) for every incident, and a plan for aggregating that data annually. The directive and the interview with the DESIGNEE support a determination of compliance is with the standard provision.

RECOMMENDED CORRECTIVE ACTIONS

115.187(a) – No corrective action required.

§115.193 – Audits of standards.

Outcome: Not low risk

Notes:

The Bakersfield Hold Room has been audited for compliance with the DHS PREA Standards within three years of July 6, 2015; it is noted that the standard provision requires this audit for facilities that hold detainees overnight and the Bakersfield Hold Room does not hold detainees overnight. This is the facility's first audit and the audit finds that 70% of applicable standards were met. Because of its open floor design and operational style, the facility's physical characteristics are favorable for sexual assault prevention. The Control Room officer has a direct view to the Processing Room and monitors all hold rooms via video surveillance. For most hold rooms, officers get a full view of detainee activity in the room from the processing floor. During detainee processing, there is lots of line staff activity on the floor of the Processing Room and hold room doors are opened frequently; this activity and the presence of line staff within a few feet of every hold room serves to detract potential opportunities for sexual abuse or assault. Not holding detainees overnight is an operational factor that contributes greatly to lower incidence of sexual assault. This finding is further supported by the facility's record of zero allegations of sexual abuse.

§115.201 – Scope of audits.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

The AUDITOR used the audit instrument developed for DHS audits and reviewed all relevant agency policy and procedures. The audit period was defined as the most recent one-year period and the scope of the audit was limited to documents and other records for that period. The AUDITOR did not have access to the HR Office and was not able to review employee files. The AUDITOR was not able to review a sample of records for detainees admitted to the holding facility in the last 12 months to determine whether the holding facility considered the required criteria in assessing detainees for risk of sexual victimization. The AUDITOR was not allowed to retain all documentation relied upon in making audit determinations, specifically, the facility provided a binder with employee and contractor training records, information provided as detainee screening records and other relevant documents. The AUDITOR asked about retaining the binder and was told it had to be returned to the facility. The AUDITOR was allowed to privately interview a representative sample of detainees at the facility at the time of the audit, as well as a representative sample of line staff and the facility provided a private office for the interviews. The audit notice was posted three weeks prior to the date of the audit and the notice tells detainees that they can report sexual abuse or assault to the AUDITOR via written correspondence. The AUDITOR did not receive any correspondence from detainees. The AUDITOR interviewed a representative from a local community-based victim advocacy agency who might have information about conditions at the facility. The information provided to the AUDITOR did not include any specific sensitivity designations or limitations on further dissemination.

AUDITOR CERTIFICATION:

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

Alberto F Caton May 3, 2018

Auditor's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Douglas K. Sproat, Jr.	**Organization:**	Creative Corrections LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Bakersfield ERO
ICE Field Office Director:	David W. Jennings
PREA Field Coordinator:	Juan Garcia
Field Office HQ physical address:	
Mailing address: *(if different from above)*	

INFORMATION ABOUT FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Bakersfield Hold Room		
Physical address:	800 Truxtun Ave. Bakersfield, CA		
Mailing address: *(if different from above)*			
Telephone number:	(661) 328-4500		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Supervisory
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	Juan Garcia	**Title:**	SDDO
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(b) (6), (b) (7)(C)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The following eight standards were found to be deficient:

§115.113 – Detainee supervision and monitoring

§115.115 – Limits to cross-gender viewing and searches

§115.116 – Accommodating detainees with disabilities and detainees who are limited English proficient

§115.121 – Evidence protocol and forensic medical examinations

§115.141 – Assessment for risk of victimization and abusiveness

§115.151 – Detainee reporting

§115.164 – Responder duties

§115.201 – Scope of Audits

All of the above now meet the specific requirements of the standard. The facility is now fully compliant with the DHS PREA Standards. Further discussion of each determination is located below.

Current Auditor's Note regarding §115.193—Audits of Standards: The original Auditor rated the facility as "Not Low Risk," even though his narrative specified the characteristics of a facility that would, in fact, usually be considered "Low Risk." He cites the favorable layout of BHR, its satisfactory level of supervision/monitoring, its short-term holding period, and its lack of any allegations of sexual abuse. The current Auditor believes the "Not Low Risk" rating was an inadvertent error since that rating is in conflict with the original Auditor's narrative for the standard; BHR should actually be rated as "Low Risk."

There are 31 standards on a Subpart B PREA audit template, with that total including §115.193, even though that standard is not calculated in the total under "Summary of Audit Findings." BHR has now met each of the 29 applicable standards, with one standard considered N/A. It should be considered "Low Risk" based on the narrative for this standard in the original audit report.

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	0
Number of standards met:	29
Number of standards not met:	0
Number of standards N/A:	1

PROVISIONS

Directions: After the corrective action period, or sooner if compliance is achieved before the corrective action period expires, the auditor shall complete the Corrective Action Plan Final Determination. The auditor shall select the provision that required corrective action and state if the facility's implementation of the provision now "Exceeds Standard," "Meets Standard," or "Does not meet Standard." The auditor shall include the evidence replied upon in making the compliance or non-compliance determination for each provision that was found non-compliant during the audit.

§115. 113 - Detainee supervision and monitoring

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

Notes:

The (b) part of the standard requires the agency to develop comprehensive detainee supervision guidelines to meet each facility's detainee supervision needs and review those guidelines and their application at least annually. The facility provided the original Auditor with the agency's Holding Facility Self-Assessment Tool or HFSAT, a compliance analysis from August 4, 2017. The self-assessment reviewed compliance with eight of the 13 subsections of ICE Directive 11087.1 (Operations of ERO Holding Facilities), reflecting that the facility was in compliance with seven of the eight areas under review.

The facility is now reviewing its staffing plan annually to ensure it provides one hundred percent coverage for all detainee-related tasks and requirements while maintaining sufficient detainee supervision during the required case processing time. Another HFSAT was completed on May 26, 2018; both HFSATs have been provided to show compliance. These materials now bring the facility into compliance for this subsection.

Under (c) an agency must evaluate various issues such as physical layout of the facility, the composition and length of stay of the population, and evidence of alleged and actual sexual abuse, when determining levels of detainee supervision and the need for video monitoring. The facility's HFSAT reviews electronic monitoring and facility staffing levels in Section 1.0 and addresses each of the six factors prescribed for assessing adequate levels of detainee supervision and the need for video monitoring. The facility has established compliance by showing that its staffing plan was created/reviewed using information from the HFSAT which considers the required factors; it provided two HFSATs as verification.

The current Auditor accepts the conclusion of the original Auditor that (b) and (c) of this standard are now in compliance. However, the signature of the current Auditor on this CAP does not signify he has personally assessed any deficiencies cited by the original Auditor, nor does it signify his having made any evaluation of actual or proposed corrections for bringing this standard into compliance.

§115. 115 - Limits to cross-gender viewing and searches

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

Notes:

Subsection (f) requires training for all law enforcement staff on the proper procedures for pat-down searches, including techniques for searching cross-gender, transgender, and intersex detainees. BHR has now achieved compliance by providing sufficient documentation of training on these methods and the training acknowledgments from the staff.

§115. 116 - Accommodating detainees with disabilities and detainees who are limited English proficient

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

Notes:

Subsection (a) of this standard requires the agency to take whatever steps are necessary to appropriately provide PREA information to detainees who are limited English proficient or are disabled in some capacity, such as an impairment related to hearing, vision, speech, or intellect. Staff must use whatever techniques or devices will allow the information to be properly communicated to a disabled or LEP detainee.

A memo from the ICE SDDO/Acting AFOD has directed staff to be mindful of meeting their responsibilities to communicate (in whatever manner necessary) PREA information correctly and effectively. The memo specifically charges staff with taking steps such as reading PREA/SAAPI materials to detainees perceived to have impairments that could affect their ability to read or understand the information. This memo also reminds staff of possible approaches to ensure effective transmission of PREA materials to detainees with other kinds of disabilities, such as those with hearing impairments. The facility uses the "ERO Language Services" informational flyer to assist employees with interpretation or translation tasks, along with the ICE "Encountering the Limited English Proficient (LEP) Individual" poster with assorted tips for helping LEP detainees.

Current Auditor's suggestions: 1. The facility should consider how to advise/train staff on specific steps for identifying detainees with disabilities, particularly disabilities that might not always be obvious, such as illiteracy and hearing or intellectual impairments. 2. The facility should consider advising/training staff on how to access techniques/tools/staff for adequately conveying PREA information to detainees to meet their needs. 3. The facility should consider noting in a detainee's record any special steps taken to address communication issues with LEP's or disabled detainees.

§115. 121 - Evidence protocols and forensic medical examinations

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

Notes:

Under (e), if an agency is not responsible for investigating allegations of sexual abuse, it must ask the investigating agency to follow sections (a) – (d) of the standard. BHR submitted documentation of its having sent a memo dated November 15, 2018, to the Bakersfield Police Department (BPD) requesting that it follow PREA Standard 115.121 (a) – (d) in any investigation it conducts at BHR. As a result of the memo sent to BPD, the BHR has now become compliant with this subsection.

Current Auditor's suggestion: Although BPD would normally be the outside agency involved in investigations, that may not always be the case. It is therefore suggested that the facility administrator or other manager take action (through writing a memo, creating a policy or SOP or other similar action) to incorporate this subsection of the policy into the on-going operational procedures of BHR. If that is done, this requirement is not likely to be overlooked if an entity other than BPD handles an investigation at the facility.

§115. 141 - Assessment or risk of victimization and abusiveness

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

Notes:

Under (c) of this standard, to the extent that the information is available, an agency is to follow nine specific criteria to assess detainees for the risk of sexual victimization; that assessment may than lead to certain actions required in subsection (d). The original Auditor was unable to determine how these nine criteria were used since he was given only a blank copy of the ICE Custody Classification Worksheet. Without the appropriate documents to review, he could not establish compliance with this subsection. During the CAP period, he required the facility (if not already using the nine criteria) to develop a methodology for using the required criteria in assessing a detainee's risk of sexual victimization.

The facility has responded that it identifies those at risk of victimization and abusiveness through the Risk Classification Assessment (RCA) and has provided certain documents to establish this practice. Finding the first RCA's sent were difficult to read, the current Auditor requested more information. An SDDO who was the Officer in Charge (OIC) during on-site audit then supplied a scanned RCA. The current Auditor was then able to verify the PREA factors set out in this subsection are a part of this instrument. The SDDO advised that there were no detainees during the audit period identified through the RCA as being high risk under PREA. The information supplied by the SDDO and the submission of a readable RCA have addressed the deficiency/deficiencies cited in the CAP, and the facility is now in compliance with (c).

Since the original Auditor could not view the documents that could establish compliance under (c), he could not evaluate the facility's compliance under subsection (d). If the BHR assessment for sexual victimization in fact used the nine criteria of Standard 115.141(c), then detainees at high risk would be identified and therefore would be subject to the heightened protection that is the central requirement of subsection (d). The current Auditor has viewed the RCA, as noted above under (c), and BHR has verified in writing that it identifies detainees at high risk through the RCA. As further noted in subsection (c) above, the SDDO interviewed by the current Auditor reported there were no detainees identified through the RCA as having a PREA risk classification during the audit period.

The SDDO also reported to the current Auditor that during the audit period there had been several detainees who self-reported information that led to PREA concerns. She stated that in any cases where detainees might have a PREA vulnerability for victimization—whether discovered through the RCA or by self-reported information—BHR's practice was to provide the kind of heightened protection described by the standard. This information both supplements and reinforces facts gathered by the original Auditor. BHR can now be found compliant for subsection (d).

Standard 115.141(e) addresses the need for controls regarding the protection of sensitive detainee information. As evidence of the corrective action taken to satisfy any deficiency/deficiencies in meeting subsection (e), BHR submitted PALMS training certificates for PII training. The number of certificates submitted (b) (7)(E) slightly exceeds the number of ICE staff (b) (7)(E) listed on the PAQ. However, there are also (b) (7) contractors listed on the PAQ, and evidence of only (b) (7) workers being trained definitely points to a number of employees/contractors who have not had the training. The original Auditor noted that both ERO and contract staff have access to detainee files.

The facility has now submitted additional staff training certificates for training in the relevant subject, along with the names of a few more staff who are currently pending access to PALMS and who will presumably be trained in due course. Based on the information provided, the current Auditor finds that BHR is making solid and verifiable progress in the corrective action required for this subsection. Although there are a few staff members who have yet to be trained, BHR has established that it is in substantial compliance with the corrective actions specified.

§115. 151 - Detainee reporting

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

Notes:

Under subsection (b), the facility is responsible for providing a way for detainees to report sexual abuse to a public or private entity not part of the agency that can forward reports to agency officials while allowing detainees to remain anonymous. There were various posters at the facility with much of the relevant information required under this subsection. However, no poster specifically informed detainees that OIG is not a part of the agency. The facility has since confirmed that it advises detainees upon intake that OIG is an entity not part of the agency that can take reports and forward them anonymously. BHR has established that it is in compliance with (b).

Current Auditor's suggestion: To reinforce what the detainees are told during intake, the facility should consider adding something like a typed sticker to its OIG reporting posters to remind detainees that OIG is not a part of the agency.

§115. 164 - Responder duties

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

Notes:

Subsection (a) requires the first law enforcement responder (or his/her supervisor) to a sexual abuse situation to perform four specified tasks. To ensure that all potential first responders know their responsibilities should such an incident happen, the facility identified every person in the category of "potential first responders" and sent them an email setting forth these specific duties. The facility provided the current Auditor with a list of everyone who was sent the email, along with a verification that everyone actually received this important email information. All of

these potential first responders now have the information which can be carried on their person to help avoid any lapses if a sexual abuse situation arises, and BHR is compliant with (a).

§115. 201 - Scope of audits
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

Subsection (e) requires the agency to supply the Auditor with the documents needed for a thorough audit. Contractor files were provided immediately after the on-site audit, and all documents requested during the CAP period were provided. These materials allowed the original Auditor to make an appropriate assessment of the facility, and the process of supplying these additional materials helped familiarize the facility with the scope of its responsibilities under PREA regarding access to records. BHR is determined to be in compliance under (e).

The current Auditor accepts the conclusion of the original Auditor that this standard is now in compliance. However, the signature of the current Auditor on this CAP does not signify he has personally assessed any deficiencies cited by the original Auditor, nor does it signify his having made any evaluation of actual or proposed corrections for bringing this standard into compliance.

AUDITOR CERTIFICATION:

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

Douglas K Sproat, Jr. February 14, 2019

Auditor's Signature & Date