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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Detroit		
Field Office Director:	Robert Lynch		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	333 Mt. Elliott Street, Detroit, MI 48207		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Calhoun County Correctional Center		
Physical address:	185 East Michigan Avenue, Battle Creek, Michigan 49014		
Mailing address: *(if different from above)*			
Telephone number:	269-969-6303		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer in Charge (OIC)
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	269-969-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	269-969-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found Calhoun County Correctional Center met 19 standards, had 0 standards that exceeded, had 1 standard that was non-applicable, and had 21 non-compliant standards. As a result of the facility being out of compliance with 21 standards, the facility entered into a 180-day corrective action period which began on August 9, 2023, and ended on February 5, 2024. The purpose of the corrective action plan period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Not Met: 21

§115.13 - Detainee supervision and monitoring
§115.15 - Limits to cross-gender viewing and searches
§115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
§115.17 - Hiring and promotion decisions
§115.22 - Policies to ensure investigation of allegations and appropriate agency oversight
§115.31 - Staff Training
§115.33 - Detainee Education
§115.34 - Specialized training: Investigations
§115.35 - Specialized training: Medical and mental health care
§115.41 - Assessment for risk of victimization and abusiveness
§115.42 - Use of assessment information
§115.51 - Detainee Reporting
§115.53 - Detainee access to outside confidential support services
§115.61 - Staff and Agency Reporting Duties
§115.64 - Responder Duties
§115.65 - Coordinated Response
§115.66 - Protection of detainees from contact with alleged abusers
§115.67 - Agency protection against retaliation
§115.71 – Criminal and administrative investigations
§115.73 - Reporting to detainees
§115.86 - Sexual abuse incident review

The facility submitted documentation, through the Agency, for the CAP on September 6, 2023, through January 31, 2024. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on February 2, 2024. In a review of the submitted documentation, to demonstrate compliance with the deficient standards, the Auditor determined compliance with all 21 of the standards.

PROVISIONS

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

§115. 13 - Detainee supervision and monitoring

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

Notes:

(a)(c): CCCC policy J100.6, Inmate Supervision, states, "The Calhoun County Jail should have trained staff available and properly scheduled to provide full coverage of designated posts, 24-hour supervision of inmates, and surveillance of inmates to ensure the control and security of the facility." CCCC policy J100.4, Electronic Surveillance, states, "Electronic surveillance devices should be used only to enhance staff supervision of inmates. Electronic devices should not be used for the following: (1) as a substitute for staff supervision; (2) unlawful, immoral, or voyeuristic purposes. Electronic surveillance devices should be used by correctional staff for the following: (1) to aid security (2) to monitor movement within the facility (3) to monitor activity from control centers (4) for monitoring and documenting special incidents." A review of the facility PAQ indicated CCCC has a total of 119 security staff, consisting of 83 male officers and 36 female officers, that may have reoccurring contact with detainees. In addition, the facility contracts with 29 medical and 1 mental health personnel employed by YesCare Corporation. Additional staff include contract staff with Tiggs Canteen, which do not have contact with the detainees. The Auditor reviewed the facility Consideration Checklist and confirmed the checklist includes all elements of subsection (c) the facility is required to consider when determining adequate staffing levels and the need for video monitoring; however, an interview with the PSA Compliance Manager indicated that she was unsure of the purpose of the form or who had completed it for the year 2022. In addition, during an interview with the facility Captain, it was confirmed the form is not utilized to determine adequate staffing levels or the need for video monitoring, as required by the standard; however, video monitoring is considered when reviewing the staffing plan. During the on-site audit, the Auditor observed staffing levels at the facility and confirmed the levels were adequate noting Security line-staff were seen within all housing units. In addition, the facility utilizes (b) (7)(E) strategically located throughout the facility to aid in supervision and the protection of detainees against sexual abuse. (b) (7)(E) operate 24/7 and are continuously monitored from the (b) (7)(E). With the exception of the (b) (7)(E) which can pan, tilt, and zoom (PTZ) (b) (7)(E)

(c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed the facility Consideration Checklist and confirmed the checklist includes all elements of subsection (c) the facility is required to consider when determining adequate staffing levels and the need for video monitoring; however, an interview with the PSA Compliance Manager indicated that she was unsure of the purpose of the form or who had completed it for the year 2022. In addition, during an interview with the facility Captain, it was confirmed the form is not utilized to determine adequate staffing levels or the need for video monitoring. To become compliant, the facility must develop and document a practice which takes into consideration all elements required in subsection (c) of the standard when determining adequate staffing levels and the need for video monitoring to protect detainees from sexual abuse. Once developed the facility must provide documentation that confirms the facility took into consideration all required elements of subsection (c) of the standard when determining adequate staffing levels and the need for video monitoring to protect detainees from sexual abuse.

Corrective Action Taken (c): The facility submitted two emails to staff which confirmed staff received training on the standard's requirement to consider all elements of subsection (c) of the standard when determining adequate staffing levels. As the facility had submitted the facility Consideration Checklist which confirmed the checklist requires the facility to include all elements of subsection (c) when determining adequate staffing levels and the need for video monitoring, the Auditor no longer requires the facility develop and document a practice to do so. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115. 15 - Limits to cross-gender viewing and searches

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

Notes:

(b)(c)(d): CCCC policy J100.13, Searches, states, "Prior to a Detainee changing into institutional clothing a Deputy of the same sex, under the observance of a witness may pat search the Detainee and/or use a metal detector to scan the Detainee for weapons or contraband." CCCC policy J100.33 states, "Staff of the same gender as the detainee should perform a pat search of a female detainee, unless staff of the same gender are not present at the facility at the time the pat search is required." An interview with the PSA Compliance Manager indicated pat-down searches are performed by staff of the same

gender as the detainee. If a pat search is required to be conducted by the opposite gender, the search is documented on a Record of Search form; however, as there were no cross-gender pat-down searches conducted during the audit period there were no completed search forms to review. Interviews with six random security line-staff indicated that cross-gender pat-down searches are not conducted on detainees at CCCC. Interviews with nineteen detainees confirmed during intake they received a pat-down search by a security staff member of the same gender. The Auditor observed several pat-down searches during the on-site audit and confirmed each pat-down search was conducted by staff of the same gender as the detainee.

(c): The facility is not in compliance with subsection (c) of the standard. A review of CCCC policy J100.33 confirms it allows for cross-gender pat-down searched of a female detainee if staff of the same gender is not present at the facility at the time the pat-down search is required; however, subsection (c) of the standard requires cross-gender pat-down searches of female detainees only be conducted in exigent circumstances. To become compliant, the facility shall develop and implement a procedure, to ensure cross-gender pat-down searches of female detainees only be conducted in exigent circumstances. Once implemented, the facility must submit documentation that confirms all security line-staff and supervisors have been trained on the implemented practice.

Corrective Action Taken (c): The facility submitted updated policy J100.33 which confirms it includes the requirement "Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances." In addition, the facility submitted a "course completion history" which confirms all applicable staff have completed training on the updated J100.33 Search Policy and updated J100.33 Sexual Abuse and Assault Prevention Program. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

(i)(j): CCCC policy J100.13 states, "Staff are prohibited from searching or physically examining a transgender or intersex inmate for the sole purpose of determining the inmate's genital status." CCCC policy J100.33 states, "Searches will be conducted courteously, professionally and in such a way to allow inmates to retain as much dignity as possible, consistent with the nature of the procedure." Policy J100.33 further states, "Special care should be taken to ensure a strip search of a transgender detainee is performed in private." CCCC policy J70.3, LGBTQI, states, "All searches done on individuals from the LGBT community are to be standardized. Searches are to be conducted by staff of the same anatomical sex or gender as the inmate/detainee to be searched." An interview with the facility PSA Compliance Manager indicated the facility utilizes facility policy J100.13 as the training curriculum to train all security staff on how to conduct a proper pat-down or strip search. The Auditor reviewed samples of the training outline which documents training received by each staff member and confirmed security staff have completed the training. Interviews with six random security line-staff confirmed all had completed pat-down and strip search training; however, each security line-staff interviewed required prompting from the Auditor regarding the requirements to conduct pat-down searches professionally, respectfully, and in the least intrusive manner. Interviews with six random security line-staff confirmed they could articulate that a transgender detainee could not be physically examined for the sole purpose of determining the detainee's genitalia; however, all six random security line-staff interviewed indicated a pat-down search of a transgender detainee would be performed by two staff members with female staff conducting the pat-down search on the detainee's female anatomy and male staff conducting the pat-down search on detainee's male anatomy.

(j): The facility is not in compliance with subsection (j) of the standard. An interview with the facility PSA Compliance Manager indicated all security staff are required to complete training on pat-down and strip searches; however, during interviews with six random security line-staff it was confirmed they could not adequately articulate the requirements to conduct pat-down searches professionally, respectfully, and in the least intrusive manner. In addition, all six random security line-staff interviewed indicated a pat-down search of a transgender detainee would be performed by two staff members with female staff conducting the pat-down search on the detainee's female anatomy and male staff conducting the pat-down search on detainee's male anatomy. To become compliant, the facility must submit documentation to the Auditor that confirms all security line-staff have been retrained on the proper procedures for conducting pat-down searches, including pat-down searches by staff of the opposite gender, and searches of transgender and intersex detainees.

Corrective Action Taken (j): The facility submitted the updated policy J100.33 which confirms it includes the requirement "Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances." In addition, the facility submitted a "course completion history" which confirms all applicable staff have completed training on the updated J100.33 Search Policy and updated J100.33 Sexual Abuse and Assault Prevention Program. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (j) of the standard.

§115. 16 - Accommodating detainees with disabilities and detainees who are limited English proficient
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): CCCC policy J100.33 states, "In compliance with Federal law and DHS policy the CCSO, takes reasonable steps to provide meaningful access to the facility's Sexual Abuse and Assault Prevention and Intervention Program for detainees with Limited English Proficiency (LEP). The CCSO makes available competent foreign language and sign language interpreters to ensure effective communication with detainees with LEP and disabilities (e.g., detainees who are deaf, hard of hearing, or blind and detainees with low vision) during all aspects of the facility's efforts to fulfill this zero-tolerance policy. To obtain a competent interpreter (oral) or translated (written) materials for a detainee with LEP, facility staff contact: The CCSO currently utilizes interpretation services through the Language Services Section, located at 26 Federal Plaza, Room 506 New York, NY 10278. To obtain accommodations for a detainee with a disability, facility staff contact: The CCSO currently utilizes interpretation services through the Language Services Section, located at 26 Federal Plaza, Room 506 New York, NY 10278." During an interview with a Classification Officer, it was indicated the facility handbook is included inside the ICE National Detainee Handbook which was confirmed by the Auditor. In addition, the Auditor confirmed should the detainee require a facility handbook not included in the ICE National Detainee Handbook, the facility has the ability to translate the handbook in the detainee's preferred language. In an interview with the Classification Officer, and through Auditor observations, it was confirmed the ICE National Detainee Handbook is available at the facility in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. During an interview with the PSA Compliance Manager, it was indicated the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet is contained within the ICE National Detainee Handbook; however, the Auditor reviewed the ICE National Detainee Handbook available on-site and confirmed the handbook includes only nine of the most prevalent languages utilized by ICE. While the Auditor was on-site, the facility obtained all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, the Auditor could not confirm the pamphlet was available to all detainees in their preferred language prior to the audit exit interview. No detainees were received at the facility during the on-site audit; however, the Auditor observed a video recording of an ICE detainee going through the intake process and confirmed the detainee had been given the National ICE Detainee Handbook that included the DHS-prescribed SSA Information pamphlet in Spanish, his preferred language. Interviews with an Intake Officer and six random security line-staff indicated if a detainee was deaf or hard of hearing, staff would provide PREA information for the detainee to read in a language he/she could understand, with the use of ERO Language Services, if necessary. In an interview with the facility Captain, it was indicated if the detainee could not read, the facility would utilize a teletypewriter (TTY) phone system. Interviews with an Intake Officer and six random security line-staff further indicated, if the detainee was blind or had low vision, the information would be read to the detainee staff utilizing ERO Language Services if the detainee was LEP. In addition, interviews with Intake staff indicated all documents could be translated with the use of the ERO Language Services or with Google Translate which is available on the facility RFID Guardian System. Intake staff further indicated they would provide the information to detainees who have intellectual, psychiatric, or speech disabilities, by using simple vocabulary and speaking slowly, to ensure effective communication had been established. If they could not establish effective communication, the assistance of medical or mental health staff would be obtained. Interviews with nineteen detainees confirmed all had received the ICE National Detainee Handbook in their preferred language.

(a): The facility is not in compliance with subsection (a) of the standard. During the on-site audit the Auditor did not observe the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet. During an interview with the PSA Compliance Manager, it was indicated the pamphlet is contained within the ICE National Detainee Handbook; however, the Auditor reviewed the ICE National Detainee Handbook available on-site and confirmed the handbook includes only nine of the most prevalent languages utilized by ICE. During the on-site audit, the facility obtained all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, the Auditor could not confirm the pamphlet was available to all detainees in their preferred language prior to the audit exit interview. To become compliant the facility must implement a practice that ensures all detainees have an equal opportunity to participate or benefit from all aspects of both the Agency's and facility 's efforts to prevent, detect, and respond to sexual abuse to include the information available in the DHS-prescribed SAA information pamphlet. Once implemented, if applicable, the facility must submit 10 detainee intake files to confirm the information available in the DHS-prescribed SAA pamphlets not included in the ICE National Detainee Handbook during the on-site audit is now available to all incoming detainees.

Corrective Action Taken (a): The facility submitted the revised Calhoun County Sheriff's Office "PREA and Handbook" signature sheet, which indicates the detainee has received the ICE National Detainee Handbook, the DHS-preferred SAA Awareness Pamphlet, and a copy of the Calhoun County Inmate Handbook. The facility submitted a document signed by detainees to indicate what accommodations were used to ensure effective communication. The Auditor reviewed the

submitted document and confirmed the document states, "I have been educated and received information on the PREA orientation that covers DHS Standard 115.33 (a)(1-6)." The facility submitted the DHS-prescribed SAA pamphlets in all 15 languages which confirmed they are available on-site. The Auditor reviewed the submitted DHS-Prescribed SAA Information pamphlets and accepts all 15 of the most prevalent languages encountered by ICE are now available in the intake area; and therefore, the Auditor, no longer requires the facility submit 10 detainee intake files to confirm all information is available to all incoming detainees. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

(c): In an interview with the PSA Compliance Manager it was indicated, the facility utilizes the services of the ERO Language Services, in matters relating to allegations of sexual abuse, to provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee. Interviews with six random security line-staff, indicated they would never use another detainee to interpret for a detainee victim of sexual abuse, even if the detainee victim made the request. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed none of the detainee victims required the services of an interpreter during the investigation.

(c): The facility is not in compliance with subsection (c) of the standard. Interviews with six random security staff, indicated they would never use another detainee to interpret for a detainee victim of sexual abuse, even if the detainee victim made the request. The Auditor reviewed seven allegations of sexual abuse. The review indicated that none of the victim detainee's need the services of interpretation during the investigation. To become compliant, the facility must implement the practice of allowing the use of another detainee in matters related to sexual abuse should the detainee express a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. In addition, the facility must train all security staff and security supervisors on the updated practice and provide training records to confirm the training was conducted during the CAP.

Corrective Action Taken (c): The facility submitted revised policy J100.33 which states, "A detainee will be allowed the use of another detainee in matters related to sexual abuse should the detainee express a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy." The facility submitted policy J150.17 which states, "In matters relating to allegations of sexual abuse, the facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone rather than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with the DHS policy." In addition, the facility submitted five samples of email read receipts which confirmed staff have reviewed the revised policy. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115. 17 - Hiring and promotion decisions
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 6-7.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. CCCC policy J100.33 states, "Sexual assault or abuse of detainees by other detainees or by employees, contractors, or volunteers is prohibited and subject to administrative, disciplinary, and criminal sanctions. CCSO shall impose upon all staff a continuing affirmative duty to disclose any such misconduct." An interview with the facility HRM indicated each applicant is required to complete the CCSO Background Investigation Warning, which states, "Now is the time for you to provide me, the background investigator, with any/all background information. If I discover at a later date/time during the course of the investigation that information (regardless of how significant it may be to you) was omitted, it will have a serious impact on the background investigation process. Omission of information is considered the same as providing false information (lying). I fully understand the above WARNING. I have not withheld any information from you, the background investigator or from the Calhoun County Sheriff Department. I also understand that withholding

any information is relevant to the hiring process and/or background investigator will be justification for removal from the hiring process." The HRM indicated the facility modified the questions on May 25, 2023, to include the current version of the form. In interviews with the HRM and the facility AFOD it was indicated there have not been any promotions of facility staff or ICE staff assigned to the facility during the audit period. In an interview with the HRM it was indicated all previous institutional employers are contacted to obtain information on substantiated allegations of sexual abuse or any resignations during a pending investigation of alleged sexual abuse and the facility would provide another institutional employer the same information for a pending applicant. Although requested by the Auditor, the facility did not provide documentation to confirm staff are aware of their continuing duty to disclose, if any, sexual misconduct as required by the standard. The Auditor reviewed six files of potential staff applicants and confirmed each applicant had completed the CCSO Background Investigation Warning and had been asked the following questions during an interview: have you engaged or been investigated for sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution; have you been investigated and convicted of sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse; and have you been civilly or administratively adjudicated to have engaged in such activity; however, a review of the revised form confirms it does not inquire if the applicant has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. Although requested by the Auditor the facility did not provide documentation to confirm the facility has not enlisted the services of any contractor or volunteer who may have contact with detainees who has engaged in the above behavior.

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. During an interview the HRM indicated the facility modified the questions on May 25, 2023, asked during an interview to include the questions required by standard 115.17. The Auditor reviewed six files of potential staff that are currently in the hiring process. Documentation contained in the files confirmed the facility does not inquire if the applicant has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. Although, the Auditor requested the facility provide documentation that confirms staff are aware of the continuing duty to disclose, if any, such misconduct should occur none was provided. To become compliant, the facility shall implement a practice that ensures the facility not hire or promote anyone or enlist the services of any contractor or volunteer who may have contact with detainees who has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. The facility must provide the Auditor with five staff, five contactors, and one volunteer file to confirm the facility did not utilize the services of any contractor or volunteer who has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. In addition, the facility must submit documentation that confirms all staff are aware of their continuing duty to disclose, any such misconduct. If applicable, the facility must provide the Auditor with any facility, and ICE staff, who may have reoccurring contact with detainees, who were promoted during the CAP period to confirm they were directly asked about previous misconduct related to sexual abuse in a written application or during an interview.

Corrective Action Taken (a) and (b): The facility submitted five contract staff files with a revised PREA Statement. The Auditor reviewed the revised PREA statement and confirmed the statement includes a signed acknowledgement advising staff contractors they have a continuing duty to disclose any misconduct related to sexual abuse. The facility provided the Auditor with five staff hiring packets which confirmed the facility revised the hiring form to include the standard's requirements to ask the applicant have you ever been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse and to advise the applicant they have a continuing duty to disclose any misconduct related to sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

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

(a)(b)(c)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." CCCC

policy J100.33 states, "The CCSO should ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for investigation by an agency with the legal authority to conduct criminal investigations and should document such referrals. The facility administrator should coordinate as necessary with the ICE Office of Professional Responsibility (OPR) and/or criminal investigative entities responsible for investigation of the incident. If the investigation needs to be assigned to an agency other that CCSO, the agency assigned the investigation will be asked to follow DHS PREA standards 115.21 sections a through d." CCCC policy J100.33 further states, "When a detainee(s) is alleged to be the perpetrator, it is the CCSO administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to ICE/ERO (this notification must go directly to the FOD), which shall report it to the OPR Joint Intake Center." and "when an employee, contractor or volunteer is alleged to the be the perpetrator of detainee sexual abuse and assault, it is the CCSO administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to ICE/ERO, which shall report it to the OPR Joint Intake Center. The local government entity or contractor that owns or operates the facility shall also be notified." In addition, J100.33 states, "All reports and referrals to be copied to the PREA Compliance Manager and kept on file. Retention of such reports and referrals shall be kept as long as the alleged abuser is detained or employed by the agency plus five years." An interview with the PSA Compliance Manager/Investigator indicated if the allegation reported was detainee/inmate-on-detainee/inmate, the facility would conduct a criminal investigation and once completed would conduct an administrative investigation. If the allegation involved staff-on-detainee, the allegation would be referred to the MSP for investigation and once completed would be referred to the Michigan Mission Team (MMT) investigators, which is comprised of investigators from all counties within Michigan that investigate administrative investigations that involve staff to ensure that the allegation is investigated by an outside agency. A review of seven sexual abuse allegation files confirmed that the MSP was notified in all cases; however, they did not complete any criminal investigations due to the allegations not being criminal in nature. A review of the PREA allegation spreadsheet further confirmed ICE OPR and the JIC were notified of all allegations as documented in the investigation files.

(a)(d)(e)(f): The facility is not in compliance with subsections (a), (d), (e), and (f) of the standard. A review of CCCC policy J100.33 confirms it does not include when a prisoner, inmate or resident of the facility, in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director. In addition, a review of CCCC policy 5.1 confirms it does not require the facility report to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director when the allegation involves a staff member, contractor or volunteer. To become compliant the facility must update CCCC policy J100.33 to include the verbiage, "When a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (e) of the standard or when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG" as required by subsections (d) and (f) of the standard. Once updated, the facility must submit documentation that all applicable staff, including facility Investigators, received training on the updated CCCC policy J100.33. If applicable, the facility must submit copies of all sexual abuse allegation investigation files that occur during the CAP period. Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of the CCCC website (https://www.calhouncountymi.gov/departments/sheriffs_office/prea), confirmed the facility has posted portions of the protocol, CCCC J100.33, on the facility website; however, the protocol as written is not compliant with the standard. In addition, the entire protocol must be posted on the facility website. To become compliant, the facility must post update the facility protocol to include all elements required by subsections (d), (e), and (f) of the standard. Once updated the facility must ensure the protocol in its entirety is posted on the facility website.

Corrective Action Taken (a)(d)(e) and (f): The facility submitted revised policy J100.33. The Auditor reviewed the revised policy and confirmed reviewed policy J100.33 includes the requirement when a detainee(s) is alleged to be the perpetrator of sexual abuse, it is the CCSO administrator's responsibility to ensure the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal). A review of revised policy J100.33 further confirmed the CCSO administrator must ensure the allegation is reported to ICE/ERO (this notification must go directly to the FOD), who will report the allegation to the OPR Joint Intake Center. In addition, a review of revised policy J100.33 confirmed it requires when an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse it is the CCSO administrator's responsibility to ensure the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and the local government entity or contractor who owns or operates the facility. A review of revised policy J100.33 further confirmed the CCSO administrator must ensure the allegation is reported to ICE/ERO (this notification must go directly to the FOD) who will report the allegation to the OPR Joint Intake Center. The facility submitted a memorandum from the

AFOD to the JA outlining ICE's notification policy for PREA incidents which include notifying the Joint Intake Center (JIC), the ICE OPR, or the DHS OIG. The facility submitted a course history which confirms staff have received training on updated policy J100.33. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a), (d), (e), and (f) of the standard.
Corrective Action Taken (c): The Auditor reviewed the facility's website (https://www.calhouncountymi.gov/departments/sheriffs_office/prea), and confirmed it includes the updated investigation protocol. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

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

(a)(b)(c): The Agency's policy 11062.5.2 states, "The Agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed training." CCCC policy J100.33 states, "Training on the facility's Sexual Abuse and Assault Prevention and Intervention Program should be included in the initial and annual refresher training for all employees, volunteers, and contract personnel." CCCC policy J100.33 further states, "The facility Program Coordinator should maintain documentation verifying employee, volunteer and contractor training." During an interview with the facility HRM, and an informal interview with a staff member responsible for new hire orientation, it was indicated that all staff and contractors are initially trained on the facility policy J100.33 during new hire orientation. The policy includes the facility zero tolerance; definitions of sexual abuse; procedures for reporting knowledge or suspicion of sexual abuse and the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigating purposes. Documentation was provided to the Auditor which indicated all staff, and ICE staff, and staff contractors, who may enter the facility have been trained on the CCCC policy. In addition, the HRM indicated, staff are required to complete PREA training through the Relias Learning system on an annual basis. The Relias Learning training curriculum for Dynamics of Sexual abuse in a Correctional System was provided to the Auditor for review. This training contains four of the required elements of this standard to include but not limited to: recognition of situations where sexual abuse may occur; recognition of physical, behavioral and emotional signs of sexual abuse, and methods for preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees and how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex or gender non-conforming. Documentation was provided to the Auditor that confirms all facility staff have completed the training for 2020, 2021 and 2022. In addition, the Relias Learning training curriculum for PREA: Reporting Obligations and Retaliation Protections was reviewed by the Auditor. This training included the elements of subsection (a) that are not included in the facility policy training received by medical and ICE staff. Documentation was provided to the Auditor, to confirm all facility staff have completed this training for years 2020, 2021 and 2022. However, no documentation was provided to the Auditor to confirm contract staff or ICE staff have completed the Relias training; and therefore, the Auditor could not confirm compliance. In addition, no additional documentation had been provided to the Auditor to indicate ICE staff have completed the Agency PREA training or additional training other than CCCC policy J100.33 which does not contain all the elements required by subsection (a) of the standard.

(a): The facility is not in compliance with subsection (a) of the standard. No documentation was provided to the Auditor to confirm contract staff have completed the training required by subsection (a). In addition, no additional documentation had been provided to the Auditor to indicate ICE staff have completed the Agency PREA training, or additional PREA training, other than CCCC policy J100.33, which does not contain all the elements required by subsection (a) of the standard. To become compliant, the facility must submit documentation that confirms all contract staff, such as medical and mental health staff, have completed the training required by subsection (a) of the standard. In addition, the Agency must submit documentation that confirms all ICE staff who may have reoccurring contact with detainees have been trained on all elements required by subsection (a) of the standard.

Corrective Action Taken (a): The facility submitted the ICE SAPPI Awareness Training curriculum which contains all elements required by the standard. The facility provided two training certificates for ICE staff and 20 training certificates for medical and mental health staff which confirm they have received the required PREA training. In addition, the facility submitted a training email and read receipts indicating medical and mental health staff, contractors, and other staff have received the required training. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115. 33 - Detainee education

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

Notes:

(a)(b)(c)(f): CCCC policy J100.33 states, "Upon admission to the CCSO, all detainees should be notified of the facility's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee handbook and provided with information about the facility's Sexual Abuse and Assault Prevention and Intervention Program. Such information should include, at a minimum: the facility's zero tolerance policy for all forms of sexual abuse or assault, the name of the facility Sexual Abuse and Assault Prevention and Intervention Program Coordinator, and information about how to contact him/her, prevention and intervention strategies, definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity, explanation of methods for reporting sexual abuse or assault, including the DHS/OIG, consular official, and the ICE/OPR investigation processes, and right of detainees to report an incident or allegation of sexual abuse, assault, or intimidation to any staff member at the facility, to ICE/DHS and to the JIC, information about self-protection and indicators of sexual abuse, prohibition against retaliation, including an explanation that reporting an assault should not negatively impact the detainee's immigration proceedings; and right of a detainee who has been subject to sexual abuse or assault to receive treatment and counseling, If an alleged victim of sexual abuse and assault that occurred elsewhere in ICE/ERO custody is subsequently transferred to the facility, the CCSO shall comply with all applicable response and intervention requirements in this standard, as appropriate based on the nature and status of the case. Detainee notification, orientation and instruction must be in a language or manner that the detainee understands. The facility should maintain documentation of the detainee participation in the instruction session." Informal and formal interviews with Intake staff, indicated detainees are given the ICE National Detainee Handbook and the facility handbook upon entering the facility and are asked to read the facility PREA Orientation which includes the elements required by standard 115.33 (a) (1-6). If a detainee is unable to read the document, due to limited reading skills or is blind or visually impaired, staff will read it to them and will utilize the language line if they are LEP. In addition, staff indicated all documents could be translated with the use of the ERO Language Services or with Google Translate which is available on the facility RFID Guardian System. During an interview with a Classification Officer, it was indicated the facility handbook is included inside the ICE National Detainee Handbook which was confirmed by the Auditor. Informal and formal interviews with Intake staff further indicated, if a detainee is intellectual, psychiatric, or otherwise disabled, the staff will read the PREA information to them in a way to ensure they understand the information. If they could not establish effective communication, the assistance of medical or mental health staff would be obtained. Intake staff further indicated if the detainee is deaf or hard of hearing, staff would provide PREA information for the detainee to read in a language he/she could understand, with the use of ERO Language Services, if necessary. In an interview with the facility Captain, it was indicated if the detainee could not read the facility would utilize a teletypewriter (TTY) phone system. The Auditor reviewed the PREA Orientation 115.33 (a) (1-6) document. The document informs detainees of the facility zero-tolerance towards all forms of sexual abuse, definitions of sexual abuse, how to report sexual abuse (which includes the Office of Inspector General (OIG) phone number, Detention Reporting and Information Line (DRIL) phone number, and any staff members), the detainee right to receive treatment and counseling, examples of sexual abuse, understanding your reaction, and safety from retaliation. An interview with the Classification Officer, and Auditor observations, confirmed the ICE Detainee Handbook is available at the facility in all 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. The Auditor reviewed the ICE National Detainee Handbook and confirmed all elements required by this standard are included. In an interview with the PSA Compliance Manager, it was indicated the DHS-prescribed SAA Information pamphlet is contained within the ICE National Detainee Handbook; however, a review of the ICE National Detainee Handbook confirmed it includes only nine of the most prevalent languages utilized by ICE. While the Auditor was on-site, the facility obtained all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, the Auditor could not confirm distribution of the pamphlet had been implemented at the facility prior to the audit exit interview. No detainees were received at the facility during the on-site audit; however, the Auditor observed a video recording of an ICE detainee going through the intake process and confirmed the detainee had been given the National ICE Detainee Handbook that included the DHS-prescribed SSA Information pamphlet and facility handbook in Spanish, his preferred language. Interviews with nineteen detainees confirmed all had received the ICE National Detainee Handbook, which included the facility handbook, and DHS-prescribed SAA Information pamphlet, in their preferred language, Spanish. An interview with the PSA Compliance Manager indicated to confirm the detainee has received the National Detainee Handbook, the local supplemental and the facility Handbook, detainees sign an ICE Detainee Orientation document. This document is printed in the detainee's preferred language. In addition, the form documents any accommodations that were needed to ensure the detainee understood the information, such as the use of the language line to provide the information to the detainee and what language was used. During interviews with nineteen detainees, all reported that during the intake process they received the ICE National Detainee Handbook; they did not remember if they had received the local facility Handbook. The Auditor reviewed eight detainee files and confirmed each file contained the ICE Detainee Orientation Document signed by the

detainee, four of the documents were in English and four were in Spanish, confirming the document was provided in a language the detainee can understand.

(d)(e): The facility is not in compliance with subsection (d) and (e) of the standard. During the on-site audit, the Auditor did not observe the DHS-prescribed SAA Information pamphlet, however, the PSA Compliance Manager indicated the pamphlet is contained within the ICE National Detainee Handbook. The Auditor confirmed only nine languages are included in the handbook. The facility was able to access all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, Vietnamese; however, although the pamphlet could be printed at the facility, interviews with Intake Staff could not confirm detainees who spoke a language not included in the ICE National Detainee Handbook received the pamphlet during the intake process. In addition, although the facility received all copies of the DHS-prescribed SAA Information pamphlet, the Auditor could not confirm distribution of the pamphlet had been implemented at the facility prior to the exit interview. The facility provided the Auditor with the SAS Flyer; however, the Auditor did not observe the flyer posted in the housing units for detainee to access. The Auditor did observe a 4' by 5' mailing label in the housing units that provided the detainee with a phone number to access SAS; however, the Auditor could not confirm information was provided to detainees that advised them who SAS is or what services they would provide to a detainee victim of sexual abuse. To become compliant, the facility must make available and distribute the DHS-prescribed SAA Information pamphlet in the detainee's preferred language as required by subsection (e) of the standard. In addition, the facility must post the SAS flyer in the housing units. The facility must submit documentation to the Auditor to confirm distribution of the DHS-prescribed SAA Information pamphlet had been implemented and the SAS flyer had been posted in all housing units.

Corrective Action Taken (d) and (e): The facility submitted 10 detainee files (6 Spanish, 2 English, 1 Russian, and 1 Chinese). The Auditor reviewed the 10 submitted files and confirmed each file included detainee sign acknowledgements to confirm the detainee had received information regarding sexual abuse and assault awareness to include the ICE National Detainee Handbook, the DHS-prescribed SAA Information pamphlet, and a copy of the Calhoun County Inmate Handbook. A review of the 10 submitted detainee files further confirmed each detainee had signed a form which included if the language line was utilized and states, "I have been educated and received information on the PREA orientation that covers DHS Standard 115.33 (a) (1-6)." The facility submitted seven photographs to confirm the facility has posted the SAS information in all housing units. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (d) and (e) of the standard.

§115. 34 - Specialized training: Investigations

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

Notes:

(a)(b): The Agency policy 11062.2 states "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement." CCCC policy 601, Sexual Assault Investigations, states, "Qualified investigators should be available for assignment of sexual assault investigations. These investigators should have specialized training in and be familiar with, interview techniques and the medal [sic] and legal issues that are specific to sexual assault investigations." CCCC policy J100.33 states, "All facility staff responsible for conducting sexual abuse or assault investigations should receive specialized training in conducting such investigations in confinement settings, which includes techniques for interviewing sexual abuse victims, sexual abuse evidence collection in confinement settings, and the criteria and evidence required for administrative action or prosecutorial referral." CCCC policy J100.33 further states, "The facility Program Coordinator should maintain documentation verifying employee, volunteer and contractor training." A review of CCCC policy J100.33 confirms it does not require training in effective cross-agency coordination as required by subsection (a) of the standard. An interview with the PSA Compliance Manager, and review of the facility PAQ, indicates eight investigators have received specialized training on sexual abuse and effective cross-agency coordination. The facility provided documentation that investigators have received general PREA training as required; however, the facility did not provide a training curriculum, or training completion certificates, to confirm each investigator has received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed seven sexual abuse allegation investigation files and could not confirm each assigned investigator had received the required specialized training.

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of CCCC policy J100.33 confirms it does not require training in effective cross-agency coordination as required by subsection (a) of the standard. An interview with the PSA Compliance Manager and review of the facility PAQ indicates eight investigators have received specialized training on sexual abuse and effective cross-agency coordination. The facility provided documentation that investigators have received general PREA training as required; however, the facility did not provide a training curriculum to confirm each investigator has received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed seven sexual abuse allegation investigation files and could not confirm each assigned investigator had received specialized training. To become compliant, the facility must submit a training curriculum to confirm it contains training on sexual abuse and effective cross-agency coordination. The facility must specially train all facility investigators who conduct sexual abuse allegation investigations and document such training. In addition, the facility must submit all sexual abuse allegation investigations that are completed during the CAP period.

Corrective Action Taken (a)(b): The facility submitted training certificates to confirm all specialized investigators completed specialized training "PREA – Investigating Sexual Abuse in a Confinement Setting" offered through NIC. As the Auditor is familiar with the training provided the Auditor no longer requires a copy of the training curriculum. The facility submitted a memorandum to Auditor which states, "There were no allegations of sexual abuse at the facility during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

§115. 35 - Specialized training: Medical and mental health care
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(b)(c): CCCC policy J100.33 states, "All full- and part-time medical and mental health care practitioners who work regularly in the facility should receive specialized training in detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse, responding effectively to victims of sexual abuse and assault, and reporting allegations or suspicions of sexual abuse or assault." During an interview with the facility HRM and an informal interview with a staff member responsible for new hire orientation, it was indicated that all medical and mental health contractors are initially trained on the facility policy J100.33 during new hire orientation. Documentation which contained signatures, was provided to the Auditor which indicated all medical and mental health contractors have completed this training. Interviews with a RN, MD, and a mental health clinician indicated they are required to complete specialized PREA training. The Auditor reviewed the YesCare Prison Rape Elimination Act (PREA) training curriculum for all medical and mental health staff contracted with the facility. The curriculum contains sections to include: the role of health care and behavioral staff and preservation of evidence; however, the curriculum does not include how to detect signs of sexual abuse and how to respond effectively and professionally to victims of sexual abuse. The Auditor was not provided documentation to indicate the medical and mental health staff have completed the specialized training required by subsection (b) of the standard. Interviews with the AFOD and the facility Captain confirmed CCCC policy J100.33 has been submitted and approved by the Agency.

(b): The facility is not in compliance with subsection (b) of the standard. The Auditor reviewed the YesCare Prison Rape Elimination Act (PREA) training curriculum for all medical and mental health staff contracted with the facility and confirmed the curriculum does not include how to detect signs of sexual abuse and how to respond effectively and professionally to victims of sexual abuse. The Auditor was not provided documentation to confirm all medical and mental health staff have completed specialized training as required by subsection (b) of the standard. To become compliant, the facility must ensure that all medical and mental health staff have completed specialized training which includes all required elements of subsection (b) of the standard including how to detect and assess signs of sexual abuse and how to respond effectively and professionally to victims of sexual abuse. Once completed the facility must submit documentation to the Auditor to confirm all medical and mental health staff have received the required training.

Corrective Action Taken (b): The facility submitted the National Commission on Correctional Health Care (NCCHC) and the National PREA Resource Center YouTube training modules. The Auditor reviewed the videos and confirmed all elements required by subsection (b) are included. The facility submitted an email sent to all medical and mental health staff advising them of the standard deficiency and included read receipts. The facility submitted the NIC Training Certificates to confirm medical and mental health staff have completed the NIC PREA 201 for Medical and Mental Health and "PREA - Your Role in Responding to Sexual Abuse." Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (b) of the standard.

§115. 41 - Assessment for risk of victimization and abusiveness

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

Notes:

(a)(b)(c)(d)(e)(f)(g): CCCC policy J100.33 states, "In accordance with Standards 2.1, "Admissions and Release", and 2.2, "Custody Classification System", the facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse and assault victims and shall house detainees to prevent sexual abuse and assault, taking necessary steps to mitigate any such danger." CCCC policy J100.33 further states, "Each new arrival shall be kept separate from the general population until he or she is classified and housed accordingly. The initial screening and classification are conducted immediately upon arrival into the facility (within 12 hours of arrival) when detainees are screened by intake staff. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: a. Whether the detainee has a mental, physical, or developmental disability, b. The age of the detainee; c. The physical build and appearance of the detainee; d. Whether the detainee has previously been incarcerated or detained, e. The nature of the detainee's criminal history, f. Whether the detainee has any convictions for sex offenses against an adult or child, g. Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, h. Whether the detainee has self-identified as having previously experienced sexual victimization, and i. The detainee's own concerns about his or her physical safety. The initial screening shall consider prior acts of sexual abuse and assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse and assault, as known to the facility, in assessing detainees for risk of being sexually abusive." In addition, policy J100,33 states, "Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to items a, g, h, or i above. CCSO shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this screening in order to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates. Detainees who are considered at risk shall be placed in the least restrictive housing that is available and appropriate." CCCC policy J100.33 further states, "The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment/screening or at any other time when warranted, based upon the receipt of additional, relevant information or following an incident of abuse or victimization." The Auditor reviewed the facility PREA Profile Screening: Initial assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. An interview with an Intake Officer indicated, upon the arrival of the detainee, the detainee waits in an area within booking referred to as "carpeted area." Detainees will wait with all other incoming persons being booked into the facility until called by intake staff. Once called detainees are provided the assessment tool to complete. The form is provided in a language they can understand, or the staff will utilize the ERO Language Services, to ensure the detainee understands the content of the document. Once the detainee has completed the assessment the Intake staff will enter all answers into the jail management system. If a detainee is identified as a potential victim or a potential predator, the system will automatically place a caution in the detainee's electronic file. The Intake Officer further indicated a detainee is not disciplined for refusing to answer or not disclosing information in response to the risk assessment questions and once the assessment is entered into the jail management system, the paper assessment is placed into a locked drawer that all security staff have access to. During the intake process, a detainee will see medical staff. Interviews with the MD and an RN indicated the medical staff will complete their own assessment and review the results of the intake assessment. If appropriate, medical staff will complete any referrals for follow-ups with medical staff or with mental health staff. An interview with an Intake Officer indicated, once the detainee booking is complete, and prior to classification, detainees are comingled in one of the two quarantine housing units being used for Covid 19 isolation for up to 14 days. In an interview with a Classification Officer, it was confirmed Classification staff work twelve-hour shifts. Upon reporting for duty, the Classification Officer must immediately begin moving inmates and detainees, who have completed the 14-day quarantine, into assigned housing units. During the interview, the Classification Officer, indicated a reassessment is completed on all detainees every 80 days, including those who identify as transgender or intersex. The Auditor reviewed eight detainee files and confirmed all had completed the assessment tool in their preferred language; however, the Auditor could not confirm the initial classification of the detainee had been completed within 12 hours or that a reassessment is completed between 60-90 days. The Auditor reviewed seven sexual abuse allegation investigation files and could not confirm a reassessment had been conducted on the detainee victim following the alleged incident of sexual abuse or victimization.

(a)(b)(c)(e): The facility is not in compliance with subsections (a), (b), (c), and (e) of the standard. The Auditor reviewed the facility PREA Profile Screening: Initial assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. An interview with an Intake Officer indicated, once the detainee booking is complete, and prior to classification, detainees are comingled in one of the two quarantine housing units being used for Covid 19 isolation for up to 14 days. The Auditor reviewed eight detainee files and confirmed all had completed the initial screening tool in their preferred language; however, the Auditor could not confirm the initial classification of the detainee had been completed within 12 hours or that a reassessment was completed

between 60-90 days. In addition, the Auditor reviewed seven sexual abuse allegation investigation files, and could not confirm a reassessment had been conducted with the alleged victim following an incident of sexual abuse or victimization. To become compliant, the facility must implement a practice that includes all required elements of subsection (c) of the standard when assessing a detainee's risk for sexual abuse or sexual aggression. In addition, the facility must implement a practice to ensure that the initial classification of the detainee is completed within 12 hours of entering the facility. The facility must provide documentation that confirms detainees risk of victimization or abusiveness be reassessed between 60 and 90 days from the date of the initial assessment. In addition, the facility must submit documentation to confirm a detainee's risk for sexual abuse of sexual aggression is reassessed at any other time when warranted based upon the receipt of additional, relevant information, and following an incident of abuse or victimization. The facility must train all classification staff on the requirements of subsections (a), (b), (c), and (e) of the standard. In addition, if applicable, the facility must submit 5 detainee files to confirm all elements of subsection (c) were considered when assessing whether a detainee is likely to be a sexual aggressor, or a sexual abuse victim, and the initial classification was completed within 12 hours of intake. The facility must submit any detainee files where the detainee required a reassessment between 60 and 90 days as required by the subsection (e) of the standard. If applicable, the facility must submit to the Auditor all sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action Taken (a)(b)(c)(e): The facility submitted an email to classification staff which confirms staff are required to consider all elements of subsection (c) of the standard when determining initial housing. In addition, the facility submitted an email to classification staff which confirms the facility notified staff of an implemented procedure to reassess detainees between 60 and 90 days of the initial assessment. The facility submitted an email to all security supervisors which confirms it requires staff to review the initial intake screening when determining initial housing and initial classification and housing is to be completed within 12 hours of intake. The facility submitted two detainee risk assessments which included, "Information gathered during the initial classification/PREA screening will be used to determine initial housing with the goal of keeping separate those inmates at high risk of being sexually victimized away from those at high risk of being sexually abusive. Were any changes made in the initial determination for housing assignments (if applicable) and other activities based upon the responses above?" Both risk assessments indicate no changes were made. The facility submitted one reassessment of a detainee which did not confirm compliance with the standard; however, the reassessment was completed prior to the implementation of the new procedure; and therefore, the Auditor accepted the implementation of the procedure and the training of classification staff for compliance. The facility submitted a memorandum to Auditor which states, "There have been no sexual abuse allegations at Calhoun that occurred during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), (c), and (e) of the standard.

§115. 42 - Use of assessment information

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

Notes:

(a)(b)(c): CCCC policy J100.33 states, "In accordance with Standards 2.1 "Admission and Release" and 2.2 "Custody Classification System," the facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse and assault victims and shall house detainees to prevent sexual abuse and assault, taking necessary steps to mitigate any such danger. The facility shall also use the assessment to inform assignment of detainees to recreation and other activities, and voluntary work." An interview with an Intake Officer indicated, once the detainee booking is complete, the detainees are automatically comingled into one of the two housing units being used for Covid 19 quarantine of all detainees and inmates; however, the Intake Officer could not articulate if the assessment is utilized to ensure the safety of the detainee when determining the initial housing of the detainee into the quarantine unit. In addition, the Intake Officer indicated if the facility received a transgender or intersex detainee, they would be housed in the medical for no more than 12 hours unit until initial housing could be determined. In an interview with the Classification Officer, it was indicated placement of a transgender or intersex detainee is not determined based solely on the detainee's physical anatomy. An Interview with the MD indicated the facility has not had a transgender or intersex detainee housed at the facility during the audit period; however, should a transgender or intersex detainee arrive at the facility placement would be made in consultation with medical and mental health staff to ensure the health and safety of the detainee. An interview with the Classification Officer indicated that information learned on the assessment tool is utilized to determine housing, recreation and other activities, and volunteer work; however, he struggled with articulating how the information obtained from the initial screening is utilized. The Auditor reviewed the PREA Profile Screening: Initial Assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. The Classification Officer further indicated all detainees, including those who identify as transgender and intersex, are reclassified every 80 days to review any threats to safety experienced by the detainee. Interviews with the facility PSA Compliance Manager and six random security line-staff indicated a transgender or intersex detainee would be given the opportunity to shower separately from other detainees.

(a): The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed the PREA Profile Screening: Initial Assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. In an interview with an Intake Officer, it was confirmed the Intake Officer could not articulate if the assessment is utilized to determine the initial placement of the detainee into the quarantine housing unit, to ensure the safety of the detainee. An interview with the Classification Officer indicated that information gathered from the risk assessment tool is utilized to determine housing, recreation and other activities, and voluntary work; however, the risk assessment tool does not include all the required elements of subsection (c) of standard 115.41. In addition, in an interview with the Classification Officer it was confirmed the Classification Officer struggled with articulating how the information obtained from the initial screening would be utilized to determine housing, recreation and other activities, and volunteer work. To become compliant, the facility must implement a practice that includes all required elements of subsection (c) of standard 115.41 when determining detainee housing, recreation and other activities, and volunteer work. Once implemented, the facility must submit documentation that confirms all applicable staff have been trained on the implemented practice. In addition, the facility must provide 10 detainee files that confirm information from the risk screening is utilized when determining initial housing, recreation and other activities, and voluntary work.

Corrective Action Taken (a): The facility submitted an email to all classification staff which confirms staff were trained on the requirements of subsection (c) of the standard. The facility submitted a course history which confirms all applicable staff have been trained on updated policy J100.33 which is compliant with the standard. The facility submitted two detainee risk assessments which included, "Information gathered during the initial classification/PREA screening will be used to determine initial housing, bed, recreation, programming assignments (if applicable) and other activities with the goal of keeping separate those inmates at high risk of being sexually victimized away from those at high risk of being sexually abusive. Were any changes made in the initial determination for housing, bed, recreation, programming assignments (if applicable) and other activities based upon the responses above?" Both risk assessments indicate no changes were made. In addition, the facility submitted a memorandum to Auditor which states, "The updated risk screen form has been implemented but there have not been any detainee risk assessments during the CAP for determining recreation and other activities. Additionally, ICE detainees are not used for volunteer work at the facility." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (a) of the standard.

§115. 51 - Detainee reporting
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c): CCCC policy J100.33 states, "Detainee reports of sexual abuse, retaliation, staff neglect, or violations of responsibilities that may have contributed to such incidents may be made using any available methods of communication, including but not limited to: Reports to the Facility: a. Verbal reports to a staff member (including the Sexual Abuse and Assault Prevention and Intervention Program Coordinator or medical staff); b. Written informal or formal requests or grievances to the facility line staff, supervisors, medical staff and/or PREA Compliance Manager; c. Anonymous Reports to a staff member; d. Sick call requests; e. Telephone calls made to the in-house PREA number of 269-555-[redacted]. Reports to Family Members, Friends, or Other Outside Entities: f. Reports to an individual or organization outside the facility who can contact facility staff. Reports to DHD/ICE: g. Written informal or formal requests or grievances (including emergency grievances) to ICE; h. Telephone calls or written reports to the DHS/OIG, ICE/OPR, ICE JIC; I. Calls can be made confidentially and anonymously and from third parties." CCCC policy J100.33 further states, "Staff shall accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports." An interview with the facility PSA Compliance Manager indicated detainees are provided multiple ways to privately report sexual abuse, retaliation and staff neglect, or violations of responsibilities that may have contributed to an incident, which include the facility PREA reporting line, through the grievance system, through any staff member, DHS OIG, DRIL, or through the detainee family members. During the on-site audit, the Auditor observed posted on the housing unit bulletin boards, in English and Spanish, the DHS-prescribed sexual assault awareness notice with the name and phone number of the PSA Compliance Manager, contact information for consular officials, contact information for the DHS OIG, and the ICE ERO Detention Reporting and Information Line (DRIL) contact number. With the assistance of a detainee, the Auditor utilized a detainee phone, and tested the facility PREA reporting line. The test of the phone confirmed the line prompts the detainee to leave a message for the PSA Compliance Manager. Upon leaving a message, the Auditor was notified within a few minutes that the message left had been received by the PSA Compliance Manager and other supervisors via email. The Auditor tested the number and instructions for contacting the consular officials and confirmed it was in good working order. However, the Auditor attempted to call the DHS OIG and the DRIL and experienced difficulty testing the phones without the facility providing specific instructions on how to access the numbers. Instructions were obtained with the assistance of the facility IT department; however, the Auditor could not confirm these instructions are provided to detainees; and therefore, the Auditor could not confirm the detainee had access to two of the multiple ways the Agency has provided detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have

contributed to such incidents. Interviews with six random security line-staff confirmed they were knowledgeable regarding the multiple ways detainees can report an allegation and were aware they must accept reports made verbally, in writing, anonymously or by third party. Interviews with nineteen detainees, indicated the detainees were aware of several ways to report an allegation of sexual abuse, including the facility PREA reporting line.

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed information posted within the housing units in English and Spanish that advised detainees how to contact their consular official, the DHS OIG and ICE ERO DRIL; however, the Auditor had difficulty testing the numbers provided for DHS OIG and the ICE ERO DRIL. Instructions were obtained with the assistance of the facility IT department; however, the Auditor could not confirm these instructions are provided to the detainees; and therefore, the Auditor could not confirm the detainee had access to two of the multiple ways the Agency has provided detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. To become compliant, the facility must submit documentation that confirms instructions on how to contact the DHS OIG and ICE ERO DRIL were provided to all detainees in a manner they can understand including those who do not speak English or Spanish.

Corrective Action Taken (a)(b): The facility submitted instructions in English for accessing OIG from the detainee phones and provided the instructions in Spanish for accessing DRIL from the detainee phones. The facility provided the Auditor with 10 detainee signatures sheets (6 Spanish, 2 English, 1 Russian, and 1 Chinese) which confirm the detainee received the CCSO facility handbook and the use of the language line for those detainees whose preferred language was other than English or Spanish. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (a) and (b) of the standard.

§115. 53 - Detainee access to outside confidential support services
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d): CCCC policy J100.33 states, "Victims should be provided emergency and ongoing medical and mental health services as needed. A outside or internal victim advocate shall provide emotional support, crisis intervention, information and referrals. The facility shall, attempt to make available to the victim a victim advocate from a rape crisis center." The Auditor reviewed a Calhoun County Sexual Assault Protocol. The protocol is provided by the Sexual Assault Services (SAS) to provide guidance and a consistent, coordinated response to reports of sexual assault in all of Calhoun County, Michigan, in an effort to aide responders while promoting community safety, victims' services, and offender accountability. The protocol is updated annually and is signed by all key stakeholders, to include Dispatch/Emergency Communications, Law Enforcement, SAS Advocates, SAS SANE, Prosecution, Victims Witness Unit, State of Michigan Crime Lab, Child Advocacy Center, Child Protection Agency, the Local Hospital, and the CCSO. The Auditor interviewed the SAS SANE Supervisor and an SAS Victim Advocate. The SANE Supervisor confirmed CCSO's participation in the Calhoun County Sexual Assault Protocol. In addition, the SAS Victim Advocate confirmed crisis intervention and counseling services are provided to the victim detainee during the SANE exam and following an incident of sexual abuse, which would include emotional support and crisis intervention during the investigatory interviews and court proceedings. The SAS Victim Advocate further confirmed SAS operates a 24/7, crisis line which offers emotional support, and crisis intervention to all victims who have experienced sexual abuse, regardless, if a SANE exam was conducted or not. In addition, the SAS Victim Advocate confirmed SAS would provide community referrals for additional services, if needed and all services are available for detainees in the custody of CCCC, by calling the crises line number provided. The facility provided the Auditor with the SAS Flyer; however, the Auditor did not observe the flyer posted in the housing units for detainees to access. The Auditor did observe a 4' by 5' mailing label in the units, that provided the detainee with a phone number to access SAS; however, no additional information was posted to inform the detainee of the services SAS could provide. A review of the facility handbook confirmed the SAS address, and crisis hotline telephone number is provided; however, no additional information is provided regarding SAS services. The facility handbook informs the detainee that all phone calls can be monitored; however, the handbook does not inform detainees the extent to which reports of sexual abuse would be forwarded to the authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor tested the SAS crisis line and confirmed the call could not be completed from a detainee phone. In addition, the facility provides detainees the 1-800 for RAINN, the National Sexual Assault Hotline. The Auditor attempted to a test call; however, the call could not be completed. Informal interviews with detainees indicated, they are prevented from calling 1-800 numbers from the detainee phones. The Auditor formally interviewed nineteen detainees, none of which could recall seeing or hearing information about organizations that can provide support services for sexual abuse victims.

(c)(d): The facility is not in compliance with subsections (c) and (d) of the standard. The facility provided the Auditor with the SAS Flyer; however, the Auditor did not observe the flyer posted in the housing units for detainees to access. The

Auditor did observe a 4' by 5' mailing label in the units, that provided the detainee with a phone number to access SAS; however, no additional information was posted to inform the detainee of the services SAS could provide. A review of the facility handbook confirmed the SAS address, and the crisis hotline telephone number is provided; however, no additional information is provided regarding SAS services. The facility handbook informs the detainee that all phone calls can be monitored; however, does not inform detainees the extent to which reports of sexual abuse would be forwarded to the authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor tested the SAS crisis line and confirmed the call could not be completed from the detainee phones. In addition, Auditor attempted a test call, to the 1-800 for RAINN, the National Sexual Assault Hotline; however, the call could not be completed. Interviews with detainees within the housing unit indicated they are prevented from calling 1-800 numbers from the detainee phones. The Auditor interviewed nineteen detainees, none of which could recall seeing or hearing information about organizations that can provide support services for sexual abuse victims. To become compliant, the facility must make available, in a manner all detainees can understand, information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses, and telephone numbers (including toll-free hotline numbers where available). In addition, the facility must inform detainees, prior to giving them access to outside resources, of the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. Once implemented, the facility must submit to the Auditor documentation that confirms compliance with subsections (c) and (d) of the standard.

Corrective Action Taken (c)(d): The facility submitted a revised detainee handbook. The Auditor reviewed the detainee handbook and confirmed the handbook includes the SAS telephone number and address and the verbiage, "Phone calls can be monitored and reports of illegal activity to include sexual abuse will be forwarded to the appropriate authorities in accordance with mandatory reporting laws." . In addition, a review of the revised detainee handbook confirmed the facility provided instructions to the detainee population on how to confidentially contact the ICE DRIL, JIC, and the DHS OIG utilizing the facility phone system. The facility submitted 10 detainee signatures sheets (6 Spanish, 2 English, 1 Russian and 1 Chinese) which confirm the detainee had received the CCSO facility handbook. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsections (c) and (d) of the standard.

§115. 61 - Staff reporting duties

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

Notes:

(a)(b)(c)(d): CCCC policy J100.33 states, "All staff must immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in the facility; 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. a. All reports should be done through the appropriate chain of command, b. If situationally appropriate, reporting can be done outside of the chain of command and/or reported to the ICE OIG Office." CCCC policy J100.33 further states, "Information concerning the identity of a detainee victim reporting a sexual assault, and the facts of the report itself, should be limited to those who have a need-to-know in order to make decisions concerning the victim's welfare, and for law enforcement/investigative purposes." A review of CCCC policy J100.33 confirms it does not require the facility to report an allegation of sexual abuse made by a detainee considered to be a vulnerable adult under a State or local vulnerable persons statue to the Agency so the Agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. During an interview with the facility Captain, it was indicated he was not aware of the reporting requirements regarding a detainee considered to be a vulnerable adult. Interviews with six random security line-staff confirmed they were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Each staff member could articulate that information obtained in a report of sexual abuse is to remain confidential, except to those with a need-to-know to ensure the detainee's welfare or during an investigation to an investigator. In addition, interviews with six security line-staff confirmed they are aware of their ability to make a report outside of the chain of command to the MSP or the DHS OIG. The Auditor reviewed seven sexual abuse allegation investigative files and confirmed none of the alleged victims were considered vulnerable adults. Interviews with the facility Captain and the AFOD confirmed CCCC policy J100,33 has been reviewed and approved by the Agency. CCCC does not house juvenile detainees.

(d): The facility is not in compliance with subsection (d) of the standard. A review of CCCC policy J100.33 confirms it does not require the facility to report an allegation of sexual abuse made by a detainee considered to be a vulnerable adult under a State or local vulnerable persons statue to the Agency so the Agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. During an interview with the facility Captain, it was indicated that he was not aware of the reporting requirements regarding a detainee considered to be a vulnerable adult. To become compliant, the facility must revise CCCC policy J100.33 to include the requirement the facility report an allegation of sexual abuse made by a detainee considered to be a vulnerable adult under a State or local vulnerable persons statue to the

Agency so the Agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. Once updated, the facility must refer the updated policy J100.33 to the Agency for review and approval. The facility must train all applicable staff on the reporting requirement for vulnerable adult victims of an alleged sexual abuse. If applicable, the facility must submit all sexual abuse investigation files that include a detainee considered to be a vulnerable adult under a State or local vulnerable persons statue to confirm the new practice has been implemented.

Corrective Action Taken (d): The facility submitted revised policy J100.33 which confirms it includes, "If the alleged victim is considered a vulnerable adult under a State or local vulnerable persons statue, the agency shall report the allegation to the designated State or local services agency under applicable reporting laws." The facility submitted a course history and email sent to all facility medical and mental health staff which confirmed it included revised policy J100.33 and required each staff member to review the policy. The facility submitted a memorandum from the Acting AFOD which confirms policy J100.33 has been reviewed and approved by the Agency. The facility submitted a memorandum which states, "During this audit timeframe, there are no investigative files to provide that include a detainee that is considered to be a vulnerable adult under a state or local vulnerable persons statute." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (d) of the standard.

§115. 64 - Responder duties

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

Notes:

(a)(b): CCCC policy states, "First Responder Requirements: a. Staff should take immediate action to separate any detainee who alleges that he/she has been sexually assaulted from the alleged assailant and should refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms; b. Staff suspected of perpetrating sexual abuse or assault should be removed from all duties requiring detainee contact pending the outcome of an investigation; c. When possible and feasible, staff should immediately preserve the crime scene, and safeguard information and evidence consistent with the facility's evidence-gathering and evidence-processing procedures, d. If the abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim and the alleged abuser not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder is not security staff, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." Interviews with six random security line-staff, indicated they were knowledgeable in their duties as a first responder by noting if a detainee reported an allegation of sexual abuse to them, they would separate the detainee, request the detainee victim and ensure the alleged abuser does not take any actions that could destroy physical evidence, preserve the crime scene and notify their immediate supervisor. The Auditor interviewed the MD and the RN, as non-security first responders. The MD and RN both indicated they would immediately call for back up, separate the detainees if possible, and notify a supervisor; however, the non-security staff first responders could not articulate they would request the victim not to take any action that could destroy physical evidence.

(b): The facility is not in compliance with subsection (b) of the standard. The Auditor interviewed the MD and the RN as non-security first responders. The MD and RN both indicated they would immediately call for back up, separate the detainees if possible and notify a supervisor; however, the non-security first responders did not articulate they would request the victim not to take any action that could destroy physical evidence. To become compliant, the facility must submit documentation to confirm all non-security first responders have been trained in their first responder responsibilities to request the victim not to take any action that could destroy physical evidence and then notify security staff. If applicable, the facility must submit all sexual abuse allegation investigation files that include a non-security first responder that occur during the CAP period.

Corrective Action Taken (b): The facility submitted an email sent to all non-custody first responders instructing them to review policy J100.33 which includes non-custody first responder duties. The facility submitted four non-custody first responder acknowledgements which confirmed they have received the required training. The facility submitted a memorandum that states, "There haven't been any sexual abuse allegations at Calhoun which included a non-security first responder that occurred during the CAP Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsection (b) of the standard.

§115. 65 - Coordinated response

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

Notes:

(c)(d): CCCC policy J100.33 states, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of 6 CFR part 115 of the federal registry, the facility shall provide ICE/ERO, as permitted by law, the victim's potential need for medical or social services. ICE/ERO will then inform the receiving facility of the incident and victim's potential need for medical or social services. CCSO would provide such information in the medical packet that is sent with outgoing detainees. If the victim is transferred from another DHS immigration detention facility to a facility not covered by DHS standard 115.65 (c) of this section, the facility shall provide ICE/ERO, as permitted by law, the victim's potential need for medical or social services. ICE/ERO will then inform the receiving facility of the incident and victim's potential need for medical or social services. CCSO would provide such information in the medical packet that is sent with outgoing detainees, unless the victim requests otherwise." An interview with the facility Captain indicated he would have to defer to medical staff, but believed the information would be shared with the receiving facility. An interview with a RN indicated with detainee consent, she would provide all medical information regarding a sexual assault to include the need for continued medical services or mental health service.

(c)(d): The facility is not in compliance with subsection (c) and (d) of the standard. An interview with the facility Captain indicated he would have to defer to medical staff, but believed the information would be shared with the receiving facility. An interview with a RN indicated, with detainee consent, she would provide all medical information regarding a sexual assault to include the need for continued medical services or mental health service. To become compliant the facility must submit documentation that all applicable staff, including medical, have been trained on the requirements of subsection (c) and (d) of the standard. In addition, if applicable, the facility must submit to the Auditor any sexual abuse allegation investigative files that include the transfer of a detainee due to an incident of sexual abuse that occur during the CAP period.

Corrective Action Taken (c)(d): The facility submitted a training memo to all medical staff which confirms medical staff have been trained on the requirements of subsections (c) and (d) of the standard. The facility submitted a memorandum which states, "There haven't been any detainees transferred from Calhoun due to an incident of sexual abuse during the CAP Period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (c) and (d) of the standard.

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

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

Notes:

CCCC policy J100.33 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse and assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." An interview with the facility Captain indicated that any staff suspected of perpetrating sexual abuse would be removed from contact with detainees and/or placed on administrative leave pending the outcome of an investigation. The facility Captain further indicated, a contractor or volunteer suspected of perpetuating sexual abuse would be removed from the facility pending the outcome of the investigations. The Auditor reviewed four sexual abuse allegation investigation files that included staff-on-detainee and could not confirm the staff member involved in the allegation was removed from detainee contact pending the outcome of the investigation.

The facility is not in compliance with the standard. The Auditor reviewed four sexual abuse allegation investigation files that included staff-on-detainee and could not confirm the staff member involved in the allegation was removed from having contact with a detainee pending the outcome of the investigation. To become compliant, the facility must submit documentation that all applicable staff have been trained on the standard's requirement to remove all staff, contractors, and volunteers suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of the investigation. If applicable, the facility shall provide all sexual abuse allegation investigations that include staff-on-detainee, contractor-on-detainee, and volunteer-on-detainee that occur during the CAP period.

Corrective Action Taken: The facility submitted updated policy J100.33 which confirms it requires all staff involved in the allegation of sexual abuse be removed from having contact with a detainee pending an outcome of the investigation. The facility provided a course history which confirmed all security staff, including supervisors, have been trained on the updated policy. The facility submitted a memorandum which states, "There have been no sexual abuse allegations that have occurred at Calhoun which included staff-on-detainee, contractor-on-detainee, or volunteer-on-detainee during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with the standard.

§115. 67 - Agency protection against retaliation

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

Notes:

(a)(b)(c): CCCC policy J100.33 states, "Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse and assault, or for participating in sexual abuse and assault as a result of force, coercion, threats, or fear of force. The facility shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse and assault or for cooperating with investigations. For at least 90 days following a report of sexual abuse and assault, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The Auditor reviewed a memorandum dated February 23, 2023, which states, "Prior to the facility Pre-PREA Audit, the facility did not physically document retaliation. However, retaliation was monitored by jail supervisors and classification deputies for at least 90 days. A form has since been created and will be used for future PREA complaints." The Auditor reviewed the CCSO PREA Retaliation Monitoring Report (30/60/90). The form states, "Following a report of sexual abuse, the facility will monitor the conduct/treatment or those persons reporting and/or cooperating with the investigations, to include inmates/detainees or staff and the alleged inmate/detainee victim, regarding changes that may suggest possible retaliation by inmates/detainees or staff; ex: inmate/detainee disciplinary, housing or program changes and staff -reassignment, negative performance review, etc." An interview with the PSA Compliance Manager indicated the facility will utilize the CCSO PREA Retaliation Monitoring Report (30/60/90) to monitor all detainee victims, witness and staff who may cooperate with an investigation. An interview with the facility Captain, indicated a detainee or a staff member who participates in retaliation of detainee victim, witness or staff will be disciplined. The Auditor reviewed seven investigative files; however, all allegations were reported prior to the retaliation monitoring being implemented at the facility; and therefore, the facility could not document the practice had been implemented prior to the exit interview.

(a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. The Auditor reviewed a memorandum dated February 23, 2023, which states, "Prior to the facility Pre-PREA Audit, the facility did not physically document retaliation. However, retaliation was monitored by jail supervisors and classification deputies for at least 90 days. A form has since been created and will be used for future PREA complaints." The Auditor reviewed the CCSO PREA Retaliation Monitoring Report (30/60/90) and confirmed it contained all elements of subsection (b) of the standard; however, a review of seven sexual abuse investigation files could not confirm retaliation monitoring had been implemented at the facility prior to the exit interview. To become compliant, if applicable, the facility must provide the Auditor with all sexual abuse allegation investigation reports and the corresponding CCSO PREA Retaliation Monitoring Report (30/60/90) that occur during the CAP period.

Corrective Action Taken (a)(b)(c): The facility submitted a memorandum which states, "There have been no sexual abuse allegations that occurred at Calhoun during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a), (b), and (c) of the standard.

§115. 71 - Criminal and administrative investigations

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

Notes:

(a)(b)(c)(e)(f): CCCC policy R903, Prison Rape Elimination Act, states, "The CCSO shall promptly, thoroughly and objectively investigate all allegations, including third party and anonymous reports of sexual abuse or sexual harassment." CCCC policy R903 further states, "The responsibilities of investigators shall include, but limited to (a) gathering and preserving direct and circumstantial evidence and any available electronic monitoring data. (b) Interviewing alleged victim, suspects and witnesses. (c) Reviewing any prior complaints and reports of sexual abuse involving the suspect. (d) Conducting compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecutions. (e) Assessing the credibility of the alleged victim, suspect or witness on an individual basis and not by the person's status as an individual in custody or a member of the Calhoun County Sheriff's Office. (f) Documenting in written reports a description of physical, testimonial, documentary and other evidence, the reasoning behind any credibility assessments, and investigative facts and findings. (g) Referring allegations of conduct that may be criminal to the County Prosecutor for possible prosecution, including any time there is probable cause to believe an individual in custody sexually abused another individual in custody at the CCSO facility. (h) Cooperating with outside investigators and remaining informed about the progress of any outside investigation." In addition, CCCC policy R903 states, "The departure of the alleged

abuser or victim from employment or control of CCSO shall not be used as a basis for terminating an investigation." A review of the facility PAQ indicates the facility has eight specially trained investigators to conduct sexual abuse allegations; however, the facility has not provided the Auditor with documentation to confirm each investigator has received specialized training on sexual abuse and effective cross-agency coordination; and therefore, the Auditor could not confirm the eight facility investigators are trained as required by subsection (a) of the standard. In an interview with the PSA Compliance Manager/Investigator it was indicated the facility will conduct an administrative investigation on all allegations of sexual abuse and each investigator will work with the criminal investigator to ensure the criminal case is not compromised. In addition, the PSA Compliance Manager/Investigator indicated all investigations are completed promptly, thoroughly and objectively and would be completed even if the alleged victim was no longer housed at the facility. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed the investigations were completed promptly and objectively; however, the Auditor could not confirm the investigations were thorough or that the investigators were properly trained and qualified. A review of the seven sexual abuse allegation investigation reports confirmed they did not include a thorough description of the physical and testimonial evidence, the reasoning behind a creditability assessment and the investigative facts and findings. In several of the investigations, the Auditor relied on the facility PREA Allegation Spreadsheet in order to determine the outcome of the investigation, as it was not contained in the report. In one investigative file, the Auditor reviewed a memorandum to the alleged victim, which notified the victim detainee that the case was determined to be unfounded. The memorandum included a description of physical evidence that was used by the investigator to determine the victim detainee was not being truthful when the allegation was reported; however, none of the evidence relied upon for the unfounded determination was contained in the investigation report.

(a)(c): The facility is not in compliance with subsection (a) and (c) of the standard. A review of the facility PAQ indicates the facility has eight specially trained investigators to conduct sexual abuse allegations; however, the facility has not provided the Auditor with documentation to confirm each investigator has received the required specialized sexual abuse and effective cross-agency coordination training. In addition, the Auditor reviewed seven sexual abuse allegation investigation files and confirmed the investigations were completed promptly and objectively; however, the reports were not thorough as they did not include a description of the physical and testimonial evidence, the reasoning behind a creditability assessment and the investigative facts and findings. To become compliant, the facility must provide the Auditor with a copy of the training curriculum to confirm it includes all required training elements as set forth in standard 115.34. In addition, the facility must specially train all staff who conduct sexual abuse allegation investigations and document such training. The facility shall ensure all investigations are thorough to include a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings as required in subsection (c) of the standard. If applicable, the facility must submit to the Auditor all sexual abuse allegation investigation files that occur during the CAP period.

Corrective Action Taken (a)(c): The facility submitted training certificates which confirm eight investigators have received specialized training "PREA – Investigating Sexual Abuse in a Confinement Setting" offered through NIC. As the Auditor is familiar with the training provided the Auditor no longer requires a copy of the training curriculum. The facility submitted a memorandum which states, "There have been no sexual abuse allegations at Calhoun that occurred during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (c) of the standard.

§115. 73 - Reporting to detainees

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

Notes:

Agency Policy 11062.2 states, "For detainees still in ICE immigration detention, or where otherwise feasible, following an investigation into a detainee's allegation of sexual abuse or assault, notify the detainee as to the result of the investigation and any responsive action taken, in coordination with the FOD." CCCC policy J100.33 states, "CCSO shall, when the detainee is still in immigration detention, or where otherwise feasible, notify the detainee of the outcome of the investigation and any responsive action taken." Interviews with the PSA Compliance Manager/Investigator indicated that a memorandum is prepared and sent to a detainee victim to notify the detainee of the outcome of the investigation. If the detainee is no longer in the facility custody, the memorandum will be sent to the detainee's last known address. The Auditor reviewed seven investigative files and confirmed six of the files contained a memorandum which notified the victim detainee of the results of the investigation; however, in the one substantiated case, the Auditor could not confirm that the facility notified the detainee of the responsive action the facility had taken as the result of the substantiated finding.

The facility is not in compliance with the standard. The Auditor reviewed seven investigative files and confirmed six of the files contained a memorandum which notified the victim detainee of the results of the investigation; however, in the one substantiated case, the Auditor could not confirm that the facility notified the detainee of the responsive action the facility

had taken as the result of the substantiated finding. To become compliant, the agency must implement a practice to ensure a detainee victim is notified of the results of an investigation, and any responsive action taken by the facility. If applicable, the facility must submit to the Auditor all closed sexual abuse allegation investigation files, and the corresponding notification to detainee, that occurred during the CAP period.

Corrective Action Taken: The facility submitted a memorandum which states, "There were no sexual abuse allegation investigation files that occurred during the CAP period; therefore, there were no substantiated cases for examples." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with the standard.

§115. 86 - Sexual abuse incident reviews

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

Notes:

(a)(b)(c): CCCC policy J100.33 states, "The facility Sexual Abuse and Assault Prevention and Intervention Program Coordinator should, together with upper-level management officials, conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation to assess and improve prevention and response efforts. Such review should ordinarily occur within 30 days of the conclusion of the investigation. In conducting the review, the Program Coordinator should seek input from line supervisors, investigators, and medical or mental health practitioners. The reviewer(s) should: (a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. (b) consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. (c) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable the abuse. (d) Assess the adequacy of staffing levels in that area during different shifts; (e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff, and (f) Prepare a written report of findings (within 30 days of all incidents) and any recommendations for improvement and submit such report to the jail administrator. The facility should implement the recommendations for improvement or should document its reasons for not doing so. The report, response and review shall be forwarded to the ICE Agency PSAC." An interview with the PSA Compliance Manager, indicated the facility utilizes a PREA Incident Review Team Checklist to document a sexual abuse incident review and a review is conducted within 30 days of conclusion of the investigation. The PSA Compliance manager further indicated, the review team is made up of the PSA Compliance Manager, security supervisors, medical/mental health staff and investigators. The Auditor reviewed the facility PREA Incident Review Team Checklist. The checklist includes elements (a) - (f) listed above in the policy, which are consistent with the standard, and requires a yes or no response to each of the elements. Section (g) of the checklist states, "if the answer to (3) is yes, does the facility implement the recommendations for improvement contained in the incident review team's report or document its reasoning for not doing so." In an interview with the PSA Compliance Manager, it was confirmed the checklist is utilized in place of a written report of the review team findings, to include but not necessarily limited to, determinations made and any recommendations for improvement; however, the checklist does not include the review team's findings or recommendations made for improvement. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed each file contained the PREA Incident Review Team Checklist, to include those investigations that were determined to be unfounded; however, the Checklist does not include a date when the form was completed; and therefore, the Auditor could not determine the checklist had been completed within 30 days of the conclusion of the investigation. In addition, the Auditor reviewed documentation to confirm the checklist and the investigation report had been forwarded to the Agency PSA Coordinator. The Auditor reviewed a memorandum to the Chief Deputy regarding a Review of PREA Incidents for 2022. The annual review includes the facility statistics of all incidents reported and investigated at the facility and does not differentiate between detainee and inmate allegations; and therefore, the Auditor could not determine if all reported allegations of sexual abuse were included in the annual report. In addition, the annual review does not indicate the annual review included a review of all sexual abuse investigations and resulting incident reviews in order to assess and improve sexual abuse interventions, preventions and response efforts, or the findings of the review. Documentation was provided to the Auditor to indicate the facility had submitted the annual review to the Agency PSA Coordinator.

(a)(c): The facility is not in compliance with subsection (a) and (c) of this standard. The Auditor reviewed the facility PREA Incident Review Team Checklist and confirmed the checklist does not include the review team's findings or recommendations made for improvement. The Auditor reviewed seven sexual abuse allegation investigation files and determined each file contained the PREA Incident Review Team Checklist; however, the checklists were not dated; and therefore, the Auditor could not determine the checklist had been completed with 30 days of the conclusion of the investigation. The Auditor reviewed the annual review for 2022 and confirmed it includes the facility statistics of all incidents reported and investigated at the facility and did not differentiate between and detainee and inmate allegations; and therefore, the Auditor could not confirm all detainee sexual abuse allegations had been reported for the year. In addition,

the review of the 2022 annual report confirmed it does not indicate the annual review included a review of all sexual abuse investigations and resulting incident reviews, in order to assess and improve sexual abuse interventions, preventions and response efforts or the findings of the review. Documentation was provided to the Auditor to indicate the facility had submitted the annual review to the Agency PSA Coordinator; however, the annual review for 2022 is not compliant with subsection (c) of the standard. To become compliant, the facility must submit documentation that confirms the sexual abuse incident review is completed within 30 days of the conclusion of the investigation. The review shall include the review team's findings or recommendations made for improvement, and implement the recommendations, or shall document the reasons for not doing so in a written response. In addition, the facility must conduct an annual review that differentiates between detainee and inmate allegations, of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse interventions, preventions and response efforts. Once completed the facility must submit documentation that the updated annual review has been forwarded to the facility administrator, FOD or his/her designee, and the Agency PSA Coordinator.

Corrective Action Taken (a)(c): The facility provided the Auditor with a revised After-Action Review for Immigration PREA Complaints which confirms it included the date of the report, improvement plan suggestions, and recommendation made by the review committee. The facility submitted the 2023 PREA Annual Report which confirmed a division between detainee allegations and inmate allegations. The facility submitted email documentation which confirmed the annual report had been forwarded to the facility administrator, the FOD, and the Agency PSA Coordinator. The facility submitted a memorandum which states, "There have been no sexual abuse allegations that occurred during the CAP period." Upon review of all submitted documentation the Auditor now finds the facility in substantial compliance with subsections (a) and (c) of the standard.

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

Robin Brock February 26, 2024
Auditor's Signature & Date

(b) (6), (b) (7)(C) February 26, 2024
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) February 27, 2024
Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	6/06/2023	**To:**	6/08/2023
AUDITOR INFORMATION			
Name of auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Detroit
Field Office Director:	Robert Lynch
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	333 Mt. Elliott Street Detroit, MI 48207

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Calhoun County Correctional Center		
Physical address:	185 East Michigan Avenue Battle Creek Michigan 49014		
Telephone number:	269-969-6303		
Facility type:	IGSA		
PREA Incorporation Date:	6/25/2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Officer In Charge (OIC)
Email address:	(b) (6), (b) (7)(C) v	**Telephone #:**	269-969-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	269-969-

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of Calhoun County Correctional Center (CCCC) was conducted June 6-8, 2023, by U.S. Department of Justice (DOJ) and DHS Certified PREA Auditor Robin M. Bruck, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Contract Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C), both DOJ and DHS Certified PREA Auditors. The PM's role is to provide oversight for the ICE PREA audit process and liaison with ICE Office of Professional Responsibilities (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility compliance with the DHS PREA Standards. CCCC is a county facility operated by the Calhoun County Sheriff's Office (CCSO) and is under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). CCCC is located in Battle Creek, Michigan. The audit is the first audit for CCCC and includes a review period of June 25, 2020, through June 8, 2023.

The facility houses adult male and female detainees with low medium and high custody levels awaiting deportation. The design capacity for the facility is 630 and is comprised of County, State, and other federal inmates. The facility PRE-Audit Questionnaire (PAQ) reported 575 ICE detainees have been booked into the facility in the last 12 months. The average daily ICE population for the prior 12 months was 65. The population on the first day of the on-site audit was 56 which included 54 male detainees and 2 female detainees. The top three nationalities housed at the facility are Mexico, Guatemala and Honduras. The average length of time in custody is 35 days.

Approximate four weeks prior to the on-site audit, ERAU Inspections and Compliance Specialist (ICS) (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) provided the Auditor with the facility PAQ, Agency policies, facility policies, and other supporting documentation through the ICE SharePoint. The PAQ, policies, and supporting documentation had been organized utilizing the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into folders for ease of auditing. The ERAU Team Lead (TL) role for this audit was reassigned to (b) (6), (b) (7)(C), prior to the on-site audit. The facility has multiple policies which contain PREA procedures; however, the main policy which governs CCCC's PREA Program is J100.33 Sexual Abuse Prevention and Intervention (SAAPI). All policies and procedures and supporting documentation were reviewed by the Auditor prior to the on-site audit. In addition. the Auditor reviewed both the facility website: https://www.calhouncountymi.gov/departments/sheriffs_office/prea and ICE website www.ice.gov.

On Tuesday, June 6, 2023, at 8:15 a.m. an entrance briefing was conducted in a facility office. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance, were:

(b) (6), (b) (7)(C) TL, ICS/OPR/ERAU
(b) (6), (b) (7)(C) PSA Compliance Manager, CCCC
Robin M. Bruck, DOJ/DHS Certified Auditor, Creative Corrections LLC

The Auditor introduced herself and provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures, but also to determine whether such policies and procedures are reflected in the knowledge of staff of all levels and the detainees housed within the facility. She further explained compliance with the PREA standards will be determined based on a review of the policies and procedures, observations during the on-site audit, documentation review, and interviews with staff and detainees.

At the conclusion of the entrance briefing, an on-site tour of the facility was conducted by the Auditor, TL, and key CCCC staff. The physical plant consists of one building with an administrative area, booking/intake area, and housing units where detainees can be housed. There are two single cell housing units, 11 multiple occupancy units, 4 open bay dormitories, and an administrative segregation area. In addition, there are three holding cells within the medical and mental health area. Currently the facility is utilizing two housing units, to quarantine incoming inmates and detainees for 14 days prior to housing them in the general population.

The Auditor observed all areas of the facility where detainees are afforded the opportunity to go, which include housing units, the booking/intake area, and medical and mental health area. In addition, the Auditor observed the control center. The Auditor made visual observations, which included examination of the detainee bathrooms and shower areas, officer post sight lines, and camera locations. Sight lines were closely examined, as were areas with a potential for blind spots. During the on-site audit, the Auditor randomly spoke with detainees and staff regarding their knowledge of PREA and facility procedures. A review of the housing unit logbooks was conducted to confirm security inspections and unannounced security inspections were being conducted by security line staff and supervisors. There is a total of (b) (7)(E) located throughout the facility. (b) (7)(E) are monitored 24/7 (b) (7)(E) with the exception of the (b) (7)(E) do not have the ability to pan or tilt. (b) (7)(E) . The Auditor observed that staff assigned to the (b) (7)(E) could view all areas of the facility at any time and facility supervisors have access (b) (7)(E) . The Auditor observed the (b) (7)(E) and confirmed those areas, had a black square box, digitally imposed to prevent viewing of detainees while performing bodily functions, showering, or changing clothes. The Auditor noted telephones are available for the detainees which allows reporting accessibility. The Auditor tested phone lines and numbers provided to the detainee to access services or for reporting an incident. PREA information, posters/brochures, to include the DHS-prescribed sexual assault awareness notice with contact information including addresses and phone numbers, how to report within and outside the facility, foreign consulates with addresses and phone numbers, I-Speak posters, the ICE Language Assistance Flyer, and the notification of audit, which was posted in English, Spanish, Portuguese, French, Haitian Creole, Bengali, Russian, and Vietnamese. The Auditor received one correspondence, prior to the on-site audit; however, the letter was confirmed to be from an inmate and not an ICE Detainee. All notifications concerning the content of the letter were shared with the facility by Creative Corrections, LLC.

CCCC employs 119 security staff, who may have recurring contact with the detainees comprised of 83 male officers and 36 female officers. In addition, there are 29 medical staff and 1 mental health clinician working at the facility employed by the YesCare Corporation. Additional staff are food service and commissary which do not have contact with detainees. The Auditor conducted 22 staff interviews to include,

Captain (1), PSA Compliance Manager (1), supervisors who conduct unannounced security inspections (2), Human Resource Manager (HRM) (1), Investigator (1), Classification Officer (1), Intake Officer (1), Grievance Officer (GO) (1), Security First Responders (5), non-Security First Responders (2), and random Security line-staff (6). In addition, the Auditor interviewed one ICE staff Assistant Field Office Director (AFOD), three contractor staff (Registered Nurse (RN), Medical Director (MD), one mental health clinician), two contractors/volunteers, and two staff employed with the Sexual Assault Services (SAS) (one Supervisor and one SAS Victim Advocate). Interviews were conducted in a private area to allow for confidentiality.

The Auditor conducted 19 detainee interviews, (18 male detainees and 1 female detainee). Two of the male detainees interviewed were Spanish speaking; and therefore, their interviews were conducted utilizing Language Services Associates (LSA) a contract language interpretative service provided by Creative Corrections, LLC. Each interview was conducted in the housing unit television room which provided the detainees with confidentiality.

The facility PAQ reported there were eight investigators who received specialized training on sexual abuse. According to the PREA allegation spreadsheet there were seven allegations of sexual abuse reported during the audit period to include two inmate-on-detainee, one-detainee-on detainee, and four staff-on-detainee. Of the seven allegations reported five allegations were determined to be unsubstantiated, one allegation was substantiated, and one allegation was unfounded. The substantiated allegation involved a detainee-on-detainee.

On June 8, 2023, an exit briefing was conducted in an office located in the facility. In attendance were:

(b) (6), (b) (7)(C) TL, ICS/OPR/ERAU
(b) (6), (b) (7)(C) PSA Compliance Manager, CCCC
Robin M. Bruck, Creative Corrections LLC, DOJ/DHS Certified Auditor

Attendance by phone included:

(b) (6), (b) (7)(C) Field Office Director (FOD), ICE/ERO
(b) (6), (b) (7)(C) AFOD, ICE/ERO
(b) (6), (b) (7)(C) Chief Deputy, CCCC
(b) (6), (b) (7)(C) Captain, CCCC

The Auditor spoke briefly and informed those present that it was too early in the process to formalize a determination of compliance on each standard. The Auditor would review all documentation, interview notes, file review notes, and on-site observations to determine compliance. The Auditor thanked all facility staff for their cooperation in the audit process. The TL explained the audit report process, timeframes for any corrective action imposed, and the timelines for the final report.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

Number of Standards Met: 19

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
- §115.18 - Upgrades to facilities and technologies
- §115.21 - Evidence protocols and forensic medical examinations
- §115.32 - Other Training
- §115.43 - Protective Custody
- §115.52 - Grievances
- §115.54 - Third-party reporting
- §115.62 - Protection Duties
- §115.63 - Reporting to other Confinement Facilities
- §115.68 - Post-allegation protective custody
- §115.72 - Evidentiary standard for administrative investigations
- §115.76 - Disciplinary sanctions for staff
- §115.77 - Corrective action for contractors and volunteers
- §115.78 - Disciplinary sanctions for detainees
- §115.81 - Medical and mental health screening; history of sexual abuse
- §115.82 - Access to emergency medical and mental health services
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.87 - Data collection
- §115.201 - Scope of Audit

Number of Standards Not Met: 21

- §115.13 - Detainee supervision and monitoring
- §115.15 - Limits to cross-gender viewing and searches
- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient
- §115.17 - Hiring and promotion decisions
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight
- §115.31 - Staff Training
- §115.33 - Detainee Education
- §115.34 - Specialized training: Investigations
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.51 - Detainee Reporting
- §115.53 - Detainee access to outside confidential support services
- §115.61 - Staff and Agency Reporting Duties
- §115.64 - Responder Duties
- §115.65 - Coordinated Response
- §115.66 - Protection of detainees from contact with alleged abusers

- §115.67 - Agency protection against retaliation
- §115.71 – Criminal and administrative investigations
- §115.73 - Reporting to detainees
- §115.86 - Sexual abuse incident review

Number of Standards Not Applicable: 1

- §115.14 - Juvenile and family detainees

PROVISIONS

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

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

Outcome: Meets Standard

Notes:

(c): CCCC policy J100.33 states, "The Calhoun County Sheriff (CCSO) maintains a zero-tolerance policy for all forms of sexual abuse or assault. It is the policy of the CCSO to provide a safe and secure environment for all detainees, employees, contractors, and volunteers, free from the threat of sexual abuse or assault, by maintaining a Sexual Abuse Prevention and Intervention Program that ensures effective procedures for preventing, reporting, responding to investigation, and tracking incidents or allegations of sexual abuse or assault." CCCC policy J100.33 outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and provides definitions of sexual abuse and general PREA definitions. During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, posted throughout the facility, to include the detainee housing units. A review of a submitted memorandum dated May 11, 2023, and interviews with the Acting AFOD and the facility Captain, confirmed that the ICE ERO Detroit Field Office has reviewed CCCC policy J100.33. A review of the facility website confirmed it includes the statement, "The Calhoun County Sheriff's Office maintains a "Zero Tolerance Policy" for all forms of sexual abuse or assault." Interviews with six random security line-staff, confirmed they were knowledgeable in both the Agency and the facility zero-tolerance policies.

(d): CCCC policy J100.33 states, "The CCSO has a compliance manager who is responsible for overseeing all aspects of the facility's efforts to comply with this zero-tolerance policy, including by: 1) Assisting with keeping current these written policies and procedures for the Sexual Abuse and Assault Prevention and Intervention Program. 2) Assisting with the development of initial and ongoing training protocols. 3) Serving as the liaison with other agencies. 4) Coordinating the gathering of statistics and reports on incidents of sexual abuse or assault. 5) Review the results of every investigation of sexual abuse and conducting an annual review of all investigations to assess and improve prevention and response efforts. 6) Reviewing facility practices to ensure required levels of confidentiality are maintained. 7) Ensuring that the facility cooperates with all ICE/ERO audits and monitoring the facility compliance with sexual abuse and assault policies and standards." The Auditor reviewed the CCSO Organizational Chart and confirmed the PSA Compliance Manager position has the authority to oversee the facility efforts to comply with the sexual abuse prevention and intervention policies and procedures. An interview with the PSA Compliance Manager confirmed she serves as a liaison and point of contact for the Agency PSA Coordinator. In addition, the PSA Compliance Manager indicated she has the time and authority to oversee the facility's efforts to comply with facility sexual abuse prevention and intervention policies and procedures.

Corrective Action:

No corrective action needed.

§115.13 - Detainee supervision and monitoring

Outcome: Does Not Meet Standard

Notes:

(a)(c): CCCC policy J100.6, Inmate Supervision, states, "The Calhoun County Jail should have trained staff available and properly scheduled to provide full coverage of designated posts, 24-hour supervision of inmates, and surveillance of inmates to ensure the control and security of the facility." CCCC policy J100.4, Electronic Surveillance, states, "Electronic surveillance devices should be used only to enhance staff supervision of inmates. Electronic devices should not be used for the following: (1) as a substitute for staff supervision; (2) unlawful, immoral, or voyeuristic purposes. Electronic surveillance devices should be used by correctional staff for the following: (1) to aid security (2) to monitor movement within the facility (3) to monitor activity from control centers (4) for monitoring and documenting special incidents." A review of the facility PAQ indicated CCCC has a total of 119 security staff, consisting of 83 male officers and 36 female officers, that may have reoccurring contact with detainees. In addition, the facility contracts with 29 medical and 1 mental health personnel employed by YesCare Corporation. Additional staff include contract staff with Tiggs Canteen, which do not have contact with the detainees. The Auditor reviewed the facility Consideration Checklist and confirmed the checklist includes all elements of subsection (c) the facility is required to consider when determining adequate staffing levels and the need for video monitoring; however, an interview with the PSA Compliance Manager indicated that she was unsure of the purpose of the form or who had completed it for the year 2022. In addition, during an interview with the facility Captain, it was confirmed the form is not utilized to determine adequate staffing levels or the need for video monitoring, as required by the standard; however, video monitoring is considered when reviewing the staffing plan. During the on-site audit, the Auditor observed staffing levels at the facility and confirmed the levels were adequate noting Security line-staff were seen within all housing units. In addition, the facility utilizes (b) (7)(E) strategically located throughout the facility to aid in supervision and the protection of detainees against sexual abuse. (b) (7)(E) operate 24/7 and are continuously monitored (b) (7)(E) . With the exception of the (b) (7)(E) which can pan, tilt, and zoom (PTZ) (b) (7)(E)

(b)(d): CCCC policy J100.29, Security Inspections, states, "Frequent unannounced security inspections shall be done to identify and deter sexual abuse of inmates and detainees. Staff shall not alert others that these security inspections are occurring, unless such announcement is related to the legitimate operation functions of the facility." Interviews with the facility Captain and the PSA Compliance Manager indicated the facility comprehensive detainee supervision guidelines (Post Orders) are reviewed annually. During the on-site audit, the Auditor confirmed the guidelines had been reviewed in January 2023. Interviews with two security supervisors indicated frequent unannounced rounds are being conducted at the facility. Each round is documented utilizing Guardian RFID. In addition, interviews with two security supervisors confirmed they could articulate that staff are prohibited from alerting others that the security inspections are being conducted. During the on-site audit, the

Auditor reviewed entries of unannounced PREA rounds documented in the system. The review confirmed unannounced inspections are occurring at different times and shifts at the facility.

Corrective Action:

(c): The facility is not in compliance with subsection (c) of the standard. The Auditor reviewed the facility Consideration Checklist and confirmed the checklist includes all elements of subsection (c) the facility is required to consider when determining adequate staffing levels and the need for video monitoring; however, an interview with the PSA Compliance Manager indicated that she was unsure of the purpose of the form or who had completed it for the year 2022. In addition, during an interview with the facility Captain, it was confirmed the form is not utilized to determine adequate staffing levels or the need for video monitoring. To become compliant, the facility must develop and document a practice which takes into consideration all elements required in subsection (c) of the standard when determining adequate staffing levels and the need for video monitoring to protect detainees from sexual abuse. Once developed the facility must provide documentation that confirms the facility took into consideration all required elements of subsection (c) of the standard when determining adequate staffing levels and the need for video monitoring to protect detainees from sexual abuse.

§115.14 - Juvenile and family detainees

Outcome: Not Applicable

Notes:

(a)(b)(c)(d): The Auditor reviewed a memorandum to the file which states, "The Calhoun County Sheriff's Office does not detain juveniles or families for ICE. The facility only detains adults and is a local jail whose primary role is to house local inmates on local charges." Through on-site observations, and staff interviews, the Auditor confirmed the facility does not house juvenile or family detainee units for ICE; and therefore, standard 115.14 is not applicable.

Corrective Action:

No corrective action needed.

§115.15 - Limits to cross-gender viewing and searches

Outcome: Does Not Meet Standard

Notes:

(b)(c)(d): CCCC policy J100.13, Searches, states, "Prior to a Detainee changing into institutional clothing a Deputy of the same sex, under the observance of a witness may pat search the Detainee and/or use a metal detector to scan the Detainee for weapons or contraband." CCCC policy J100.33 states, "Staff of the same gender as the detainee should perform a pat search of a female detainee, unless staff of the same gender are not present at the facility at the time the pat search is required." An interview with the PSA Compliance Manager indicated pat-down searches are performed by staff of the same gender as the detainee. If a pat search is required to be conducted by the opposite gender, the search is documented on a Record of Search form; however, as there were no cross-gender pat-down searches conducted during the audit period there were no completed search forms to review. Interviews with six random security line-staff indicated that cross-gender pat-down searches are not conducted on detainees at CCCC. Interviews with nineteen detainees confirmed during intake they received a pat-down search by a security staff member of the same gender. The Auditor observed several pat-down searches during the on-site audit and confirmed each pat-down search was conducted by staff of the same gender as the

detainee.

(e)(f): CCCC policy J100.13 states, “A detainee should not be strip searched upon admission to our facility unless there is “reasonable suspicion” that a Detainee may be concealing a weapon or other contraband. 1. Prior to a strip search on a Detainee, the Deputy performing the search will contact his/her immediate supervisor for approval. The supervisor will make the final determination that enough reasonable suspicion exists to warrant the strip search. 2. Strip searches should be performed in a private designated area by a Deputy and a Witness, both of the same sex as the Detainee. 3. The Deputy overseeing the strip search will collect take immediate possession of the Detainee’s personal clothing and effects. 4. The Deputy will immediately count and log all of the Detainees funds and will also inspect, search, and log all clothing, and personal property. 5. The Deputy performing the search will complete the Office of the Sheriff strip search form and forward copies to the Shift Supervisor” And “except as provided in subsection 3, the search of a body cavity should not be conducted without a valid search warrant. A body cavity search should be conducted by a licensed physician or a physician's assistant, or a licensed practical nurse or registered professional nurse acting with the approval of a licensed physician. If the body cavity search is conducted by a person of the opposite sex of the person being searched, the search should be conducted in the presence of a person of the same sex as the person being searched.” CCCC policy J100.33 states, “All strip searches should be performed by staff of the same gender as the detainee. In the case of an emergency, a staff member of the same gender as the detainee should be present to observe a strip search performed by an officer of the opposite gender.” The Auditor reviewed samples of a Record of Search, which is utilized by the facility to document a strip search of a detainee. The form includes the basis for conducting the strip search. Interviews with six random security line-staff indicated if a strip search or a visual body cavity search, were to be conducted, it would be documented on a Record of Search. In interviews with eighteen male detainees and one female detainee it was indicated that three male detainees had been stripped searched during the intake process: however, the Auditor reviewed (b) (7)(E) of the intake processing of the three detainees and confirmed none of the detainees had been subjected to a strip search as they reported.

(g): CCCC policy J100.33 states, “Staff may not visually observe detainees while changing clothing or showering but should be present immediately outside the room with the door ajar to hear what transpires inside. Staff of the opposite gender must also announce their presence upon entering detainee living areas which include shower areas and areas where detainees perform bodily functions and changing clothes.” During the on-site audit, the Auditor confirmed camera views were modified with a black square to prevent staff monitoring cameras from viewing the detainees while showering, changing clothing, or performing bodily functions. Interviews with six random security line-staff, eighteen male detainees, and one female detainee, all indicated detainees are permitted to shower, change clothing, and perform bodily functions without being viewed by staff of the opposite gender. The Auditor observed signage on each housing unit door, prior to entering, which is a reminder for staff of the opposite gender to announce their presence when entering the unit. Interviews with six random security line-staff, eighteen male detainees, and one female detainee, all indicated opposite gender staff announce their presence when entering housing units occupied by detainees of the opposite gender. In addition, the Auditor observed staff of the opposite gender announcing “female in the unit” or “male in the unit” as they entered the housing units.

(h): CCCC is not designated as a Family Residential Center; and therefore, subsection (h) is not applicable.

(i)(j): CCCC policy J100.13 states, “Staff are prohibited from searching or physically examining a transgender or

intersex inmate for the sole purpose of determining the inmate's genital status." CCCC policy J100.33 states, "Searches will be conducted courteously, professionally and in such a way to allow inmates to retain as much dignity as possible, consistent with the nature of the procedure." Policy J100.33 further states, "Special care should be taken to ensure a strip search of a transgender detainee is performed in private." CCCC policy J70.3, LGBTQI, states, "All searches done on individuals from the LGBT community are to be standardized. Searches are to be conducted by staff of the same anatomical sex or gender as the inmate/detainee to be searched." An interview with the facility PSA Compliance Manager indicated the facility utilizes facility policy J100.13 as the training curriculum to train all security staff on how to conduct a proper pat-down or strip search. The Auditor reviewed samples of the training outline which documents training received by each staff member and confirmed security staff have completed the training. Interviews with six random security line-staff confirmed all had completed pat-down and strip search training; however, each security line-staff interviewed required prompting from the Auditor regarding the requirements to conduct pat-down searches professionally, respectfully, and in the least intrusive manner. Interviews with six random security line-staff confirmed they could articulate that a transgender detainee could not be physically examined for the sole purpose of determining the detainee's genitalia; however, all six random security line-staff interviewed indicated a pat-down search of a transgender detainee would be performed by two staff members with female staff conducting the pat-down search on the detainee's female anatomy and male staff conducting the pat-down search on detainee's male anatomy.

Corrective Action:

(c): The facility is not in compliance with subsection (c) of the standard. A review of CCCC policy J100.33 confirms it allows for cross-gender pat-down searched of a female detainee if staff of the same gender is not present at the facility at the time the pat-down search is required; however, subsection (c) of the standard requires cross-gender pat-down searches of female detainees only be conducted in exigent circumstances. To become compliant, the facility shall develop and implement a procedure, to ensure cross-gender pat-down searches of female detainees only be conducted in exigent circumstances. Once implemented, the facility must submit documentation that confirms all security line-staff and supervisors have been trained on the implemented practice.

(j): The facility is not in compliance with subsection (j) of the standard. An interview with the facility PSA Compliance Manager indicated all security staff are required to complete training on pat-down and strip searches; however, during interviews with six random security line-staff it was confirmed they could not adequately articulate the requirements to conduct pat-down searches professionally, respectfully, and in the least intrusive manner. In addition, all six random security line-staff interviewed indicated a pat-down search of a transgender detainee would be performed by two staff members with female staff conducting the pat-down search on the detainee's female anatomy and male staff conducting the pat-down search on detainee's male anatomy. To become compliant, the facility must submit documentation to the Auditor that confirms all security line-staff have been retrained on the proper procedures for conducting pat-down searches, including pat-down searches by staff of the opposite gender, and searches of transgender and intersex detainees.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b): CCCC policy J100.33 states, "In compliance with Federal law and DHS policy the CCSO, takes reasonable steps to provide meaningful access to the facility's Sexual Abuse and Assault Prevention and

Intervention Program for detainees with Limited English Proficiency (LEP). The CCSO makes available competent foreign language and sign language interpreters to ensure effective communication with detainees with LEP and disabilities (e.g., detainees who are deaf, hard of hearing, or blind and detainees with low vision) during all aspects of the facility's efforts to fulfill this zero-tolerance policy. To obtain a competent interpreter (oral) or translated (written) materials for a detainee with LEP, facility staff contact: The CCSO currently utilizes interpretation services through the Language Services Section, located at 26 Federal Plaza, Room 506 New York, NY 10278. To obtain accommodations for a detainee with a disability, facility staff contact: The CCSO currently utilizes interpretation services through the Language Services Section, located at 26 Federal Plaza, Room 506 New York, NY 10278." , During an interview with a Classification Officer, it was indicated the facility handbook is included inside the ICE National Detainee Handbook which was confirmed by the Auditor. In addition, the Auditor confirmed should the detainee require a facility handbook not included in the ICE National Detainee Handbook, the facility has the ability to translate the handbook in the detainee's preferred language. In an interview with the Classification Officer, and through Auditor observations, it was confirmed the ICE National Detainee Handbook is available at the facility in 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. Duing an interview with the PSA Compliance Manager, it was indicated the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet is contained within the ICE National Detainee Handbook; however, the Auditor reviewed the ICE National Detainee Handbook available on-site and confirmed the handbook includes only nine of the most prevalent languages utilized by ICE. While the Auditor was on-site, the facility obtained all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, the Auditor could not confirm the pamphlet was available to all detainees in their preferred language prior to the audit exit interview. No detainees were received at the facility during the on-site audit; however, the Auditor observed a (b) (7)(E) of an ICE detainee going through the intake process and confirmed the detainee had been given the National ICE Detainee Handbook that included the DHS-prescribed SSA Information pamphlet in Spanish, his preferred language. Interviews with an Intake Officer and six random security line-staff indicated if a detainee was deaf or hard of hearing, staff would provide PREA information for the detainee to read in a language he/she could understand, with the use of ERO Language Services, if necessary. In an interview with the facility Captain, it was indicated if the detainee could not read, the facility would utilize a teletypewriter (TTY) phone system. Interviews with an Intake Officer and six random security line-staff further indicated, if the detainee was blind or had low vision, the information would be read to the detainee staff utilizing ERO Language Services if the detainee was LEP. In addition, interviews with Intake staff indicated all documents could be translated with the use of the ERO Language Services or with Google Translate which is available on the facility RFID Guardian System. Intake staff further indicated they would provide the information to detainees who have intellectual, psychiatric, or speech disabilities, by using simple vocabulary and speaking slowly, to ensure effective communication had been established. If they could not establish effective communication, the assistance of medical or mental health staff would be obtained. Interviews with nineteen detainees confirmed all had received the ICE National Detainee Handbook in their preferred language.

(c): In an interview with the PSA Compliance Manager it was indicated, the facility utilizes the services of the ERO Language Services, in matters relating to allegations of sexual abuse, to provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee. Interviews with six random security line-staff, indicated they would never use another detainee to

interpret for a detainee victim of sexual abuse, even if the detainee victim made the request. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed none of the detainee victims required the services of an interpreter during the investigation.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. During the on-site audit the Auditor did not observe the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet. During an interview with the PSA Compliance Manager, it was indicated the pamphlet is contained within the ICE National Detainee Handbook; however, the Auditor reviewed the ICE National Detainee Handbook available on-site and confirmed the handbook includes only nine of the most prevalent languages utilized by ICE. During the on-site audit, the facility obtained all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, the Auditor could not confirm the pamphlet was available to all detainees in their preferred language prior to the audit exit interview. To become compliant the facility must implement a practice that ensures all detainees have an equal opportunity to participate or benefit from all aspects of both the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse to include the information available in the DHS-prescribed SAA information pamphlet. Once implemented, if applicable, the facility must submit 10 detainee intake files to confirm the information available in the DHS-prescribed SAA pamphlets not included in the ICE National Detainee Handbook during the on-site audit is now available to all incoming detainees.

(c): The facility is not in compliance with subsection (c) of the standard. Interviews with six random security staff, indicated they would never use another detainee to interpret for a detainee victim of sexual abuse, even if the detainee victim made the request. The Auditor reviewed seven allegations of sexual abuse. The review indicated that none of the victim detainee's need the services of interpretation during the investigation. To become compliant, the facility must implement the practice of allowing the use of another detainee in matters related to sexual abuse should the detainee express a preference for another detainee to provide interpretation and the Agency determines that such interpretation is appropriate and consistent with DHS policy. In addition, the facility must train all security staff and security supervisors on the updated practice and provide training records to confirm the training was conducted during the CAP.

§115.17 - Hiring and promotion decisions

Outcome: Does Not Meet Standard

Notes:

(a)(b)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0, and ICE Suitability Screening Requirements for Contractor Personnel Directive 6-8.0 collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 6-7.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement

facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. CCCC policy J100.33 states, "Sexual assault or abuse of detainees by other detainees or by employees, contractors, or volunteers is prohibited and subject to administrative, disciplinary, and criminal sanctions. CCSO shall impose upon all staff a continuing affirmative duty to disclose any such misconduct." An interview with the facility HRM indicated each applicant is required to complete the CCSO Background Investigation Warning, which states, "Now is the time for you to provide me, the background investigator, with any/all background information. If I discover at a later date/time during the course of the investigation that information (regardless of how significant it may be to you) was omitted, it will have a serious impact on the background investigation process. Omission of information is considered the same as providing false information (lying). I fully understand the above WARNING. I have not withheld any information from you, the background investigator or from the Calhoun County Sheriff Department. I also understand that withholding any information is relevant to the hiring process and/or background investigator will be justification for removal from the hiring process." The HRM indicated the facility modified the questions on May 25, 2023 to include the current version of th form. In interviews with the HRM and the facility AFOD it was indicated there have not been any promotions of facility staff or ICE staff assigned to the facility during the audit period. In an interview with the HRM it was indicated all previous institutional employers are contacted to obtain information on substantiated allegations of sexual abuse or any resignations during a pending investigation of alleged sexual abuse and the facility would provide another institutional employer the same information for a pending applicant. Although requested by the Auditor, the facility did not provide documentation to confirm staff are aware of their continuing duty to disclose, if any, sexual misconduct as required by the standard. The Auditor reviewed six files of potential staff applicants and confirmed each applicant had completed the CCSO Background Investigation Warning and had been asked the following questions during an interview: have you engaged or been investigated for sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution; have you been investigated and convicted of sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse; and have you been civilly or administratively adjudicated to have engaged in such activity; however, a review of the revised form confirms it does not inquire if the applicant has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. Although requested by the Auditor the facility did not provide documentation to confirm the facility has not enlisted the services of any contractor or volunteer who may have contact with detainees who has engaged in the above behavior.

(c)(d): During a training session in November 2021, and through review of the training documentation available on SharePoint, the Unit Chief of OPR PSO explained that all ICE staff having contact with detainees must clear a background investigation through PSO before hiring. The staff complete an Electronic Questionnaire for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE. CCSO policy R1000, Recruitment and Selection, states, "Every candidate shall undergo a thorough background investigation to verify his/her personal integrity and high ethical standards, and to identify any past behavior that may be indicative of the candidate's unsuitability to perform duties relevant to the operations of the Calhoun County Sheriff's Office." An interview with the facility HRM confirmed the facility completes a thorough background investigation prior to anyone

being hired by the facility, or providing services to the facility, to ensure the candidate is suitable for employment. The background check includes a criminal background check through the National Crime Information Center (NCIC). During the on-site audit, the Auditor reviewed an Excel spreadsheet that includes the date of when the NCIC and the background investigation had been completed and the outcome of that investigation. The Auditor reviewed six files of potential staff currently in the hiring process, one file of a contracted maintenance person, and seven files of contracted medical staff and confirmed background checks had been completed prior to beginning employment or providing services at the facility. In addition, the Auditor submitted the names of five ICE staff to PSO to verify the background check process. ICE PSO confirmed the investigation status of all five ICE staff prior to hiring and every five years, thereafter, as required by the standard.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. During an interview the HRM indicated the facility modified the questions on May 25, 2023, asked during an interview to include the questions required by standard 115.17. The Auditor reviewed six files of potential staff that are currently in the hiring process. Documentation contained in the files confirmed the facility does not inquire if the applicant has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. Although, the Auditor requested the facility provide documentation that confirms staff are aware of the continuing duty to disclose, if any, such misconduct should occur none was provided. To become compliant, the facility shall implement a practice that ensures the facility not hire or promote anyone or enlist the services of any contractor or volunteer who may have contact with detainees who has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. The facility must provide the Auditor with five staff, five contactors, and one volunteer file to confirm the facility did not utilize the services of any contractor or volunteer who has ever attempted to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or refuse, as required by the standard. In addition, the facility must submit documentation that confirms all staff are aware of their continuing duty to disclose, any such misconduct. If applicable, the facility must provide the Auditor with any facility, and ICE staff, who may have reoccurring contact with detainees, who were promoted during the CAP period to confirm they were directly asked about previous misconduct related to sexual abuse in a written application or during an interview.

§115.18 - Upgrades to facilities and technologies

Outcome: Meets Standard

Notes:

(a)(b): An interview with the facility Captain indicated the facility has not designed or acquired any new facility or planned any substantial expansion or modification of the existing facility since June 25, 2020; however, CCCC's PAQ indicates the facility updated and replaced the video monitoring system in the fall of 2022. Although the facility Captain could not provide written documentation, during an interview, it was confirmed the facility considered how the technology would enhance their ability to protect detainees from sexual abuse by conducting repeated testing, review and reconfiguring the system to achieve a strategic positional advantage to ensure the safety and security of inmates and detainees while protecting their privacy while showering, changing clothing or performing bodily functions.

Corrective Action:

No corrective action needed.

§115.21 - Evidence protocols and forensic medical examinations

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e): The Agency's policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted. CCCC policy J100.33 states, "The facility administrator should coordinate as necessary with the ICE Office of Professional Responsibility (OPR) and/or criminal investigative entities responsible for investigations of the incident. If the investigation needs to be assigned to an agency other that CCSO, the agency assigned the investigation will be asked to follow DHS PREA standards 115.21 sections a through d. At no cost to the detainee and only with detainee's consent, the facility administrator shall arrange for the victim to undergo a forensic medical examination." CCCC policy J100.33 further states, "Victims should be provided emergency and ongoing medical and mental health services as needed. A outside or internal victim advocate shall provide emotional support, crisis intervention, information and referrals. The facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If adequate health care services may not be available, the CCSO will consult with the ICE Field Office Director to determine if ICE can provide additional assistance." A review of the facility policy confirms that the evidence protocol maximizes the potential for obtaining usable physical evidence for administrative and criminal prosecutions. Interviews with the AFOD, the facility Captain, and the PSA Compliance Manager confirmed the policy has been developed in coordination with DHS. Interviews with the facility PSA Compliance Manager/Investigator confirmed the facility is responsible for conducting administrative and criminal detainee-on-detainee sexual abuse allegations; however, if the allegation involves criminal staff-on-detainee allegations, the facility will utilize the Michigan State Police (MSP) to conduct the criminal investigation. The Auditor reviewed an email, which confirmed the facility has requested the MSP to follow the requirements of paragraphs (a) through (d) of this standard and that the MSP has agreed to comply with the standard requirements. In an interview with the PSA Compliance Manager, it was indicated if a sexual abuse were to occur at the facility, the facility will utilize the Sexual Assault Services (SAS) to conduct a SANE examine. The Auditor reviewed the Calhoun County Sexual Assault Protocol, 2020 and interviewed the SAS SANE Supervisor and a SAS Victim Advocate. The SAS SANE Supervisor confirmed there are six SANE nurses available in the community to provide the detainee assistance following an instance of sexual abuse. The SAS SANE Supervisor further indicated, all SANE services are at no cost and conducted only with the detainee's consent. The SAS Victim Advocate confirmed emotional support, crisis intervention and referrals would be provided to the victim detainee during the SANE exam and following an incident of sexual abuse, to include investigatory interviews and court proceedings. The Auditor reviewed seven sexual abuse investigation files and confirmed advocacy information was provided to all detainee victims alleging sexual

abuse. In addition, a review of seven sexual abuse allegation files confirmed that the MSP was notified in all cases; however, they did not complete any criminal investigations due to the allegations not being criminal in nature.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." CCCC policy J100.33 states, "The CCSO should ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for investigation by an agency with the legal authority to conduct criminal investigations and should document such referrals. The facility administrator should coordinate as necessary with the ICE Office of Professional Responsibility (OPR) and/or criminal investigative entities responsible for investigation of the incident. If the investigation needs to be assigned to an agency other that CCSO, the agency assigned the investigation will be asked to follow DHS PREA standards 115.21 sections a through d." CCCC policy J100.33 further states, "When a detainee(s) is alleged to be the perpetrator, it is the CCSO administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to ICE/ERO (this notification must go directly to the FOD), which shall report it to the OPR Joint Intake Center." and "when an employee, contractor or volunteer is alleged to the be the perpetrator of detainee sexual abuse and assault, it is the CCSO administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation (if the incident is potentially criminal) and reported to ICE/ERO, which shall report it to the OPR Joint Intake Center. The local government entity or contractor that owns or operates the facility shall also be notified." In addition, J100.33 states, "All reports and referrals to be copied to the PREA Compliance Manager and kept on file. Retention of such reports and referrals shall be kept as long as the alleged abuser is detained or employed by the agency plus five years." An interview with the PSA Compliance Manager/Investigator indicated if the allegation reported was detainee/inmate-on-detainee/inmate, the facility would conduct a criminal investigation and once completed would conduct an administrative investigation. If the allegation involved staff-on-detainee, the allegation would be referred to the MSP for investigation and once completed would be referred to the Michigan Mission Team (MMT) investigators, which is comprised of investigators from all counties within Michigan that investigate administrative investigations that involve staff to ensure that the allegation is investigated by an outside

agency. A review of seven sexual abuse allegation files confirmed that the MSP was notified in all cases; however, they did not complete any criminal investigations due to the allegations not being criminal in nature. A review of the PREA allegation spreadsheet further confirmed ICE OPR and the JIC were notified of all allegations as documented in the investigation files.

(c): The Auditor reviewed the ICE website, (https://www.ice.gove/prea) and confirmed the Agency protocol had been posted and made available to the public. A review of the CCCC website (https://www.calhouncountymi.gov/departments/sheriffs_office/prea), confirmed the facility has posted portions of the protocol on the facility website; however, the protocol as written is not compliant with the standard. In addition, a review of the facility website confirmed the entire protocol was not posted on the facility website as required by subsection (c) of the standard.

Corrective Action:

(a)(d)(e)(f): The facility is not in compliance with subsections (a), (d), (e), and (f) of the standard. A review of CCCC policy J100.33 confirms it does not include when a prisoner, inmate or resident of the facility, in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director. In addition, a review of CCCC policy 5.1 confirms it does not require the facility report to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director when the allegation involves a staff member, contractor or volunteer. To become compliant the facility must update CCCC policy J100.33 to include the verbiage, "When a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG as required by subsections (d) and (e) of the standard or when a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported the Joint Intake Center (JIC), the ICE OPR or the DHS OIG" as required by subsections (d) and (f) of the standard. Once updated, the facility must submit documentation that all applicable staff, including facility Investigators, received training on the updated CCCC policy J100.33. If applicable, the facility must submit copies of all sexual abuse allegation investigation files that occur during the CAP period. Does Not Meet (c): The facility is not in compliance with subsection (c) of the standard. A review of the CCCC website (https://www.calhouncountymi.gov/departments/sheriffs_office/prea), confirmed the facility has posted portions of the protocol, CCCC J100.33, on the facility website; however, the protocol as written is not compliant with the standard. In addition, the entire protocol must be posted on the facility website. To become compliant, the facility must post update the facility protocol to include all elements required by subsections (d), (e), and (f) of the standard. Once updated the facility must ensure the protocol in its entirety is posted on the facility website.

§115.31 - Staff Training

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): The Agency's policy 11062.5.2 states, "The Agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed training." CCCC policy J100.33 states, "Training on the facility's Sexual Abuse and Assault Prevention and Intervention Program should be included in the initial

and annual refresher training for all employees, volunteers, and contract personnel." CCCC policy J100.33 further states, "The facility Program Coordinator should maintain documentation verifying employee, volunteer and contractor training." During an interview with the facility HRM, and an informal interview with a staff member responsible for new hire orientation, it was indicated that all staff and contractors are initially trained on the facility policy J100.33 during new hire orientation. The policy includes the facility zero tolerance; definitions of sexual abuse; procedures for reporting knowledge or suspicion of sexual abuse and the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigating purposes. Documentation was provided to the Auditor which indicated all staff, and ICE staff, and staff contractors, who may enter the facility have been trained on the CCCC policy. In addition, the HRM indicated, staff are required to complete PREA training through the Relias Learning system on an annual basis. The Relias Learning training curriculum for Dynamics of Sexual abuse in a Correctional System was provided to the Auditor for review. This training contains four of the required elements of this standard to include but not limited to: recognition of situations where sexual abuse may occur; recognition of physical, behavioral and emotional signs of sexual abuse, and methods for preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees and how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex or gender non-conforming. Documentation was provided to the Auditor that confirms all facility staff have completed the training for 2020, 2021 and 2022. In addition, the Relias Learning training curriculum for PREA: Reporting Obligations and Retaliation Protections was reviewed by the Auditor. This training included the elements of subsection (a) that are not included in the facility policy training received by medical and ICE staff. Documentation was provided to the Auditor, to confirm all facility staff have completed this training for years 2020, 2021 and 2022. However, no documentation was provided to the Auditor to confirm contract staff or ICE staff have completed the Relias training; and therefore, the Auditor could not confirm compliance. In addition, no additional documentation had been provided to the Auditor to indicate ICE staff have completed the Agency PREA training or additional training other than CCCC policy J100.33 which does not contain all the elements required by subsection (a) of the standard.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. No documentation was provided to the Auditor to confirm contract staff have completed the training required by subsection (a). In addition, no additional documentation had been provided to the Auditor to indicate ICE staff have completed the Agency PREA training, or additional PREA training, other than CCCC policy J100.33, which does not contain all the elements required by subsection (a) of the standard. To become compliant, the facility must submit documentation that confirms all contract staff, such as medical and mental health staff, have completed the training required by subsection (a) of the standard. In addition, the Agency must submit documentation that confirms all ICE staff who may have reoccurring contact with detainees have been trained on all elements required by subsection (a) of the standard.

§115.32 - Other Training

Outcome: Meets Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "Training on the facility's Sexual Abuse and Assault Prevention and Intervention Program should be included in the initial and annual refresher training for all employees, volunteers, and contract personnel." CCCC policy J100.33 further states, "The facility Program Coordinator should maintain

documentation verifying employee, volunteer and contractor training." During an interview with the facility HRM, and an informal interview with a staff member responsible for new hire orientation, it was indicated that all other contractors and volunteers are initially trained on the facility policy J100.33 during new hire orientation. The policy includes the facility zero tolerance; definitions of sexual abuse; procedures for reporting knowledge or suspicion of sexual abuse and the requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigating purposes. Contractors and volunteers are required to review and sign the Calhoun County Sheriff's Office Contractor and Volunteer PREA Statement which informs them of the facility zero tolerance and how to report an allegation of sexual abuse. The Auditor reviewed training documentation that confirms other contractors and volunteers received the required training.

Corrective Action:

No corrective action needed.

§115.33 - Detainee Education

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(f): CCCC policy J100.33 states, "Upon admission to the CCSO, all detainees should be notified of the facility's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee handbook and provided with information about the facility's Sexual Abuse and Assault Prevention and Intervention Program. Such information should include, at a minimum: the facility's zero tolerance policy for all forms of sexual abuse or assault, the name of the facility Sexual Abuse and Assault Prevention and Intervention Program Coordinator, and information about how to contact him/her, prevention and intervention strategies, definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity, explanation of methods for reporting sexual abuse or assault, including the DHS/OIG, consular official, and the ICE/OPR investigation processes, and right of detainees to report an incident or allegation of sexual abuse, assault, or intimidation to any staff member at the facility, to ICE/DHS and to the JIC, information about self-protection and indicators of sexual abuse, prohibition against retaliation, including an explanation that reporting an assault should not negatively impact the detainee's immigration proceedings; and right of a detainee who has been subject to sexual abuse or assault to receive treatment and counseling, If an alleged victim of sexual abuse and assault that occurred elsewhere in ICE/ERO custody is subsequently transferred to the facility, the CCSO shall comply with all applicable response and intervention requirements in this standard, as appropriate based on the nature and status of the case. Detainee notification, orientation and instruction must be in a language or manner that the detainee understands. The facility should maintain documentation of the detainee participation in the instruction session." Informal and formal interviews with Intake staff, indicated detainees are given the ICE National Detainee Handbook and the facility handbook upon entering the facility and are asked to read the facility PREA Orientation which includes the elements required by standard 115.33 (a) (1-6). If a detainee is unable to read the document, due to limited reading skills or is blind or visually impaired, staff will read it to them and will utilize the language line if they are LEP. In addition, staff indicated all documents could be translated with the use of the ERO Language Services or with Google Translate which is available on the facility RFID Guardian System. During an interview with a Classification Officer, it was indicated the facility handbook is included inside the ICE National Detainee Handbook which was confirmed by the Auditor. Informal and formal interviews with Intake staff further indicated, if a detainee is intellectual,

psychiatric or otherwise disabled, the staff will read the PREA information to them in a way to ensure they understand the information. If they could not establish effective communication, the assistance of medical or mental health staff would be obtained. Intake staff further indicated if the detainee is deaf or hard of hearing, staff would provide PREA information for the detainee to read in a language he/she could understand, with the use of ERO Language Services, if necessary. In an interview with the facility Captain, it was indicated if the detainee could not read the facility would utilize a teletypewriter (TTY) phone system. The Auditor reviewed the PREA Orientation 115.33 (a) (1-6) document. The document informs detainees of the facility zero-tolerance towards all forms of sexual abuse, definitions of sexual abuse, how to report sexual abuse (which includes the Office of Inspector General (OIG) phone number, Detention Reporting and Information Line (DRIL) phone number, and any staff members), the detainee right to receive treatment and counseling, examples of sexual abuse, understanding your reaction, and safety from retaliation. An interview with the Classification Officer, and Auditor observations, confirmed the ICE Detainee Handbook is available at the facility in all 14 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, and Vietnamese. The Auditor reviewed the ICE National Detainee Handbook and confirmed all elements required by this standard are included. In an interview with the PSA Compliance Manager, it was indicated the DHS-prescribed SAA Information pamphlet is contained within the ICE National Detainee Handbook; however, a review of the ICE National Detainee Handbook confirmed it includes only nine of the most prevalent languages utilized by ICE. While the Auditor was on-site, the facility obtained all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, and Vietnamese; however, the Auditor could not confirm distribution of the pamphlet had been implemented at the facility prior to the audit exit interview. No detainees were received at the facility during the on-site audit; however, the Auditor observed a (b) (7)(E) of an ICE detainee going through the intake process and confirmed the detainee had been given the National ICE Detainee Handbook that included the DHS-prescribed SSA Information pamphlet and facility handbook in Spanish, his preferred language. Interviews with nineteen detainees confirmed all had received the ICE National Detainee Handbook, which included the facility handbook, and DHS-prescribed SAA Information pamphlet, in their preferred language, Spanish. An interview with the PSA Compliance Manager indicated to confirm the detainee has received the National Detainee Handbook, the local supplemental and the facility Handbook, detainees sign an ICE Detainee Orientation document. This document is printed in the detainee's preferred language. In addition, the form documents any accommodations that were needed to ensure the detainee understood the information, such as the use of the language line to provide the information to the detainee and what language was used. During interviews with nineteen detainees, all reported that during the intake process they received the ICE National Detainee Handbook; they did not remember if they had received the local facility Handbook. The Auditor reviewed eight detainee files and confirmed each file contained the ICE Detainee Orientation Document signed by the detainee, four of the documents were in English and four were in Spanish, confirming the document was provided in a language the detainee can understand.

(d)(e): The facility is not in compliance with subsections (d) and (e) of the standard. During an interview the PSA Compliance Manager, indicated the pamphlet is contained within the ICE National Detainee Handbook. The Auditor confirmed only nine languages are included in the handbook. In addition, in an interview with the PSA Compliance Manager it was confirmed that the detainees sign an ICE Detainee Orientation document, to confirm the detainee has received the National Detainee Handbook, the local supplemental and the facility Handbook; however, the document does not confirm the detainee received the DHS-prescribed SAA Information pamphlet. During the on-site audit, the facility was able to access all 15 most prevalent languages encountered by ICE,

which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, Vietnamese and could ensure the language needed could be printed for the detainee; however, the Auditor could not confirm distribution of the pamphlet in all available languages had been implemented at the facility prior to the audit exit interview. The facility provided the Auditor with the SAS Flyer; however, the Auditor did not observe the flyer posted in the housing units for detainees to access. The Auditor did observe a 4' by 5' mailing label in the units, that provided the detainee with a phone number to access SAS; however, no information was provided to detainees who SAS is or what services they may provide to the detainee.

Corrective Action:

(d)(e): The facility is not in compliance with subsection (d) and (e) of the standard. During the on-site audit, the Auditor did not observe the DHS-prescribed SAA Information pamphlet, however, the PSA Compliance Manager, indicated the pamphlet is contained within the ICE National Detainee Handbook. The Auditor confirmed only nine languages are included in the handbook. The facility was able to access all 15 most prevalent languages encountered by ICE, which include in English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi, Bengali, Romanian, Russian, Turkish, Ukrainian, Vietnamese; however, although the pamphlet could be printed at the facility, interviews with Intake Staff could not confirm detainees who spoke a language not included in the ICE National Detainee Handbook received the pamphlet during the intake process. In addition, although the facility received all copies of the DHS-prescribed SAA Information pamphlet, the Auditor could not confirm distribution of the pamphlet had been implemented at the facility prior to the exit interview. The facility provided the Auditor with the SAS Flyer; however, the Auditor did not observe the flyer posted in the housing units for detainee to access. The Auditor did observe a 4' by 5' mailing label in the housing units that provided the detainee with a phone number to access SAS; however, the Auditor could not confirm information was provided to detainees that advised them who SAS is or what services they would provide to a detainee victim of sexual abuse. To become compliant, the facility must make available and distribute the DHS-prescribed SAA Information pamphlet in the detainee's preferred language as required by subsection (e) of the standard. In addition, the facility must post the SAS flyer in the housing units. The facility must submit documentation to the Auditor to confirm distribution of the DHS-prescribed SAA Information pamphlet had been implemented and the SAS flyer had been posted in all housing units.

§115.34 - Specialized training: Investigations

Outcome: Does Not Meet Standard

Notes:

(a)(b): The Agency policy 11062.2 states "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct an investigation of sexual abuse in a confinement setting. The Agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the

standard's requirement." CCCC policy 601, Sexual Assault Investigations, states, "Qualified investigators should be available for assignment of sexual assault investigations. These investigators should have specialized training in and be familiar with, interview techniques and the medal [sic] and legal issues that are specific to sexual assault investigations." CCCC policy J100.33 states, "All facility staff responsible for conducting sexual abuse or assault investigations should receive specialized training in conducting such investigations in confinement settings, which includes techniques for interviewing sexual abuse victims, sexual abuse evidence collection in confinement settings, and the criteria and evidence required for administrative action or prosecutorial referral." CCCC policy J100.33 further states, "The facility Program Coordinator should maintain documentation verifying employee, volunteer and contractor training." A review of CCCC policy J100.33 confirms it does not require training in effective cross-agency coordination as required by subsection (a) of the standard. An interview with the PSA Compliance Manager, and review of the facility PAQ, indicates eight investigators have received specialized training on sexual abuse and effective cross-agency coordination. The facility provided documentation that investigators have received general PREA training as required; however, the facility did not provide a training curriculum, or training completion certificates, to confirm each investigator has received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed seven sexual abuse allegation investigation files and could not confirm each assigned investigator had received the required specialized training.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. A review of CCCC policy J100.33 confirms it does not require training in effective cross-agency coordination as required by subsection (a) of the standard. An interview with the PSA Compliance Manager and review of the facility PAQ indicates eight investigators have received specialized training on sexual abuse and effective cross-agency coordination. The facility provided documentation that investigators have received general PREA training as required; however, the facility did not provide a training curriculum to confirm each investigator has received specialized training on sexual abuse and effective cross-agency coordination. The Auditor reviewed seven sexual abuse allegation investigation files and could not confirm each assigned investigator had received specialized training. To become compliant, the facility must submit a training curriculum to confirm it contains training on sexual abuse and effective cross-agency coordination. The facility must specially train all facility investigators who conduct sexual abuse allegation investigations and document such training. In addition, the facility must submit all sexual abuse allegation investigations that are completed during the CAP period.

§115.35 - Specialized training: Medical and mental health care

Outcome: Does Not Meet Standard

Notes:

(a): The facility does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners; and therefore, subsection (a) of the standard is not applicable.

(b)(c): CCCC policy J100.33 states, "All full- and part-time medical and mental health care practitioners who work regularly in the facility should receive specialized training in detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse, responding effectively to victims of sexual abuse and assault, and reporting allegations or suspicions of sexual abuse or assault." During an interview with the facility HRM and an informal interview with a staff member responsible for new hire orientation, it was indicated that all medical and mental health contractors are initially trained on the facility policy J100.33 during new hire

orientation. Documentation which contained signatures, was provided to the Auditor which indicated all medical and mental health contractors have completed this training. Interviews with a RN, MD, and a mental health clinician indicated they are required to complete specialized PREA training. The Auditor reviewed the YesCare Prison Rape Elimination Act (PREA) training curriculum for all medical and mental health staff contracted with the facility. The curriculum contains sections to include: the role of health care and behavioral staff and preservation of evidence; however, the curriculum does not include how to detect signs of sexual abuse and how to respond effectively and professionally to victims of sexual abuse. The Auditor was not provided documentation to indicate the medical and mental health staff have completed the specialized training required by subsection (b) of the standard. Interviews with the AFOD and the facility Captain confirmed CCCC policy J100.33 has been submitted and approved by the Agency.

Corrective Action:

(b): The facility is not in compliance with subsection (b) of the standard. The Auditor reviewed the YesCare Prison Rape Elimination Act (PREA) training curriculum for all medical and mental health staff contracted with the facility and confirmed the curriculum does not include how to detect signs of sexual abuse and how to respond effectively and professionally to victims of sexual abuse. The Auditor was not provided documentation to confirm all medical and mental health staff have completed specialized training as required by subsection (b) of the standard. To become compliant, the facility must ensure that all medical and mental health staff have completed specialized training which includes all required elements of subsection (b) of the standard including how to detect and assess signs of sexual abuse and how to respond effectively and professionally to victims of sexual abuse. Once completed the facility must submit documentation to the Auditor to confirm all medical and mental health staff have received the required training.

§115.41 - Assessment for risk of victimization and abusiveness

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f)(g): CCCC policy J100.33 states, “In accordance with Standards 2.1, “Admissions and Release”, and 2.2, “Custody Classification System”, the facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse and assault victims and shall house detainees to prevent sexual abuse and assault, taking necessary steps to mitigate any such danger.” CCCC policy J100.33 further states, “Each new arrival shall be kept separate from the general population until he or she is classified and housed accordingly. The initial screening and classification are conducted immediately upon arrival into the facility (within 12 hours of arrival) when detainees are screened by intake staff. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: a. Whether the detainee has a mental, physical, or developmental disability, b. The age of the detainee; c. The physical build and appearance of the detainee; d. Whether the detainee has previously been incarcerated or detained, e. The nature of the detainee’s criminal history, f. Whether the detainee has any convictions for sex offenses against an adult or child, g. Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, h. Whether the detainee has self-identified as having previously experienced sexual victimization, and i. The detainee’s own concerns about his or her physical safety. The initial screening shall consider prior acts of sexual abuse and assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse and assault, as known to the facility, in assessing detainees for risk of being sexually abusive.” In addition, policy J100,33 states, “Detainees shall not be disciplined for refusing to

answer, or for not disclosing complete information in response to, questions asked pursuant to items a, g, h, or i above. CCSO shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this screening in order to ensure that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates. Detainees who are considered at risk shall be placed in the least restrictive housing that is available and appropriate." CCCC policy J100.33 further states, "The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment/screening or at any other time when warranted, based upon the receipt of additional, relevant information or following an incident of abuse or victimization." The Auditor reviewed the facility PREA Profile Screening: Initial assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. An interview with an Intake Officer indicated, upon the arrival of the detainee, the detainee waits in an area within booking referred to as "carpeted area." Detainees will wait with all other incoming persons being booked into the facility until called by intake staff. Once called detainees are provided the assessment tool to complete. The form is provided in a language they can understand, or the staff will utilize the ERO Language Services, to ensure the detainee understands the content of the document. Once the detainee has completed the assessment the Intake staff will enter all answers into the jail management system. If a detainee is identified as a potential victim or a potential predator, the system will automatically place a caution in the detainee's electronic file. The Intake Officer further indicated a detainee is not disciplined for refusing to answer or not disclosing information in response to the risk assessment questions and once the assessment is entered into the jail management system, the paper assessment is placed into a locked drawer that all security staff have access to. During the intake process, a detainee will see medical staff. Interviews with the MD and an RN indicated the medical staff will complete their own assessment and review the results of the intake assessment. If appropriate, medical staff will complete any referrals for follow-ups with medical staff or with mental health staff. An interview with an Intake Officer indicated, once the detainee booking is complete, and prior to classification, detainees are comingled in one of the two quarantine housing units being used for Covid 19 isolation for up to 14 days. In an interview with a Classification Officer, it was confirmed Classification staff work twelve-hour shifts. Upon reporting for duty, the Classification Officer must immediately begin moving inmates and detainees, who have completed the 14-day quarantine, into assigned housing units. During the interview, the Classification Officer, indicated a reassessment is completed on all detainees every 80 days, including those who identify as transgender or intersex. The Auditor reviewed eight detainee files and confirmed all had completed the assessment tool in their preferred language; however, the Auditor could not confirm the initial classification of the detainee had been completed within 12 hours or that a reassessment is completed between 60-90 days. The Auditor reviewed seven sexual abuse allegation investigation files and could not confirm a reassessment had been conducted on the detainee victim following the alleged incident of sexual abuse or victimization.

Corrective Action:

(a)(b)(c)(e): The facility is not in compliance with subsections (a), (b), (c), and (e) of the standard. The Auditor reviewed the facility PREA Profile Screening: Initial assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. An interview with an Intake Officer indicated, once the detainee booking is complete, and prior to classification, detainees are comingled in one of the two quarantine housing units being used for Covid 19 isolation for up to 14 days. The Auditor reviewed eight detainee files and confirmed all had completed the initial screening tool in their preferred language; however, the Auditor could not confirm the initial classification of the detainee had been completed within 12 hours or that a reassessment was completed between 60-90 days. In addition, the Auditor

reviewed seven sexual abuse allegation investigation files, and could not confirm, a reassessment had been conducted with the alleged victim following an incident of sexual abuse or victimization. To become compliant, the facility must implement a practice that includes all required elements of subsection (c) of the standard when assessing a detainee's risk for sexual abuse or sexual aggression. In addition, the facility must implement a practice to ensure that the initial classification of the detainee is completed within 12 hours of entering the facility. The facility must provide documentation that confirms detainees risk of victimization or abusiveness be reassessed between 60 and 90 days from the date of the initial assessment. In addition, the facility must submit documentation to confirm a detainee's risk for sexual abuse of sexual aggression is reassessed at any other time when warranted based upon the receipt of additional, relevant information, and following an incident of abuse or victimization. The facility must train all classification staff on the requirements of subsections (a), (b), (c), and (e) of the standard. In addition, if applicable, the facility must submit 5 detainee files to confirm all elements of subsection (c) were considered when assessing whether a detainee is likely to be a sexual aggressor, or a sexual abuse victim, and the initial classification was completed within 12 hours of intake. The facility must submit any detainee files where the detainee required a reassessment between 60 and 90 days as required by the subsection (e) of the standard. If applicable, the facility must submit to the Auditor all sexual abuse allegation investigation files that occur during the CAP period.

§115.42 - Use of assessment information

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "In accordance with Standards 2.1 "Admission and Release" and 2.2 "Custody Classification System," the facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse and assault victims and shall house detainees to prevent sexual abuse and assault, taking necessary steps to mitigate any such danger. The facility shall also use the assessment to inform assignment of detainees to recreation and other activities, and voluntary work." An interview with an Intake Officer indicated, once the detainee booking is complete, the detainees are automatically comingled into one of the two housing units being used for Covid 19 quarantine of all detainees and inmates; however, the Intake Officer could not articulate if the assessment is utilized to ensure the safety of the detainee when determining the initial housing of the detainee into the quarantine unit. In addition, the Intake Officer indicated if the facility received a transgender or intersex detainee, they would be housed in the medical for no more than 12 hours unit until initial housing could be determined. In an interview with the Classification Officer, it was indicated placement of a transgender or intersex detainee is not determined based solely on the detainee's physical anatomy. An Interview with the MD indicated the facility has not had a transgender or intersex detainee housed at the facility during the audit period; however, should a transgender or intersex detainee arrive at the facility placement would be made in consultation with medical and mental health staff to ensure the health and safety of the detainee. An interview with the Classification Officer indicated that information learned on the assessment tool is utilized to determine housing, recreation and other activities, and volunteer work; however, he struggled with articulating how the information obtained from the initial screening is utilized. The Auditor reviewed the PREA Profile Screening: Initial Assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. The Classification Officer further indicated all detainees, including those who identify as transgender and intersex, are reclassified every 80 days to review any threats to safety experienced by the detainee. Interviews with the facility PSA

Compliance Manager and six random security line-staff indicated a transgender or intersex detainee would be given the opportunity to shower separately from other detainees.

Corrective Action:

(a): The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed the PREA Profile Screening: Initial Assessment tool and confirmed it does not include whether the detainee identifies as gender non-conforming or if the detainee has concerns about his or her physical safety. In an interview with an Intake Officer, it was confirmed the Intake Officer could not articulate if the assessment is utilized to determine the initial placement of the detainee into the quarantine housing unit, to ensure the safety of the detainee. An interview with the Classification Officer indicated that information gathered from the risk assessment tool is utilized to determine housing, recreation and other activities, and voluntary work; however, the risk assessment tool does not include all the required elements of subsection (c) of standard 115.41. In addition, in an interview with the Classification Officer it was confirmed the Classification Officer struggled with articulating how the information obtained from the initial screening would be utilized to determine housing, recreation and other activities, and volunteer work. To become compliant, the facility must implement a practice that includes all required elements of subsection (c) of standard 115.41 when determining detainee housing, recreation and other activities, and volunteer work. Once implemented, the facility must submit documentation that confirms all applicable staff have been trained on the implemented practice. In addition, the facility must provide 10 detainee files that confirm information from the risk screening is utilized when determining initial housing, recreation and other activities, and voluntary work.

§115.43 - Protective Custody

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): CCCC policy J110.1, Administrative Segregation Housing, states, "All movement of these inmates shall be assessed on an individual basis. Staff must document detailed reasons for placement of an individual in administrative segregation. If applicable, reasons for placement should include any vulnerability to sexual abuse or assault." CCCC policy J110.1 further states, "Use of administration segregation by facilities to protect detainees vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days" and "programs and services available to the general population should be made available to inmates assigned to the administrative segregation unit but scheduled as a separate group in order to maintain the separation of these inmates from the rest of the inmate population unless authorized by the Jail Administrator or designee. All basic inmate privileges, such as telephone access, visitation, commissary, etc., should be granted those inmates in the administrative segregation unit under the same conditions as the general population." In addition, CCCC policy J110.1 states, "A supervisory staff member shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted; and (2) A supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter." Policy CCCC J110.1 further states, "Facilities shall notify the appropriate ICE Field Office Director

no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault." Interviews with the facility Captain and the AFOD confirmed CCCC policy J110.1 has been developed in coordination with the with the ICE FOD who has jurisdiction over the facility. The facility Captain further indicated the facility has not placed a detainee in protective custody due to vulnerability to sexual abuse during the audit period; however, if there was to be such a placement, the ICE FOD would be notified with 72 hours by email. In addition, the facility Captain indicated the facility utilizes an Administrative Segregation Order to document all placements into segregation or protective custody and an Administrative Segregation Review to document supervisory staff reviews. The facility Captain further indicated a review is required within 72 hours of the detainee placement, again at 7 days, every week thereafter for the first 30 days, and every 10 days thereafter. In addition, in an interview with the facility Captain, it was indicated a detainee would not be housed in segregation longer than 30 days.

Corrective Action:

No corrective action needed.

§115.51 - Detainee Reporting

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "Detainee reports of sexual abuse, retaliation, staff neglect, or violations of responsibilities that may have contributed to such incidents may be made using any available methods of communication, including but not limited to: *Reports to the Facility*: a. Verbal reports to a staff member (including the Sexual Abuse and Assault Prevention and Intervention Program Coordinator or medical staff); b. Written informal or formal requests or grievances to the facility line staff, supervisors, medical staff and/or PREA Compliance Manager; c. Anonymous Reports to a staff member; d. Sick call requests; e. Telephone calls made to the in-house PREA number of 269-555-(b) (7)(E). *Reports to Family Members, Friends, or Other Outside Entities:* f. Reports to an individual or organization outside the facility who can contact facility staff. *Reports to DHD/ICE:* g. Written informal or formal requests or grievances (including emergency grievances) to ICE; h. Telephone calls or written reports to the DHS/OIG, ICE/OPR, ICE JIC; i. Calls can be made confidentially and anonymously and from third parties." CCCC policy J100.33 further states, "Staff shall accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports." An interview with the facility PSA Compliance Manager indicated detainees are provided multiple ways to privately report sexual abuse, retaliation and staff neglect, or violations of responsibilities that may have contributed to an incident, which include the facility PREA reporting line, through the grievance system, through any staff member, DHS OIG, DRIL, or through the detainee family members. During the on-site audit, the Auditor observed posted on the housing unit bulletin boards, in English and Spanish, the DHS-prescribed sexual assault awareness notice with the name and phone number of the PSA Compliance Manager, contact information for consular officials, contact information for the DHS OIG, and the ICE ERO Detention Reporting and Information Line (DRIL) contact number. With the assistance of a detainee, the Auditor utilized a detainee phone, and tested the facility PREA reporting line. The test of the phone confirmed the line prompts the detainee to leave a message for the PSA Compliance Manager. Upon leaving a message, the Auditor was notified within a few minutes that the message left had been received by the PSA Compliance Manager and other supervisors via email. The Auditor tested the number and instructions for contacting the consular officials and confirmed it was in good working

order. However, the Auditor attempted to call the DHS OIG and the DRIL and experienced difficulty testing the phones without the facility providing specific instructions on how to access the numbers. Instructions were obtained with the assistance of the facility IT department; however, the Auditor could not confirm these instructions are provided to detainees; and therefore, the Auditor could not confirm the detainee had access to two of the multiple ways the Agency has provided detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. Interviews with six random security line-staff confirmed they were knowledgeable regarding the multiple ways detainees can report an allegation and were aware they must accept reports made verbally, in writing, anonymously or by third party. Interviews with nineteen detainees, indicated the detainees were aware of several ways to report an allegation of sexual abuse, including the facility PREA reporting line.

Corrective Action:

(a)(b): The facility is not in compliance with subsections (a) and (b) of the standard. During the on-site audit, the Auditor observed information posted within the housing units in English and Spanish that advised detainees how to contact their consular official, the DHS OIG and ICE ERO DRIL; however, the Auditor had difficulty testing the numbers provided for DHS OIG and the ICE ERO DRIL. Instructions were obtained with the assistance of the facility IT department; however, the Auditor could not confirm these instructions are provided to the detainees; and therefore, the Auditor could not confirm the detainee had access to two of the multiple ways the Agency has provided detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. To become compliant, the facility must submit documentation that confirms instructions on how to contact the DHS OIG and ICE ERO DRIL were provided to all detainees in a manner they can understand including those who do need speak English or Spanish.

§115.52 - Grievances

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): CCCC policy J100.33 states, "Detainee Grievance Procedure a. The facility shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. b. The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. c. The facility shall implement written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. Time-sensitive grievances will be addressed immediately by the on-duty supervisor. d. Facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment. e. The facility shall issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. The facility shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the ICE/ERO FOD at the end of the grievance process. f. To prepare a grievance, a detainee may obtain assistance from another detainee, the housing deputy or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties." The facility handbook, states, "ICE Detainees have the right to file formal grievance regarding sexual abuse at any time in lieu of an informal grievance. There are no imposed time limits to filing a sexual abuse grievance. Any medical grievances can be sent directly to medical. If the grievance is an emergency, you should speak to a staff member to determine on if the message can be sent electronically or if a supervisor needs to be notified immediately. If you need help with any part of your

complaint, you can obtain assistance from other detainees or inmates, a staff member, family members, legal counsel or file a request for assistance. Both are obliged to offer reasonable assistance to assist you in the complaint procedure. This may be the help of other detainees or witnesses, etc." During an interview with the facility GO, the Auditor confirmed a detainee can file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint and the facility does not impose a time limit for sexual abuse grievances. The GO further indicated, if a sexual abuse grievance is received, the GO would immediately ensure the safety and welfare of the detainee and would ensure the grievance is brought to the attention of medical staff. In addition, the GO indicated he would be responsible to ensure detainees can obtain assistance with filing a grievance if necessary. The GO further indicated the facility would issue a decision on the grievance within five days of receipt and would respond to an appeal of the grievance decision within 30 days. In addition, the GO indicated, the facility would send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the ICE/ERO FOD at the end of the grievance process. The Auditor reviewed seven sexual abuse allegation investigations and confirmed none of the allegations were received through the grievance process.

Corrective Action:

No corrective action needed.

§115.53 - Detainee access to outside confidential support services

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): CCCC policy J100.33 states, "Victims should be provided emergency and ongoing medical and mental health services as needed. A outside or internal victim advocate shall provide emotional support, crisis intervention, information and referrals. The facility shall, attempt to make available to the victim a victim advocate from a rape crisis center." The Auditor reviewed a Calhoun County Sexual Assault Protocol. The protocol is provided by the Sexual Assault Services (SAS) to provide guidance and a consistent, coordinated response to reports of sexual assault in all of Calhoun County, Michigan, in an effort to aide responders while promoting community safety, victims' services, and offender accountability. The protocol is updated annually and is signed by all key stakeholders, to include Dispatch/Emergency Communications, Law Enforcement, SAS Advocates, SAS SANE, Prosecution, Victims Witness Unit, State of Michigan Crime Lab, Child Advocacy Center, Child Protection Agency, the Local Hospital, and the CCSO. The Auditor interviewed the SAS SANE Supervisor and an SAS Victim Advocate. The SANE Supervisor confirmed CCSO's participation in the Calhoun County Sexual Assault Protocol. In addition, the SAS Victim Advocate confirmed crisis intervention and counseling services are provided to the victim detainee during the SANE exam and following an incident of sexual abuse, which would include emotional support and crisis intervention during the investigatory interviews and court proceedings. The SAS Victim Advocate further confirmed SAS operates a 24/7, crisis line which offers emotional support, and crisis intervention to all victims who have experienced sexual abuse, regardless, if a SANE exam was conducted or not. In addition, the SAS Victim Advocate confirmed SAS would provide community referrals for additional services, if needed and all services are available for detainees in the custody of CCCC, by calling the crises line number provided. The facility provided the Auditor with the SAS Flyer; however, the Auditor did not observe the flyer posted in the housing units for detainees to access. The Auditor did observe a 4' by 5' mailing label in the units, that provided the detainee with a phone number to access SAS; however, no additional information was posted to inform the detainee of the services SAS could provide. A

review of the facility handbook confirmed the SAS address, and crisis hotline telephone number is provided; however, no additional information is provided regarding SAS services. The facility handbook informs the detainee that all phone calls can be monitored; however, the handbook does not inform detainees the extent to which reports of sexual abuse would be forwarded to the authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor tested the SAS crisis line and confirmed the call could not be completed from a detainee phone. In addition, the facility provides detainees the 1-800 for RAINN, the National Sexual Assault Hotline. The Auditor attempted to a test call; however, the call could not be completed. Informal interviews with detainees indicated, they are prevented from calling 1-800 numbers from the detainee phones. The Auditor formally interviewed nineteen detainees, none of which could recall seeing or hearing information about organizations that can provide support services for sexual abuse victims.

Corrective Action:

(c)(d): The facility is not in compliance with subsections (c) and (d) of the standard. The facility provided the Auditor with the SAS Flyer; however, the Auditor did not observe the flyer posted in the housing units for detainees to access. The Auditor did observe a 4' by 5' mailing label in the units, that provided the detainee with a phone number to access SAS; however, no additional information was posted to inform the detainee of the services SAS could provide. A review of the facility handbook confirmed the SAS address, and the crisis hotline telephone number is provided; however, no additional information is provided regarding SAS services. The facility handbook informs the detainee that all phone calls can be monitored; however, does not inform detainees the extent to which reports of sexual abuse would be forwarded to the authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor tested the SAS crisis line and confirmed the call could not be completed from the detainee phones. In addition, Auditor attempted a test call, to the 1-800 for RAINN, the National Sexual Assault Hotline; however, the call could not be completed. Interviews with detainees within the housing unit indicated, they are prevented from calling 1-800 numbers from the detainee phones. The Auditor interviewed nineteen detainees, none of which could recall seeing or hearing information about organizations that can provide support services for sexual abuse victims. To become compliant, the facility must make available, in a manner all detainees can understand, information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses, and telephone numbers (including toll-free hotline numbers where available). In addition, the facility must inform detainees, prior to giving them access to outside resources, of the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. Once implemented, the facility must submit to the Auditor documentation that confirms compliance with subsections (c) and (d) of the standard.

§115.54 - Third-party reporting

Outcome: Meets Standard

Notes:

The Auditor reviewed the Agency website https://www.ice.gov/prea and the facility website https://www.calhouncountymi.gov/departments/sheriffs_office/prea and confirmed the information regarding third party reporting is posted on both sites. The facility website states, “If you have information regarding a subject in custody at CCSO who has been the victim of a PREA violation, while in CCSO custody, you can report this by calling 269-969-(b) (7)(E) and asking to speak to an on-duty supervisor or the PSA Compliance Manager. Reporting to CCSO can be done anonymously using the form at the bottom of this page.” In addition, it states, “ICE DETAINEES ONLY- on behalf of an ICE detainee, sexual abuse reports can be done utilizing the

ICE ERO Detention Reporting and Information Line (DRIL) at 1-888-351-(b) (7)(E). Or report directly to ICE online here, https://www.ice.gov/webform/ero-contact-form." The Auditor completed the form at the bottom of the webpage. The Auditor was not required to enter a name, phone number or email; therefore, allowing for anonymous reporting. The Auditor received a response from the facility within a matter of minutes, thus confirming the webpage third party reporting is in good working order.

Corrective Action:

No corrective action needed.

§115.61 - Staff and Agency Reporting Duties

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): CCCC policy J100.33 states, "All staff must immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in the facility; 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. a. All reports should be done through the appropriate chain of command, b. If situationally appropriate, reporting can be done outside of the chain of command and/or reported to the ICE OIG Office." CCCC policy J100.33 further states, "Information concerning the identity of a detainee victim reporting a sexual assault, and the facts of the report itself, should be limited to those who have a need-to-know in order to make decisions concerning the victim's welfare, and for law enforcement/investigative purposes." A review of CCCC policy J100.33 confirms it does not require the facility to report an allegation of sexual abuse made by a detainee considered to be a vulnerable adult under a State or local vulnerable persons statue to the Agency so the Agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. During an interview with the facility Captain, it was indicated he was not aware of the reporting requirements regarding a detainee considered to be a vulnerable adult. Interviews with six random security line-staff confirmed they were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Each staff member could articulate that information obtained in a report of sexual abuse is to remain confidential, except to those with a need-to-know to ensure the detainee's welfare or during an investigation to an investigator. In addition, interviews with six security line-staff confirmed they are aware of their ability to make a report outside of the chain of command to the MSP or the DHS OIG. The Auditor reviewed seven sexual abuse allegation investigative files and confirmed none of the alleged victims were considered vulnerable adults. Interviews with the facility Captain and the AFOD confirmed CCCC policy J100,33 has been reviewed and approved by the Agency. CCCC does not house juvenile detainees.

Corrective Action:

(d): The facility is not in compliance with subsection (d) of the standard. A review of CCCC policy J100.33 confirms it does not require the facility to report an allegation of sexual abuse made by a detainee considered to be a vulnerable adult under a State or local vulnerable persons statue to the Agency so the Agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. During an interview with the facility Captain, it was indicated that he was not aware of the reporting requirements regarding a detainee considered to be a vulnerable adult. To become compliant, the facility must revise CCCC policy J100.33 to include the requirement the facility report an allegation of sexual abuse made by a detainee considered

to be a vulnerable adult under a State or local vulnerable persons statue to the Agency so the Agency can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. Once updated, the facility must refer the updated policy J100.33 to the Agency for review and approval. The facility must train all applicable staff on the reporting requirement for vulnerable adult victims of an alleged sexual abuse. If applicable, the facility must submit all sexual abuse investigation files that include a detainee considered to be a vulnerable adult under a State or local vulnerable persons statue to confirm the new practice has been implemented.

§115.62 - Protection Duties

Outcome: Meets Standard

Notes:

CCCC policy J100.33 states, "All staff and detainees are responsible for being alert to signs of potential situations in which sexual abuse and assaults might occur, and for making reports and intervention referrals as appropriate. If a staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse and assault, he or she shall take immediate action to protect the detainee." An interview with the facility Captain, indicated that the detainee's safety would be the first priority and all staff have the responsibility to take immediate action to protect a detainee. Interviews with six random security line-staff, confirmed if they become aware a detainee is at substantial risk of sexual abuse, their first response would be the safety of the detainee at risk; and therefore, their first course of action would be to seek out the detainee, separate him/her, and notify their supervisor. The Auditor reviewed seven sexual abuse allegation investigation files and determined in all cases immediate action had been taken by the staff to protect the alleged detainee victim.

Corrective Action:

No corrective action needed.

§115.63 - Reporting to other Confinement Facilities

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): CCCC policy J100.33 states, "Upon receiving an allegation that a detainee was sexually abused and assaulted while confined at another facility, the facility whose staff received the allegation shall notify ICE/ERO and the appropriate administrator of the facility where the alleged abuse occurred. The notification provided in this section shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. CCSO shall document that it has provided such notification. The facility where the alleged abuse occurred shall then ensure the allegation is referred for investigation and reported to ICE/ERO (this notification must go directly to the FOD) in accordance with this standard." The Auditor reviewed a memorandum dated February 23, 2023, which states, "The Calhoun County Sheriff's Office has not fielded a sexual abuse compliant from another facility during the inspection period. If there is an allegation from another confinement facility the PSA Compliance Manager will contact ICE ERO, contact the Administrator of the confinement facility in which the abuse compliant originated, and provide sexual assault services for the victim that's alleging the abuse." Interviews with the facility Captain and the PSA Compliance Manager confirmed notification would be made within 72 hours by phone and followed up by an email to serve as documentation to the facility where the alleged abuse occurred. The facility Captain and PSA Compliance Manager further indicated, if the facility received such

notification, an investigation would be initiated immediately. The Auditor reviewed seven investigative files and determined one of the investigations indicated notification of the allegation was received from another facility in the State of Michigan. The notification had been documented and an investigation into the allegations was immediately initiated.

Corrective Action:

No corrective action needed.

§115.64 - Responder Duties

Outcome: Does Not Meet Standard

Notes:

(a)(b): CCCC policy states, "First Responder Requirements: a. Staff should take immediate action to separate any detainee who alleges that he/she has been sexually assaulted from the alleged assailant and should refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms; b. Staff suspected of perpetrating sexual abuse or assault should be removed from all duties requiring detainee contact pending the outcome of an investigation; c. When possible and feasible, staff should immediately preserve the crime scene, and safeguard information and evidence consistent with the facility's evidence-gathering and evidence-processing procedures, d. If the abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim and the alleged abuser not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder is not security staff, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." Interviews with six random security line-staff, indicated they were knowledgeable in their duties as a first responder by noting if a detainee reported an allegation of sexual abuse to them, they would separate the detainee, request the detainee victim and ensure the alleged abuser does not take any actions that could destroy physical evidence, preserve the crime scene and notify their immediate supervisor. The Auditor interviewed the MD and the RN, as non-security first responders. The MD and RN both indicated they would immediately call for back up, separate the detainees if possible, and notify a supervisor; however, the non-security staff first responders could not articulate they would request the victim not to take any action that could destroy physical evidence.

Corrective Action:

(b): The facility is not in compliance with subsection (b) of the standard. The Auditor interviewed the MD and the RN as non-security first responders. The MD and RN both indicated they would immediately call for back up, separate the detainees if possible and notify a supervisor; however, the non-security first responders did not articulate they would request the victim not to take any action that could destroy physical evidence. To become compliant, the facility must submit documentation to confirm all non-security first responders have been trained in their first responder responsibilities to request the victim not to take any action that could destroy physical evidence and then notify security staff. If applicable, the facility must submit all sexual abuse allegation investigation files that include a non-security first responder that occur during the CAP period.

§115.65 - Coordinated Response

Outcome: Does Not Meet Standard

Notes:

(a)(b): CCCC policy J100.33 states, "Staff must use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a security staff member, and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise. The CCSO currently utilizes the services of Bronson Battle Creek Hospital for the medical intake and Sexual Assault Services of Calhoun County for the forensic examination." A review of CCCC policy J100.33 confirms the facility coordinates the actions taken by first responders, medical and mental health practitioners', investigators and facility leadership in response to an incident of sexual abuse. During interviews with the PSA Compliance Manager/Investigator, MD, RN, a mental health clinician, and six random security staff it as confirmed they were knowledgeable and could describe their responsibilities when responding to an incident of sexual abuse.

(c)(d): CCCC policy J100.33 states, "If a victim of sexual abuse is transferred between facilities covered by subpart A or B of 6 CFR part 115 of the federal registry, the facility shall provide ICE/ERO, as permitted by law, the victim's potential need for medical or social services. ICE/ERO will then inform the receiving facility of the incident and victim's potential need for medical or social services. CCSO would provide such information in the medical packet that is sent with outgoing detainees. If the victim is transferred from another DHS immigration detention facility to a facility not covered by DHS standard 115.65 (c) of this section, the facility shall provide ICE/ERO, as permitted by law, the victim's potential need for medical or social services. ICE/ERO will then inform the receiving facility of the incident and victim's potential need for medical or social services. CCSO would provide such information in the medical packet that is sent with outgoing detainees, unless the victim requests otherwise." An interview with the facility Captain indicated he would have to defer to medical staff, but believed the information would be shared with the receiving facility. An interview with a RN indicated with detainee consent, she would provide all medical information regarding a sexual assault to include the need for continued medical services or mental health service.

Corrective Action:

(c)(d): The facility is not in compliance with subsection (c) and (d) of the standard. An interview with the facility Captain indicated he would have to defer to medical staff, but believed the information would be shared with the receiving facility. An interview with a RN indicated, with detainee consent, she would provide all medical information regarding a sexual assault to include the need for continued medical services or mental health service. To become compliant the facility must submit documentation that all applicable staff, including medical, have been trained on the requirements of subsection (c) and (d) of the standard. In addition, if applicable, the facility must submit to the Auditor any sexual abuse allegation investigative files that include the transfer of a detainee due to an incident of sexual abuse that occur during the CAP period.

§115.66 - Protection of detainees from contact with alleged abusers

Outcome: Does Not Meet Standard

Notes:

CCCC policy J100.33 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse and assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." An interview with the facility Captain indicated that any staff suspected of perpetrating sexual abuse would be removed from contact with detainees and/or placed on administrative leave pending the outcome of an investigation. The facility Captain further indicated, a contractor or volunteer suspected of perpetuating sexual abuse would be removed from the facility pending the outcome of the investigations. The Auditor reviewed four sexual abuse allegation investigation files that included staff-on-detainee and could not confirm the staff member involved in the allegation was removed from detainee contact pending the outcome of the investigation.

Corrective Action:

The facility is not in compliance with the standard. The Auditor reviewed four sexual abuse allegation investigation files that included staff-on-detainee and could not confirm the staff member involved in the allegation was removed from having contact with a detainee pending the outcome of the investigation. To become compliant, the facility must submit documentation that all applicable staff have been trained on the standard's requirement to remove all staff, contractors, and volunteers suspected of perpetrating sexual abuse be removed from all duties requiring detainee contact pending the outcome of the investigation. If applicable, the facility shall provide all sexual abuse allegation investigations that include staff-on-detainee, contractor-on-detainee, and volunteer-on-detainee that occur during the CAP period.

§115.67 - Agency protection against retaliation

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "Staff, contractors, volunteers, and detainees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse and assault, or for participating in sexual abuse and assault as a result of force, coercion, threats, or fear of force. The facility shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse and assault or for cooperating with investigations. For at least 90 days following a report of sexual abuse and assault, the facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff and shall act promptly to remedy any such retaliation. Items the facility should monitor include any detainee disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The Auditor reviewed a memorandum dated February 23, 2023, which states, "Prior to the facility Pre-PREA Audit, the facility did not physically document retaliation. However, retaliation was monitored by jail supervisors and classification deputies for at least 90 days. A form has since been created and will be used for future PREA complaints." The Auditor reviewed the CCSO PREA Retaliation Monitoring Report (30/60/90). The form states, "Following a report of sexual abuse, the facility will monitor the conduct/treatment or those persons reporting and/or cooperating with the investigations, to include inmates/detainees or staff and the alleged inmate/detainee victim, regarding changes

that may suggest possible retaliation by inmates/detainees or staff; ex: inmate/detainee disciplinary, housing or program changes and staff -reassignment, negative performance review, etc." An interview with the PSA Compliance Manager indicated the facility will utilize the CCSO PREA Retaliation Monitoring Report (30/60/90) to monitor all detainee victims, witness and staff who may cooperate with an investigation. An interview with the facility Captain, indicated a detainee or a staff member who participates in retaliation of detainee victim, witness or staff will be disciplined. The Auditor reviewed seven investigative files; however, all allegations were reported prior to the retaliation monitoring being implemented at the facility; and therefore, the facility could not document the practice had been implemented prior to the exit interview.

Corrective Action:

(a)(b)(c): The facility is not in compliance with subsections (a), (b), and (c) of the standard. The Auditor reviewed a memorandum dated February 23, 2023, which states, "Prior to the facility Pre-PREA Audit, the facility did not physically document retaliation. However, retaliation was monitored by jail supervisors and classification deputies for at least 90 days. A form has since been created and will be used for future PREA complaints." The Auditor reviewed the CCSO PREA Retaliation Monitoring Report (30/60/90) and confirmed it contained all elements of subsection (b) of the standard; however, a review of seven sexual abuse investigation files could not confirm retaliation monitoring had been implemented at the facility prior to the exit interview. To become compliant, if applicable, the facility must provide the Auditor with all sexual abuse allegation investigation reports and the corresponding CCSO PREA Retaliation Monitoring Report (30/60/90) that occur during the CAP period.

§115.68 - Post-allegation protective custody

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): CCCC policy J100.33 states, "The victim should be housed in a supportive environment that represents the least restrictive housing option possible, and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. Victims may not be held for longer than five days in any type of administrative segregation for protective purposes, except in highly unusual circumstances or at the request of the victim. If any of these requirements cannot be met, the CCSO will consult with the ICE Field Office Director to determine if ICE can provide additional assistance." CCCC policy J110.1, states, "Facilities shall notify the appropriate ICE Field Office Director no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault." An interview with the facility Captain indicated that the facility has not placed a detainee in protective custody due to vulnerability to sexual abuse during the audit period. The facility Captain further indicated, a detainee would not be held for longer than five days in administrative segregation or protective custody unless the victim detainee requested it, and the request would be documented. In addition, the facility Captain indicated, if there was to be such a placement, the ICE FOD would be notified with 72 hours by email.

Corrective Action:

No corrective action needed.

§115.71 - Crimininal and administrative investigations

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(e)(f): CCCC policy R903, Prison Rape Elimination Act, states, "The CCSO shall promptly, thoroughly and objectively investigate all allegations, including third party and anonymous reports of sexual abuse or sexual harassment." CCCC policy R903 further states, "The responsibilities of investigators shall include, but limited to (a) gathering and preserving direct and circumstantial evidence and any available electronic monitoring data. (b) Interviewing alleged victim, suspects and witnesses. (c) Reviewing any prior complaints and reports of sexual abuse involving the suspect. (d) Conducting compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecutions. (e) Assessing the credibility of the alleged victim, suspect or witness on an individual basis and not by the person's status as an individual in custody or a member of the Calhoun County Sheriff's Office. (f) Documenting in written reports a description of physical, testimonial, documentary and other evidence, the reasoning behind any credibility assessments, and investigative facts and findings. (g) Referring allegations of conduct that may be criminal to the County Prosecutor for possible prosecution, including any time there is probable cause to believe an individual in custody sexually abused another individual in custody at the CCSO facility. (h) Cooperating with outside investigators and remaining informed about the progress of any outside investigation." In addition, CCCC policy R903 states, "The departure of the alleged abuser or victim from employment or control of CCSO shall not be used as a basis for terminating an investigation." A review of the facility PAQ indicates the facility has eight specially trained investigators to conduct sexual abuse allegations; however, the facility has not provided the Auditor with documentation to confirm each investigator has received specialized training on sexual abuse and effective cross-agency coordination; and therefore, the Auditor could not confirm the eight facility investigators are trained as required by subsection (a) of the standard. In an interview with the PSA Compliance Manager/Investigator it was indicated the facility will conduct an administrative investigation on all allegations of sexual abuse and each investigator will work with the criminal investigator to ensure the criminal case is not compromised. In addition, the PSA Compliance Manager/Investigator indicated all investigations are completed promptly, thoroughly and objectively and would be completed even if the alleged victim was no longer housed at the facility. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed the investigations were completed promptly and objectively; however, the Auditor could not confirm the investigations were thorough or that the investigators were properly trained and qualified. A review of the seven sexual abuse allegation investigation reports confirmed they did not include a thorough description of the physical and testimonial evidence, the reasoning behind a creditability assessment and the investigative facts and findings. In several of the investigations, the Auditor relied on the facility PREA Allegation Spreadsheet in order to determine the outcome of the investigation, as it was not contained in the report. In one investigative file, the Auditor reviewed a memorandum to the alleged victim, which notified the victim detainee that the case was determined to be unfounded. The memorandum included a description of physical evidence that was used by the investigator to determine the victim detainee was not being truthful when the allegation was reported; however, none of the evidence relied upon for the unfounded determination was contained in the investigation report.

Corrective Action:

(a)(c): The facility is not in compliance with subsection (a) and (c) of the standard. A review of the facility PAQ indicates the facility has eight specially trained investigators to conduct sexual abuse allegations; however, the facility has not provided the Auditor with documentation to confirm each investigator has received the required specialized sexual abuse and effective cross-agency coordination training. In addition, the Auditor reviewed seven

sexual abuse allegation investigation files and confirmed the investigations were completed promptly and objectively; however, the reports were not thorough as they did not include a description of the physical and testimonial evidence, the reasoning behind a creditability assessment and the investigative facts and findings. To become compliant, the facility must provide the Auditor with a copy of the training curriculum to confirm it includes all required training elements as set forth in standard 115.34. In addition, the facility must specially train all staff who conduct sexual abuse allegation investigations and document such training. The facility shall ensure all investigations are thorough to include a description of the physical and testimonial evidence, the reasoning behind credibility assessments and investigative facts and findings as required in subsection (c) of the standard. If applicable, the facility must submit to the Auditor all sexual abuse allegation investigation files that occur during the CAP period.

§115.72 - Evidentiary standard for administrative investigations

Outcome: Meets Standard

Notes:

Agency Policy 11062.2 states, “The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse.” CCCC policy R903, states, “The Sheriff or County Administrator shall review the investigation and determine whether any allegations of sexual abuse or sexual harassment have been substantiated by a preponderance of the evidence (28 CFR 115.172).” In an interview with the PSA Compliance Manager/Investigator, it was indicated the facility will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed the facility imposed no standard higher than a preponderance of evidence in determining whether the allegations would be substantiated.

Corrective Action:

No corrective action needed.

§115.73 - Reporting to detainees

Outcome: Does Not Meet Standard

Notes:

Agency Policy 11062.2 states, “For detainees still in ICE immigration detention, or where otherwise feasible, following an investigation into a detainee’s allegation of sexual abuse or assault, notify the detainee as to the result of the investigation and any responsive action taken, in coordination with the FOD.” CCCC policy J100.33 states, "CCSO shall, when the detainee is still in immigration detention, or where otherwise feasible, notify the detainee of the outcome of the investigation and any responsive action taken.” Interviews with the PSA Compliance Manager/Investigator indicated that a memorandum is prepared and sent to a detainee victim to notify the detainee of the outcome of the investigation. If the detainee is no longer in the facility custody, the memorandum will be sent to the detainee's last known address. The Auditor reviewed seven investigative files and confirmed six of the files contained a memorandum which notified the victim detainee of the results of the investigation; however, in the one substantiated case, the Auditor could not confirm that the facility notified the detainee of the responsive action the facility had taken as the result of the substantiated finding.

Corrective Action:

The facility is not in compliance with the standard. The Auditor reviewed seven investigative files and confirmed six of the files contained a memorandum which notified the victim detainee of the results of the investigation; however, in the one substantiated case, the Auditor could not confirm that the facility notified the detainee of the responsive action the facility had taken as the result of the substantiated finding. To become compliant, the agency must implement a practice to ensure a detainee victim is notified of the results of an investigation, and any responsive action taken by the facility. If applicable, the facility must submit to the Auditor all closed sexual abuse allegation investigation files, and the corresponding notification to detainee, that occurred during the CAP period.

§115.76 - Disciplinary sanctions for staff

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): CCCC policy R903 states, “All CCSO members shall be subject to disciplinary sanctions up to and including termination for violating this policy. Termination shall be the presumptive disciplinary sanction for members who have engaged in sexual abuse. All discipline shall be commensurate with the nature and circumstances of the acts committed, the member’s disciplinary history and the sanctions imposed for comparable offenses by other members with similar histories (28 CFR 115.176). All terminations for violations of this policy, or resignations by members who would have been terminated if not for their resignation, shall be criminally investigated unless the activity was clearly not criminal and reported to any relevant licensing body (28 CFR 115.176).” A review of CCCC policy R903, confirms it does not contain the verbiage, “including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies” and “including removal from the Federal service, when there is a substantiated allegation of sexual abuse, or Agency sexual abuse rules, policies, or standards. In addition, the policy does not indicate that “removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer.” However, termination is greater than removal from Federal Service; and therefore, the Auditor finds the facility to be substantial compliance with subsections (a) and (b) of the standard. An interview the facility Captain indicated that staff would be removed from their post, placed on administrative leave, and even terminated depending on the outcome of investigation. In addition, the facility Captain confirmed there have not been any staff resignations, terminations, or discipline for violating the facility's policy on sexual abuse during the audit period. In an interview with the AFOD it was confirmed the Agency has reviewed and approved CCCC policy R903.

Corrective Action:

No corrective action needed.

§115.77 - Corrective action for contractors and volunteers

Outcome: Meets Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse and assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." CCCC policy R903 states, "Any contractor who engages in sexual abuse shall be prohibited from

contact with individuals in custody and reported to any relevant licensing bodies (28 CFR 115.177). The Sheriff shall take appropriate remedial measures and consider whether to prohibit further contact with individuals in custody by a contractor." An interview with the facility Captain indicated that contractors and volunteers who are suspected of engaging in sexual abuse are prohibited from contact with detainees and they would be removed from the facility pending the outcome of an investigation, and that if the allegation was substantiated, the incident would be reported to the contractor's employer, law enforcement, and any other relative licensing bodies. The Auditor reviewed seven sexual abuse allegation investigation files and determined none of the allegations involved a contractor or volunteer. In addition, four of the seven files reviewed were staff-on-detainee allegations; however, none were determined to be substantiated; and therefore, no disciplinary action had been taken.

Corrective Action:

No corrective action needed.

§115.78 - Disciplinary sanctions for detainees

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): CCCC policy J100.33 states, "The facility shall subject a detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse. At all steps of the disciplinary process shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. Each facility holding detainees in custody shall have a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures. The disciplinary process shall consider whether a detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanctions, if any, should be imposed. The facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary actions, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation." An interview with the facility Captain, indicated that the facility would not discipline any detainee for sexual contact with staff unless there is a finding that the staff member did not consent to the contact. The facility Captain further indicated the facility would not discipline a detainee for falsely reporting an incident or lying if he or she made a report of sexual abuse in good faith based on a reasonable belief that the alleged conduct occurred. The Auditor reviewed one detainee-on-detainee substantiated sexual abuse investigation and confirmed an Institutional Disciplinary Panel Hearing was conducted resulting in the detainee perpetrator being found guilty of engaging in sexual acts and receiving 30 days in disciplinary segregation.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "If a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and mental health follow up as appropriate." CCCC policy J100.33 further states, "If a referral for medical follow up is initiated, the detainee shall receive a health evaluation no later than 2 working days from the date of assessment. If a referral for mental health follow up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." Interviews with a facility RN and the MD, indicated medical staff will see all detainees during the intake process to obtain basic information. The facility RN and MD further indicated, in addition to the risk assessment completed by intake staff, medical staff will complete their own assessment of risk. In addition, the RN and MD indicated, medical staff will review questions asked by the intake officer and if a detainee has reported a history of sexual abuse, medical staff will immediately complete a referral to mental health and set an appointment for the detainee to see the mental health clinician the following day. If a medical follow up is needed, the detainee would be seen within two days from the date of the intake. An interview with the mental health clinician confirmed the detainee would be seen the following day. During the on-site audit, there were no detainees who reported prior sexual abuse housed at the facility, and therefore, no interview was conducted.

Corrective Action:

No corrective action needed.

§115.82 - Access to emergency medical and mental health services

Outcome: Meets Standard

Notes:

(a)(b): CCCC policy J100.33 states, "Victims should be provided emergency and ongoing medical and mental health services as needed. An outside or internal victim advocate shall provide emotional support, crisis intervention, information and referrals. The facility shall attempt to make available to the victim a victim advocate from a rape crisis center." CCCC policy J100.33 further states, "The facility shall offer and provide such victims with medical and mental health services consistent with the community level of care to all detainees who have been victimized by sexual abuse while in immigration detention." In addition, CCCC policy J100.33 states, "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." Interviews with the SAS Supervisor and an SAS Victim Advocate indicated that detainees would receive timely and unimpeded access to emergency medical treatment and crisis intervention. Detainees would be offered emergency contraceptives and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate and that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed no alleged detainee victims of sexual abuse required transport to the local hospital for a SANE exam; however, six of the victim detainees had been seen by medical and mental health staff following the allegation report. In

the seventh reviewed file the victim reported the allegation at another facility and was not at CCCC at the time the allegation was made.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "All facility medical staff responsible for examination or treatment of sexual abuse or assault victims should be specially trained or certified in such procedures. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility shall offer and provide such victims with medical and mental health services consistent with the community level of care to all detainees who have been victimized by sexual abuse while in immigration detention." Interviews with the MD, RN and a mental health clinician confirmed detainees would receive timely emergency access to medical and mental treatment that includes as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to or placement in, other facilities, or their release from custody in accordance with professionally accepted standards of care. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed six detainee victims were seen by medical and mental health, immediately upon reporting an allegation. In the seventh reviewed file the victim reported the allegation at another facility and was not at CCCC at the time the allegation was made.

(d)(e)(f)(g): CCCC policy J100.33 states, "Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. 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 facility shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners." Interviews with the MD, RN, and a mental health clinician indicated that a detainee who has been victimized by sexual abuse is offered a medical and mental health evaluation. The evaluation and treatment would include follow-up services, treatment plans and referrals for continued care following their transfer or release from custody. Interviews with the MD, RN, and a mental health clinician further indicated, detainee victims of sexual abuse are provided medical and mental health services, free of charge and that are consistent, if not better, than the level of care they would receive in the community. In addition, interviews with the MD, RN, and a mental health clinician indicated the facility will attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days and offer treatment. An interview with the SAS Supervisor indicated female detainee victims would be offered pregnancy tests, and if there is a positive result, they are given timely comprehensive information about lawful pregnancy related medical services and are offered those services, if requested. The SAS Supervisor further indicated, all detainee victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate, and

all services are offered free of charge regardless of if the victim detainee names the abuser or cooperates with the investigation. The Auditor reviewed seven sexual abuse allegation and investigation files and confirmed six detainee victims were taken immediately to medical for an assessment and seen by mental health after reporting a sexual abuse allegation. In the seventh reviewed file the victim reported the allegation at another facility and was not at CCCC at the time the allegation was made. In addition, the Auditor reviewed a substantiated detainee-on-detainee sexual abuse allegation investigation file and confirmed the perpetrator had been referred and seen by mental health.

Corrective Action:

No corrective action needed.

§115.86 - Sexual abuse incident review

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): CCCC policy J100.33 states, "The facility Sexual Abuse and Assault Prevention and Intervention Program Coordinator should, together with upper-level management officials, conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation to assess and improve prevention and response efforts. Such review should ordinarily occur within 30 days of the conclusion of the investigation. In conducting the review, the Program Coordinator should seek input from line supervisors, investigators, and medical or mental health practitioners. The reviewer(s) should: (a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. (b) consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. (c) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable the abuse. (d) Assess the adequacy of staffing levels in that area during different shifts; (e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff, and (f) Prepare a written report of findings (within 30 days of all incidents) and any recommendations for improvement and submit such report to the jail administrator. The facility should implement the recommendations for improvement or should document its reasons for not doing so. The report, response and review shall be forwarded to the ICE Agency PSAC." An interview with the PSA Compliance Manager, indicated the facility utilizes a PREA Incident Review Team Checklist to document a sexual abuse incident review and a review is conducted within 30 days of conclusion of the investigation. The PSA Compliance manager further indicated, the review team is made up of the PSA Compliance Manager, security supervisors, medical/mental health staff and investigators. The Auditor reviewed the facility PREA Incident Review Team Checklist. The checklist includes elements (a) - (f) listed above in the policy, which are consistent with the standard, and requires a yes or no response to each of the elements. Section (g) of the checklist states, "if the answer to (3) is yes, does the facility implement the recommendations for improvement contained in the incident review team's report or document its reasoning for not doing so." In an interview with the PSA Compliance Manager, it was confirmed the checklist is utilized in place of a written report of the review team findings, to include but not necessarily limited to, determinations made and any recommendations for improvement; however, the checklist does not include the review team's findings or recommendations made for improvement. The Auditor reviewed seven sexual abuse allegation investigation files and confirmed each file contained the PREA Incident Review Team Checklist, to include those investigations that were determined to be

unfounded; however, the Checklist does not include a date when the form was completed; and therefore, the Auditor could not determine the checklist had been completed within 30 days of the conclusion of the investigation. In addition, the Auditor reviewed documentation to confirm the checklist and the investigation report had been forwarded to the Agency PSA Coordinator. The Auditor reviewed a memorandum to the Chief Deputy regarding a Review of PREA Incidents for 2022. The annual review includes the facility statistics of all incidents reported and investigated at the facility and does not differentiate between detainee and inmate allegations; and therefore, the Auditor could not determine if all reported allegations of sexual abuse were included in the annual report. In addition, the annual review does not indicate the annual review included a review of all sexual abuse investigations and resulting incident reviews in order to assess and improve sexual abuse interventions, preventions and response efforts, or the findings of the review. Documentation was provided to the Auditor to indicate the facility had submitted the annual review to the Agency PSA Coordinator.

Corrective Action:

(a)(c): The facility is not in compliance with subsection (a) and (c) of this standard. The Auditor reviewed the facility PREA Incident Review Team Checklist and confirmed the checklist does not include the review team's findings or recommendations made for improvement. The Auditor reviewed seven sexual abuse allegation investigation files and determined each file contained the PREA Incident Review Team Checklist; however, the checklists were not dated; and therefore, the Auditor could not determine the checklist had been completed with 30 days of the conclusion of the investigation. The Auditor reviewed the annual review for 2022 and confirmed it includes the facility statistics of all incidents reported and investigated at the facility and did not differentiate between and detainee and inmate allegations; and therefore, the Auditor could not confirm all detainee sexual abuse allegations had been reported for the year. In addition, the review of the 2022 annual report confirmed it does not indicate the annual review included a review of all sexual abuse investigations and resulting incident reviews, in order to assess and improve sexual abuse interventions, preventions and response efforts or the findings of the review. Documentation was provided to the Auditor to indicate the facility had submitted the annual review to the Agency PSA Coordinator; however, the annual review for 2022 is not compliant with subsection (c) of the standard. To become compliant, the facility must submit documentation that confirms the sexual abuse incident review is completed within 30 days of the conclusion of the investigation. The review shall include the review team's findings or recommendations made for improvement, and implement the recommendations, or shall document the reasons for not doing so in a written response. In addition, the facility must conduct an annual review that differentiates between detainee and inmate allegations, of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse interventions, preventions and response efforts. Once completed the facility must submit documentation that the updated annual review has been forwarded to the facility administrator, FOD or his/her designee, and the Agency PSA Coordinator.

§115.87 - Data collection

Outcome: Meets Standard

Notes:

(a): CCCC policy J100.33 states, “All reports and referrals to be copied to the PREA Compliance Manager and kept on file. Retention of such reports and referrals shall be kept as long as the alleged abuse is detained or employed by the agency plus five years. This information to be reported annually to the United States Department of Justice.” In an interview with the facility PSA Compliance Manager, and through Auditor observations, it was confirmed the facility maintains all case records associated with the allegations of sexual

abuse including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings and recommendations for post-release, if necessary, in a secure filing cabinet within her office.

Corrective Action:

No corrective action needed.

§115.201 - Scope of Audit

Outcome: Meets Standard

Notes:

(d)(e)(i)(j): During all stages of the audit, including the on-site audit, the Auditor was able to review available memos and other documentation required to make an assessment on PREA Compliance. Interviews with detainees were conducted in private on-site and remained confidential. The Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor received one correspondence prior to the on-site audit; however, the correspondence was from an inmate and not an ICE detainee.

Corrective Action:

No corrective action needed.

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.

Robin Bruck 8/1/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 8/1/2023

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 8/1/2023

Assistant Program Manager's Signature & Date