PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	8/2/2022	**To:**	8/4/2022
AUDITOR INFORMATION			
Name of auditor:	Mark McCorkle	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	661-618-(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:**	772-579-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Washington Field Office
Field Office Director:	Russell Hott
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	14797 Murdock Street, Chantilly, VA 20151
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Caroline Detention Facility		
Physical address:	11093 S.W. Lewis Memorial Drive, Bowling Green, VA 22427		
Mailing address: (if different from above)	P.O. Box 1460, Bowling Green, VA 22427		
Telephone number:	804-633-0043		
Facility type:	D-IGSA		
PREA Incorporation Date:	7/1/2018		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Superintendent
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	804-633-(b) (6), (b) (7)(C)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Administrative Support Chief
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	804-622-(b) (6), (b) (7)(C)

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	Click or tap here to enter text.

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Caroline Detention Facility (CDF) was conducted from August 2, 2022, through August 4, 2022. The audit was performed by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor Mark McCorkle, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by ICE PREA 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 to the ICE PREA audit process and liaison with the ICE, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The audit period is from August 2, 2021, to August 1, 2022.

The ERAU Team Lead (b) (6), (b) (7)(C) forwarded the audit notification poster to the facility. The poster included the dates of the audit, the purpose of the audit, the Auditor's contact information through Creative Corrections LLC, and a statement regarding the confidentiality of any communication received. The facility staff placed posters throughout the facility, including all housing units, and all common areas. The Auditor verified the placement of the audit notification poster during the facility tour, and the detainee and staff interviews. The Auditor received no correspondence from detainees, staff, or any other person prior to the onsite audit.

The facility employs a total of 66 security staff members: 52 males and 14 females. There are 31 medical staff and three mental health staff members. At the time of the audit, CDF housed only adult male detainees with a design capacity of 336, but the facility has housed adult female detainees in the past. The average time in custody for CDF is 76 days. In the previous 12 months, the facility booked/processed 945 male detainees and 3 female detainees, who were released from the facility prior to the onsite audit. CDF houses low, medium, and high security detainees. At the time of the onsite audit, there were 188 male detainees being housed at the facility. There were no females at the facility at the time of the audit. CDF does not house juvenile or family units.

On August 2, 2022, at approximately 8:00 a.m., the Auditor arrived at the facility and established a working area in a secure conference room at the CDF. At approximately 8:15 a.m., Team Lead (b) (6), (b) (7)(C) telephonically moderated an entry briefing conducted by the Auditor. In attendance at the briefing were the following:

- (b) (6), (b) (7)(C) Superintendent, CDF
- (b) (6), (b) (7)(C) Security Chief (Captain), CDF
- (b) (6), (b) (7)(C) Detainee Management Chief (Captain), CDF
- (b) (6), (b) (7)(C) Administrative Chief, CDF
- (b) (6), (b) (7)(C) Administrative Lieutenant, CDF
- (b) (6), (b) (7)(C) Detention Services Manager (DSM), ICE/ERO
- (b) (6), (b) (7)(C), Acting PSA Compliance Manager (A/PSA Compliance Manager), CDF
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
- (b) (6), (b) (7)(C) Deportation Officer (DO), ICE/ERO
- (b) (6), (b) (7)(C) Records Coordinator, CDF
- (b) (6), (b) (7)(C) Maintenance Supervisor, CDF
- (b) (6), (b) (7)(C) Food Services Director, CDF
- (b) (6), (b) (7)(C), Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU (Via Telephone)
- Mark McCorkle, Auditor, Creative Corrections, LLC

The entry briefing provided an opportunity for all parties to establish a positive working relationship and outline the proposed schedule for the three onsite audit days. After the entry briefing, the Auditor was provided a complete tour of the CDF by the Superintendent, Security Chief, Detainee Management Chief, and the A/PSA Compliance Manager.

The facility is comprised of six total buildings, including administrative offices for CDF and ICE staff, which are both located inside of security. (b) (7)(E) , which are primarily used for historical purposes, and are not used as a replacement for personnel, but rather to enhance safety for detainees and staff.

Entry into the facility for non-employees is made through a sallyport consisting of two hard doors. Visitors must then pass through a metal detector and check in at the facility's main control to exchange personal identification for facility credentials. Non-employees are then escorted through a hard door into the administration building controlled by the facility control officers. The administrative building contains multiple offices, a conference room, and a kitchen/breakroom area. Detainees are not permitted in the administrative area of the building.

The detainee visiting area is attached to the administration building but has not been in use since the onset of COVID-19. When in operation, the facility conducts contact and non-contact visits. There are no cameras in the main visiting area (contact visit area), but three convex mirrors would allow officers to properly monitor activities in the room. Non-contact visits are conducted through a series of windows, where the visitor sits on one side, and the detainee on the other, communicating through a handset. According to the Superintendent, an officer would be stationed on the detainee side of the glass to monitor activities.

A hard door exits the administration into the main compound of the facility. All doors are controlled by the facility control officers.

Once on the main compound, the Riverstone housing unit, Medical, Intake/Records, Stonecrest housing unit, Food Services, Laundry, and Industry operations are located on the north side of the facility. The Timberidge (East/West) and Oakledge (East/West) housing units, along with the programs area and gymnasium are located on the south side of the facility. Each of the housing units has a design capacity for 56 detainees per unit. The two-tier housing units include Riverstone which currently houses male detainees and includes a separate housing area for detainees in disciplinary detention and administrative segregation; Stonecrest is almost identical in design and has general population detainees and a separate housing area for disciplinary detention and administrative segregation; Timberidge houses low to medium low male detainees; Oakledge houses medium to medium high male detainees. These housing units are designed in a nearly identical fashion to Riverstone and Stonecrest.

All general population cells contain four beds and include a storage locker for each detainee. The dayrooms are equipped with seating, a television, and an officer desk. General population cells are dry cells with a toilet area off the large dayroom. The restroom area contains three individual, private stalls. The shower area is also off the dayroom and contains individual stalls, with a privacy curtain in each. For officers to see into these areas, they must walk into the restroom and shower area. There are no video cameras in the bathroom areas. Segregation housing units are wet cells with two bunk beds per cell.

The dayroom provides seating for detainees and a television. The officer's desk is stationed in the dayroom. PREA postings were displayed throughout the facility, as well as a posting notifying staff and detainees of the upcoming PREA audit. Each of the housing areas also contained posters regarding the facility's Zero-Tolerance policy and a direct contact number to the A/PSA Compliance Manager. Additionally, each housing unit contained posters for the Rappahannock Council Against Sexual Abuse (RCASA), which provides counseling and advocacy services, along with posters on how to contact the DHS Office of Inspector General (OIG). Posters were displayed in English and Spanish.

Each phone area contained signs above the phones, in English and Spanish, explaining that legal calls are not monitored. There are no video cameras in the general population housing areas. During the tour, the Superintendent stated that he was in the process of assessing the need for additional video surveillance cameras in each of the housing area dayrooms. Supervision of each housing area is provided through a detention officer posted inside each housing area, as well as security supervisors conducting unannounced rounds at least once per shift. Unannounced rounds by supervisors are noted in the housing area logbook in red ink. The Auditor reviewed the logbooks in each housing area and confirmed that unannounced rounds are being conducted at least once per shift and at irregular intervals.

The food services area is staffed by a food services manager, a detention officer, and up to five detainees. It included two dining areas equipped with video surveillance. The kitchen area is rectangular in shape and kitchen equipment creates blind spots; however, the placement of convex mirrors enable staff to see into those areas. Dry storage, freezers, and coolers are all locked and detainees do not have access to those areas.

The laundry area is staffed by a laundry supervisor, along with up to six detainee workers and contains numerous blind spots; however, is equipped with four convex mirrors. The laundry office has windows which affords easy view of the convex mirrors and front of the laundry. The Auditor stood in various areas of the laundry and found that the mirrors provided excellent coverage of the blind spots created by equipment. PREA posters were prominently displayed in this area.

The intake area and sallyport were equipped with video surveillance. PREA postings were visible to detainees as they enter the area. The posters were in Spanish and English. There is a waiting area in intake where detainees are placed to complete intake processing. A PREA video is shown in English and Spanish in this area while detainees await processing. The interview area is equipped with partitions which allow for privacy while detainees are being interviewed by intake staff. The bathroom areas and changing areas allowed for direct supervision, while also providing privacy to the detainee.

Health services are provided by ICE Health Services Corps (IHSC). The health services area had PREA posters throughout the area. Exam rooms provided privacy through movable curtains. (b) (7)(E) Twenty-four-hour nursing coverage is not provided but health care staff is on call any time staff is not present. Nursing coverage is provided until 11:00 p.m., seven days per week.

The program building houses offices for ICE staff, facility staff, telecommunication interview rooms for immigration hearings, a chaplain's office, and chapel area. A large window from the chaplain's office allows for viewing by detention officers. PREA posters were posted throughout this area. (b) (7)(E)

(b) (7)(E) There are four detainee classrooms and a detainee library. An area previously used as classroom space has been converted into hearing rooms, where detainees can teleconference for their hearings.

During the tour, the Auditor utilized detainee telephones in the housing areas to contact the A/PSA Compliance Manager, RCASA and the DHS OIG. On each call, the Auditor identified himself and that a test call was being placed. The Auditor determined that all three entities accept telephone calls from detainees and will maintain confidentiality if requested.

The facility had six closed PREA allegations documented on its PREA Allegation Spreadsheet, and two additional cases which were reported after submission of the spreadsheet, but within the audit period. Six of the eight allegations involved detainee-on-detainee sexual abuse, and two were regarding staff-on-detainee sexual abuse. Six of the eight cases were determined unfounded, and two unsubstantiated. Three of the cases contained allegations that may have been criminal, but only one of those was referred to the local sheriff for investigation. In five of the eight cases, no retaliation monitoring occurred; in one case, the reporting was made during intake, but due to a discrepancy in translation, did not occur while the detainee was in custody, but rather occurred earlier in the detainee's life outside of ICE custody; in two cases, retaliation monitoring occurred.

At the conclusion of the facility tour, the Auditor began interviews of staff, which took place during all three days of the onsite audit. All interviews were conducted in private settings between the Auditor and staff member. The Auditor conducted the interviews with all staff in the same manner, with a prefacing statement to the interview relayed to the staff member explaining the purpose of the interview, how they were selected, that they did not have to speak with the Auditor if they chose not to. No staff refused to speak with the Auditor. The Auditor asked all interviewed staff questions utilizing the various staff Interview Guides for Immigration Detention Facilities. The Auditor conducted 25 individual interviews with members, (12 randomly selected security staff and 13 specialized staff), chosen from a list of all staff members assigned to the facility. These staff members included 10 security officers; 2 supervisory staff; 2 medical/mental health staff members; 2 intake staff; a contractor; the Health Services Administrator (HSA); an investigator; the Human Resources Manager (HRM); the Grievance Coordinator; an SDDO; and the Superintendent. The Grievance Coordinator also covers the duties of the Training Manager and A/PSA Compliance Manager. The Auditor also randomly selected 10 personnel records, 10 staff training records, and 10 detainee files for review to ensure compliance with ICE PREA hiring, promotion, and training standards.

On the second day of the onsite audit, the Auditor interviewed a total of 20 detainees. All interviews conducted with detainees occurred in a private office between the detainee and the Auditor only. The Auditor conducted the interviews with all detainees in the same manner; a prefacing statement was made to each detainee with the Auditor explaining the purpose of the interview, how they were selected, and that they did not have to speak with the Auditor if they chose not to. No detainees refused to speak with the Auditor. All detainees were asked questions utilizing the Detainee Interview Guides for Immigration Detention Facilities. During the interviews, the Auditor utilized a copy of the initial PREA information provided to every detainee upon arrival at the facility, which includes the ICE National Detainee Handbook, CDF Supplement to the National Detainee Handbook, and the DHS-prescribed Sexual Abuse Assault Awareness information pamphlet. The Auditor further utilized a blank copy of the acknowledgment form they would sign for the PREA information received at intake. These materials were used to visually stimulate the detainee's recollection of their initial intake process.

The following targeted detainee interviews were conducted: One detainee who identified as bisexual; one detainee who identified as gay; one detainee who had reported previous sexual abuse; one detainee who reported sexual abuse; one detainee with a cognitive disability; and one detainee with a physical disability. Eight of the 20 detainees interviewed were LEP. Fourteen of the 20 were randomly selected detainees, chosen by the Auditor from a list of all detainees housed at the facility during the onsite audit. There were no detainees at the facility who identified as transgender or intersex at the time of the onsite audit.

Twelve of the interviews were conducted in English, and eight were conducted using the language services telephone line contracted by Creative Corrections, LLC. Translation services were utilized for the following languages: Spanish (5); French (1); Bengali (1); and Arabic (1); The detainees interviewed represented the following countries: El Salvador (7); Mexico (2); Guatemala (2); and one each from Bangladesh, Sierra Leon, Guinea, Ethiopia, Ghana, Sudan, Honduras, Colombia, and Jamaica.

Upon conclusion of the site visit on August 4, 2022, the Auditor conducted an exit briefing, with Team Lead (b) (6), (b) (7)(C) moderating telephonically. In attendance at the briefing were:

- (b) (6), (b) (7)(C) Superintendent, CDF
- (b) (6), (b) (7)(C) Security Chief (Captain), CDF
- (b) (6), (b) (7)(C) Detainee Management Chief (Captain), CDF
- (b) (6), (b) (7)(C) Administrative Chief, CDF
- (b) (6), (b) (7)(C) Administrative Lieutenant, CDF
- (b) (6), (b) (7)(C) DSM, ICE/ERO
- (b) (6), (b) (7)(C) A/PSA Compliance Manager, CDF
- (b) (6), (b) (7)(C) DO, ICE/ERO
- (b) (6), (b) (7)(C) Records Coordinator, CDF
- (b) (6), (b) (7)(C) Maintenance Supervisor, CDF
- (b) (6), (b) (7)(C) Food Services Director, CDF
- (b) (6), (b) (7)(C) Classification Officer, CDF
- (b) (6), (b) (7)(C) ICS, ICE/OPR/ERAU (Via Telephone)
- Mark McCorkle, Auditor, Creative Corrections, LLC

At the exit briefing, the Auditor provided an overview of the audit findings. The Auditor expressed that all staff members interviewed possessed an excellent grasp of not only the PREA standards, but specifically how they are applied at the facility. He also conveyed that nearly all detainees interviewed expressed at least basic knowledge of PREA and the resources available to them, if needed. Even with the multitude of languages spoken by detainees, all understood the basic concepts of sexual safety at ICE detention facilities.

The Auditor expressed that an inspection of randomly selected detainee records indicated that 100% of the records reflected detainees had received the required educational material and orientation required by the standards. It was evident to the Auditor that the facility had conveyed to detainees the importance of sexual safety. The ICE National Detainee Handbooks are available in a multitude of languages, and when a specific language may not be on hand, processing staff has access to PDF files to print in the needed language for distribution to the detainee (further context will be provided in the related standard's narrative below). It was evident in interviews with detainees, that the PREA acronym is not easily understood by those who are non-English speaking. However, when specific questions were asked by the Auditor regarding sexual safety, and information extracted by officers at intake, the detainees understood the subject matter. At the time of the exit briefing, the Auditor informed those present that there were areas of non-compliance; however, corrective actions were attainable and would be discussed in detail with facility leadership once developed in cooperation with ICE.

In the preparation of this audit report, the Auditor conducted a thorough review of CDF policies, related ICE policies, documentation provided by the facility, a complete review of investigative reports, interviews with staff, detainees, and contractors, all coupled with his observations and inspections during the three days of the onsite audit, to evaluate the facility for compliance with each of the 41 DHS PREA Standards for a Subpart A facility.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 2
§115.31 Staff training
§115.64 Responder duties

Number of Standards Met: 34
§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
§115.18 Upgrades to facilities and technologies
§115.21 Evidence protocols and forensic medical examinations
§115.32 Other 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
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.68 post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.87 Data collection
§115.201 Scope of audits.

Number of Standards Not Met: 4
§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.67 Agency protection against retaliation
§115.86 Sexual abuse incident reviews

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. If additional space for notes is needed, please utilize space provided on the last page.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(c) CDF Policy 2.11, Security, Sexual Abuse and Assault Prevention and Intervention (SAAPI), mandates zero tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to incidents of sexual abuse and sexual harassment. The policies furthermore define sexual abuse and sexual harassment. The entirety of this policy was reviewed and fully approved by the Superintendent in April 2020. The staffing plan documentation provided in §115.13 indicated that the facility had submitted all policies to ICE for review, but no documentation was provided that the agency has approved this policy.

Does Not Meet (c): This standard requires that the facility policy be approved by the agency (ICE). The facility did not provide documentation indicating that the policy had been presented for review and approval by ICE, therefore the Auditor finds that the facility is not in compliance with this standard. In order to become compliant, the facility must show that the agency has reviewed and approved this policy.

(d) The facility employs a PSA Compliance Manager at the rank of captain who is responsible for overseeing policies and procedures related to the PREA standards and ensures facility compliance; he is a direct report to the Superintendent in SAAPI matters and serves as the facility point of contact for the agency PSA Coordinator. At the time of the onsite audit, the PSA Compliance Manager was away from the facility and in his absence, the Grievance Coordinator/Training Manager was the designated A/PSA Compliance Manager. During his interview, he stated that the PSA Compliance Manager has sufficient time to dedicate to PREA. The A/PSA Compliance Manager was extremely knowledgeable of the facility's PREA policies and procedures and was able to manage the responsibilities for coordinating the facility's efforts to comply with the PREA standards while the PSA Compliance Manager was away. The A/PSA Compliance Manager was thoroughly engaged throughout the audit process. The Auditor reviewed the facility's organization chart, and the PSA Compliance Manager is not listed as a designated policy on the chart, although the ranking structure was verified during the Superintendent's interview.

Recommendation (d): The Auditor recommends that the PSA Compliance Manager be added to the facility's Organizational Chart to indicate the reporting structure and formal authority at the facility.

§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) The Auditor reviewed the current staffing plan, the CDF Post Orders, current placement of video monitoring equipment and current staff roster, and the facility's organizational chart. Those documents, coupled with observations made during the onsite inspection of the facility, and interviews with the Superintendent and A/PSA Compliance Manager have enabled the Auditor to determine that the facility has incorporated sufficient levels of supervision for the detainee population.

During their interviews with the Auditor, the Superintendent and A/PSA Compliance Manager stated that the evaluation of supervision of the detainee population is an ongoing process. The Superintendent stated that although the facility (b) (7)(E) , (b) (7)(E) . It was the Auditor's observation that staff and supervisors were highly attentive, and during informal conversations, staff acknowledged necessary vigilance in the absence of cameras.

(b)(c) The CDF provided its post orders which constitute the facility's comprehensive detainee supervision guidelines; the post orders were inspected by the Auditor and found to be detailed and provide the requisite guidance necessary for staff to satisfactorily complete their duties, with the sexual safety of detainees being at the forefront. In his interview with the Auditor, the Superintendent stated that he reviews the post orders annually. CDF provided documentation of the last annual review of the facility's policies and procedures, which is inclusive of the comprehensive supervision guidelines. This annual review was approved April 4, 2022, by the Superintendent and PSA Compliance Manager, and documented that all policies were submitted to ICE/ERO for review. The staffing plan states that the following factors were considered in its development: "generally accepted detention and correctional practices; any judicial findings of inadequacy; any findings of inadequacy from Federal investigative agencies; any findings of inadequacy from internal or external oversight bodies; all components of the facility's physical plant, (including "blind spots" or areas where staff or offender/detainees may be isolated); the composition of the offender/detainee population; the number and placement of supervisory staff; institution programs occurring on a particular shift; any applicable State or local laws, regulations or standards; the prevalence of substantiated or unsubstantiated incidents of sexual abuse; and, any other relevant factors." The Superintendent, in his interview with the Auditor, said that all managers and supervisors have equal input and that the safety of staff and detainees is the top priority.

(d) CDF Policy 2.4, Facility Security and Control, says that the "shift commanders conduct frequent unannounced security inspections on day and night shifts to control the introduction of contraband; identify and deter sexual abuse of detainees; ensure facility safety, security, and good order; prevent escapes; maintain sanitary standards; and eliminate fire and safety hazards. Staff are prohibited from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operational functions of the facility." The policy goes on to say that "the inspections must occur at least once per shift." The facility provided log sheets from each shift demonstrating the unannounced rounds were being conducted. Additionally, during the facility tour, the Auditor inspected the logbooks in each housing area and found each to contain entries from supervisors conducting unannounced rounds during day and night hours.

In their interviews with the Auditor, supervisory staff expressed their responsibilities in conducting unannounced rounds and that the purpose was to ensure the sexual safety of the detainee population at the facility.

All 10 randomly selected security staff members interviewed also stated that they were forbidden from alerting other staff members to unannounced rounds when they were being made. Each also stated that it was routine for supervisory staff to be in the housing units, so their presence is never unusual, or cause for concern.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The CDF does not house juvenile detainees, which was articulated in a memo prepared by the Superintendent. In his interview with the Auditor, the A/PSA Compliance Manager confirmed the information contained in the memo. This standard is not applicable.

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

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

Notes:

(b)(c) CDF Policy 2.10, Searches of Detainees says, "Cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required, or in exigent circumstances. Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances."

The Auditor interviewed 10 randomly selected staff members related to this standard. Each stated they have never conducted nor observed a cross-gender pat search of a detainee. Each also said that in their experience, no emergency has ever existed requiring a cross-gender pat-down search of a detainee. The facility provided a memo signed by the Superintendent, stating that no cross-gender pat-down searches had been conducted at the facility during the audit period. The A/PSA Compliance Manager confirmed this during his interview.

(d) CDF Policy 2.10 states "All cross-gender pat-down searches shall be documented." In the event a cross-gender pat-down search is necessary due to exigent circumstances; the facility created a form to document such instances. The Auditor reviewed a copy of the blank form and found that it contained the necessary information to properly account for such a search, should one occur. All staff members interviewed (line staff and supervisory) were extremely well-versed in cross-gender pat-down search policy and were aware of the requirement to document cross-gender pat-down searches.

(e)(f) CDF Policy 2.10 states, "An officer of the same gender as the detainee shall perform the search (strip search). Special care should be taken to ensure that transgender detainees are searched in private. In the case of an emergency, a staff member of the same gender as the detainee shall be present to observe a strip search performed by an officer of the opposite gender." The A/PSA Compliance Manager was interviewed regarding the language in this policy. He stated that a strip search may only be performed by an officer. In the case of the policy, if an emergency existed, and there was no male officer present, a female officer could perform the search; however, a male staff member (when a male officer is not available) must be present. The A/PSA Compliance Manager said there have been no instances of this occurring at the facility.

During the audit period, there was one incident of a strip search. Based on documentation provided to the Auditor, a third-party caller to the facility identified a detainee being held in segregation (non-PREA related) and believed he would attempt to harm himself with medication he had collected. Believing there was an imminent danger to the detainee, supervisory and mental health staff responded to the segregation cell and conducted a strip search of the detainee. No medications were located. The incident was detailed in an incident report and on a strip-search documentation form, which were all signed by the Superintendent. This search was conducted by an officer of the same gender.

In their interviews with the Auditor, medical staff stated that if a body cavity search needed to be performed, it would be conducted by a practitioner. Each of the 10 randomly selected staff members interviewed stated that they have never conducted a body cavity search, and that a body cavity search would need to be performed by a member of the medical staff. The 10 security staff members also said that a cross-gender strip search would never be performed by security staff; however, they understood that if for some reason a cross-gender strip search was performed, it would have to be documented. The facility provided a memo signed by the Superintendent stating that no cross-gender strip searches or visual body cavity searches had been conducted at the facility during the audit period. The A/PSA Compliance Manager confirmed this during his interview.

(g) CDF Policy 2.11 says, "Detainees are able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement." The policy additionally says, "Staff of the opposite gender shall announce their presence when entering a detainee living unit [or] an area where detainees are likely to be showering, performing bodily functions, or changing clothing."

During the onsite audit, the Auditor observed the shower and toilet areas in each housing unit and found that all had either a privacy curtain, or short wall that prevented cross-gender viewing of the detainees yet allowed security staff to see that the area was occupied. Additionally, the Auditor observed it would be physically impossible for video surveillance (where available) to see into the toilet or shower area. The Auditor interviewed 20 detainees and 19 said they felt they are not in view of female staff when showering or using restroom facilities. Additionally, 13 of the 20 said some announcement is made by female staff when they enter a housing area. Four of the seven detainees who said announcements were not made did not speak English, so they are unaware of what specifically is being said when officers enter the housing unit. It was the Auditor's observation during the facility tour that many of the detainees congregate inside the four-person cells, making it difficult, if not impossible to hear an announcement made by female staff.

During their interviews with the Auditor, all 10 randomly selected staff members said that announcements by females were required when entering all housing areas of the facility. During the onsite audit, a female SDDO accompanied the tour for a short time, and in each instance an announcement was made when she entered a housing area.

Recommendation (g): Due to the number of Spanish speaking detainees at the facility and results of the detainee interviews, the Auditor recommends the cross-gender announcements be made in English and Spanish. Additionally, the Auditor recommends that permanent placards be placed on the hard doors reminding female staff to make the announcement. Sample language: "Opposite Gender Must Announce Presence in English and Spanish When Entering Housing Area."

(h) CDF is not a family residential facility; therefore, this subpart is not applicable.

(i) CDF Policy 2.10, Searches states, "Staff shall not search or physically examine a detainee for the sole purpose of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner." All interviewees, including medical and mental health staff, security staff, and security supervisors, were extremely articulate when it came to this area of policy and all stated that to their knowledge a strip search had never been conducted for this purpose.

(j) CDF Policy 2.10 says, "Security staff shall be trained in proper procedures for conducting pat searches, including cross-gender pat searches and searches of transgender and intersex detainees." The policy also states that, "An officer of the same gender as the detainee shall perform the search. Special care should be taken to ensure that transgender detainees are searched in private. The Auditor reviewed the SAAPI training Course Objectives and found that staff receive training on "Guidance on Cross-Gender/Transgender Pat Searches". All 10 randomly selected staff, and supervisory staff, stated they had been trained on conducting searches of cross-gender, transgender, and intersex detainees. A review of 10 randomly selected training records by the Auditor contained documentation that all 10 personnel had received the training.

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

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

Notes:

(a)(b)(c) CDF Policy 2.11 says, "The CDF shall take appropriate steps to ensure that detainees with disabilities (including for example detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an opportunity to participate in or benefit from all aspect[s] of the facility's efforts to prevent, detect, and respond to sexual abuse." The policy further states, "the facility's orientation video shall be in audio and closed captioned....]. Classification staff shall identify detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities during the booking process. Individualized efforts will be made by classification staff to ensure these detainees receive prevention detection and response information." CDF Policy 2.11 further states the facility will, "…[Provide] access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary; and…[provide] access to written materials related to sexual abuse in formats or through methods that ensure effective communication. Classification staff will coordinate with the detainee ADA Coordinator (Assistant Health Services Administrator) to determine an appropriate delivery method."

In their interviews with the Auditor, intake staff members stated that if a detainee with low vision were to be processed, the intake staff member would read PREA education material and the transcript of the PREA video to the detainee to ensure comprehension. They said the same would be done for detainees with a cognitive disability. In the case of a detainee with limited or no hearing, they would have the detainee read each section of the transcript and confirm they understood the contents. The Superintendent and A/PSA Compliance Manager confirmed this process in their interviews.

The Auditor interviewed one detainee with a cognitive disability, who also was LEP. The detainee said that staff, using a Spanish-language interpreter, read all the documentation at intake. He said he did not specifically remember all the documentation that was

presented. The Auditor confirmed through the review of the detainee's file that he did receive the appropriate documentation, each containing a signature on the receipt documents. The detainee said he remembered that a video was played while he awaited processing, but that he was not paying attention to the content.

The Auditor also interviewed an English-speaking detainee with a physical disability who said that his disability did not interfere with his ability to function at the facility, or at any point during the intake process. The Auditor also confirmed through a review of the detainee's file that he had received all the appropriate PREA materials at intake.

CDF Policy 2.11 also states, "In matters relating to allegations of sexual abuse, the CDF shall employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. The facility shall provide detainees with disabilities and detainees with Limited English Proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. A staff member will be utilized for interpretive services when available. If a staff member is unavailable to interpret the language line shall be utilized. Another detainee may be utilized If a detainee expresses a preference for another detainee to provide interpretation and management determines that such interpretation is appropriate and consistent with DHS policy."

During the onsite audit and tour, the DHS PREA Posters were placed prominently in all housing areas of the facility, and all had the name of the PSA Compliance Manager printed on the first page of the poster. During the tour, the Auditor used a housing area telephone and was able to successfully reach the PSA Compliance Manager.

Additionally, CDF provided the ERO Language Services Resources Flyer. This flyer provides resources for use by staff to ensure effective communication with detainees. These resources include a 24-hour Language Line and translation or transcription services.

During the three-day onsite audit, no detainees were processed during the hours of the audit. However, during the interview of an intake staff member, the Auditor asked staff to walk through the intake process as if the Auditor were a new detainee. The staff member showed exceptional knowledge of the process and was very familiar with the steps to access translation services if they were necessary. Based on his presentation to the Auditor, the intake staff member understood all the materials presented, and specifically those dealing with initial PREA education.

In his interview, the Superintendent emphasized the need for reliable interpretive services because of the number of detainees who do not speak English. He was confident that all the staff at the facility were familiar with accessing interpretive services since it is a routine aspect of their daily duties. In interviews with the 10 randomly selected staff, all had knowledge of not only the interpretive services available to staff and detainees, but each were able to acknowledge the presence of the PREA postings and ERO language service information in the housing units.

Of the eight LEP detainees interviewed, six specifically recalled receiving information in writing regarding PREA that they could understand. The other two detainees said they did not recall what specific information they received.

Of the eight allegations reviewed, five files documented that the detainees involved spoke English and the other two indicated the detainees spoke Spanish. The files of the Spanish speaking detainees indicated that an interpreter was used, and that written statements were translated from Spanish to English by a staff member. In interviews with the Auditor, security staff stated that language services would be used if a detainee involved in an allegation of sexual abuse needed to be interviewed and did not speak English. All indicated that at no time would an involved staff member or involved detainee be used as an interpreter. The Superintendent explained that if a detainee expresses a preference for another detainee to provide interpretation it would be allowable, provided ICE determines the request to be appropriate and consistent with DHS policy. At the time of the onsite audit, there were no LEP detainees to be interviewed who had been involved in a sexual abuse allegation,

§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)(c)(d)(e) CDF policy 2.11 states, "The CDF will not hire or promote anyone who may have contact with detainees, and shall not enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution, who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity." CDF policy 2.11 also states, "all candidates for employment, as well as contractors and volunteers, are required to undergo a Background Investigation prior to being considered at the CDF. The CDF will provide employees the training and direction needed to: act affirmatively to prevent sexual abuse and assaults on detainees; provide prompt and effective intervention and treatment for victims of sexual abuse and assault; and control, discipline and prosecute the perpetrators of sexual abuse and assault." Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive, require collectively to the extent permitted by law, the agency/facility decline to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have contact

with detainees, who: has 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); has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity as outlined above.

In her interview with the Auditor, the HRM said that the facility utilizes the ICE OPR Personnel Security Operations (PSO) to conduct the background investigations on all applicants, employees, or contractors with the agency. The facility conducts a criminal history background check for all prospective applicants which is the first level of clearance. This investigation ensures that the facility does not hire or promote anyone who may have contact with detainees, nor enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution or who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity.

According to the HRM, each new employee candidate is required to complete an application and an attestation to having not engaged in the sexual assault and abuse behaviors outlined in this standard. Additionally, the HRM stated that during the application process, if any prospective employee provides information which indicates they have engaged in any of those behaviors, they would not be submitted to ICE for hire. These factors are compliant with ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive.

During the background process, the applicant, employee, or contractor is asked questions directly related to sexual abuse in confinement settings enumerated in the standard; these questions are asked both in a written form and in person by the assigned investigator who conducts the interviews. The Auditor confirmed these practices during his interview with the captain, who conducts the background interviews. During staff interviews at the facility, the Auditor confirmed that all contractors and employees were also asked these questions prior to being hired. The Auditor reviewed one personnel file of an employee who was promoted during the audit period, and confirmed it contained documentation that they were asked the misconduct questions prior to their promotion in subpart (a).

CDF documentation signed by the employee at hiring requires them that they have an affirmative duty to disclose any misconduct as it is described in section (a)-1 of this policy. The Auditor confirmed this through the inspection of 10 randomly selected employee files. The HRM confirmed that employees are advised of this policy when they complete the authorization form to have their background check completed. During staff interviews, the Auditor confirmed that employees are aware of their continuing affirmative duty to report any misconduct. Additionally, the HRM, Superintendent, and A/PSA Compliance Manager confirmed during interviews that former institutional employers are contacted to learn of any substantiated allegations of sexual abuse or any resignations during an investigation of new hires during the application process and prior to onboarding.

During the A/PSA Compliance Manager and HRM interviews, the Auditor confirmed if any prospective employee or contractor were involved in any misconduct of this nature, they would not be offered employment by the facility; and any current employee, or contractor involved in misconduct of this nature would be terminated.

The Auditor completed a PREA Audit: Background and Investigation for Employees and Contractors DHS Facilities form and submitted to the ICE OPR PSO for verification that background investigations were conducted and were current; this request included eight CDF employees and four ICE employees who have access to detainees. 5 CFR 731, and ICE Directive 6-8.0 requires the agency to conduct a background investigation on everyone to determine access into government employment or into a facility. 5 CFR 731 also requires investigations every five years. The Auditor confirmed the background investigations; however, since the facility was reopened in 2018 as an ICE facility, no employees have yet met the five-year reinvestigation requirement.

During this hiring process, and subsequent background investigation, the investigator asks questions related to character, integrity, and overall suitability for employment. The Auditor confirmed during the staff interviews at the facility that all interviewed staff had been asked the same questions during the background investigation process. The HRM stated that any material omissions regarding misconduct covered in subpart (a) of this standard, or the provision of materially false information, shall be grounds for termination. This was confirmed by the Superintendent in his interview. He added that he personally reviews the background packets of all new hires and that any omissions would be grounds for disqualification from hire.

The Unit Chief of OPR 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. Based on information provided in an email by the OPR PSO (A) Division Chief, information on substantiated allegations of sexual abuse involving a former employee would be provided to prospective employers upon request, unless prohibited by law. The prevention of sexual abuse in any agency begins with the hiring process and initial background investigation. ICE utilizes a system where not only current misconduct is identified, which will make the applicant, employee, or contractor unsuitable for employment, but continually monitors their employees and contractors for any misconduct or behavior that will make them unsuitable

in the future. Due to the nature of the work DHS performs, this process is necessary to create a safe environment for detainees who are held in their custody or detained at a contracted facility. The HRM confirmed this policy and practice in her interview with the Auditor.

The Auditor randomly selected 10 employee files and inspected each for appropriate documentation regarding this standard. The Auditor observed that all contained the pre-employment PREA screening acknowledgement. The documentation review also consisted of an inspection of annual evaluations performed by facility management, which contain a form signed by the staff member affirming they have not been involved in any misconduct.

The Auditor discussed the hiring and promotional processes with the Superintendent and the A/PSA Compliance Manager. Each demonstrated a thorough knowledge of the policy and confirmed that anyone who has any substantiated finding in a case regarding sexual abuse, sexual assault, or sexual harassment would automatically be disqualified from the hiring process. In his visual inspection of randomly selected personnel files, the Auditor found that every file was neatly organized and all documentation to verify this standard was easily located. During the interview, the HRM was very knowledgeable and demonstrated a solid understanding of the requirements for hiring and promotion.

(f) The HRM stated during her interview that she would provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from a prospective employer on a prior employee if requested.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a)(b) CDF Policy 2.11 states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility shall consider the effect of the design, acquisition, expansion, or modification upon its ability to protect detainees from sexual abuse. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, the facility shall consider how such technology may enhance its ability to protect detainees from sexual abuse." The facility has not acquired a new facility or made a substantial expansion to the existing facility since the last audit. In its ongoing assessment of facility security and safety needs, the A/PSA Compliance Manager and the Superintendent said that the Facility leadership team identified numerous blind spots in the facility, a lack of continuity in video surveillance technology, and areas of the facility which did not have video coverage. (b) (7)(E) [redacted] There was no documentation available related to the installation of these cameras, but compliance was determined through the Auditor's visual inspection of the placement of the cameras and interviews.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a)(b)(c)(d) CDF Policy 2.11A, Coordinated Response Plan, establishes that CDF staff shall follow a uniform evidence protocol and details steps to be taken that maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol was developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable. The Superintendent and A/PSA Compliance Manager both confirmed in their interviews that the facility strictly follows protocols which have been developed and coordinated with DHS. The facility does not house juveniles.

Agency policy 11062.2 (Sexual Abuse and Assault Prevention and Intervention) 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 personnel in accordance with OPR policies and procedures. OPR does not perform sex crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or a local law enforcement agency. The OPR will coordinate with the Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not accepted or assigned by the DHS OIG, OPR, or local law enforcement agency, the case would be referred to ERO for assignment and completion of an administrative investigation.

Policy 2.11A states, "The Rappahannock Council Against Sexual Assault [RCASA] is a part of the coalition within the Commonwealth who refers victims to rape crisis centers in the participating jurisdiction. A representative from RCASA may make referrals for assistance if/when a detainee is released to the community. Provision will be made for testing for sexually transmitted diseases (for example, HIV, gonorrhea)." In addition to offering advocacy services through an MOU with RCASA, the Superintendent and A/PSA Compliance Manager both stated that they have a strong relationship with RCASA and include them in ongoing discussions on ways to improve sexual safety at the facility. The Auditor observed telephonic contact information for RCASA in all housing and other common areas of the facility. The Auditor telephonically interviewed a representative from RCASA, who stated that they would provide services to detainees from CDF.

As it relates to access to forensic medical examinations, CDF Policy 2.11A says, "Any physical examination of an alleged victim of sexual assault will be conducted in accordance with a SANE (Sexual Assault Nurse Examiner) representative at Mary Washington Hospital and an officer from the Caroline County Sheriff's Office [(CCSO)]." Facility policy requires any examination or treatment provided is at no cost to the detainee and must be done only with the detainee's consent. CDF provided an MOU with the Mary Washington Hospital to

provide medical services to detainees from CDF. The MOU states that if a SANE is needed, the detainee would be referred to the hospital for the exam. The Auditor confirmed this process through telephonic interviews with staff from Mary Washington Hospital.

During their interviews with the Auditor, facility IHSC medical staff personnel stated that they would not perform sexual assault exams and that any detainee requiring a forensic exam would be transported to Mary Washington Hospital for a SANE examination. Each medical staff member interviewed told the Auditor their only treatment would be for any other traumatic injury suffered by the detainee.

CDF Policy 2.11A states that victims would be provided an outside or internal victim advocate, including victim advocacy services offered by a hospital conducting forensic exams, and the advocate shall be allowed to be present for support during a forensic exam and investigatory interviews. This was confirmed by the Auditor in his interview with the A/PSA Compliance Manager and the staff member trained to be an advocate.

(e) The facility provided a copy of its MOU with the CCSO, which states that the sheriff's office will follow all requirements of paragraphs (a) through (d) of this standard. This was confirmed in interviews with the A/PSA Compliance Manager and an investigative staff at the sheriff's office.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(d) CDF Policy 2.11 says, "All allegations of sexual assault and sexual harassment, including third-party and anonymous reports, are normally reported through the chain of command. The Superintendent will assign a trained sexual abuse investigator to determine the outcome of the allegation. All criminal allegations of sexual assault or sexual harassment will be reported to the Caroline County Sheriff's Office for criminal investigation. Sexual assault/harassment administrative investigations are prompt, thorough, objective, including third-party and anonymous reports, and conducted by investigators who have received special training in sexual assault investigations. When the Caroline County Sheriff's Office investigates sexual assault or sexual harassment, facility investigators will keep abreast of the investigation and cooperate with Sheriff's Office Investigators and remain informed about the progress of the investigation."

The agency's policy 11062.2 outlines the agency's evidence and investigation protocols. All investigations are to be reported to the Joint Intake Center (JIC), which routes allegations for assessment to determine which fall within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the investigation allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the investigation allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff.

CDF provided a memo signed by the Superintendent, which stated that CDF had no allegations that required a criminal investigation. The memo goes on to say that had one been received, it would be handled in accordance with CDF Policy 2.11. However, during a review of the eight investigative files by the Auditor, it was discovered that three of the allegations contained potentially criminal activity. In one case, a third party notified the Court regarding an allegation made by a detainee that contained potential criminal activity. Two months after receiving the allegation, and after receiving the third-party notification, CDF contacted the CCSO, who ultimately conducted a criminal investigation, and determined the allegation to be unfounded. Additionally, the Auditor identified two additional allegations that contained potentially criminal activity that were not referred to the sheriff for investigation. Both SAAPI cases #4139 and #3927 contain what appear to be potentially criminal allegations. In their interviews with the Auditor, both the Superintendent and A/PSA Compliance Manager acknowledged that the cases referenced above should have been referred to the sheriff's office for investigation. They did say, however, that the cases were reported to the Deputy Field Office Director, Assistant Officer in Charge, and the SDDO with ICE/ERO. The Auditor confirmed those notifications during the investigative file review process. The Superintendent stated he would ensure that all allegations would be referred to the sheriff's office in the future if the allegation contained possible criminal activity.

The Auditor reviewed the MOU with the CCSO and confirmed that it contains language consistent with this standard. In addition, in their interviews with the Auditor, the Superintendent, A/PSA Compliance Manager, a facility investigator, and an investigator from the sheriff's office all stated they understood their respective responsibilities as outlined and would adhere to the tenets of this standard. CDF Policy 2.11 says the agency shall, "retain all written reports referenced [in this policy] for as long as the alleged abuser is detained, or employed by the agency, plus five years." The A/PSA Compliance Manager confirmed that records would be retained according to the requirements of the policy.

(c) The Auditor confirmed that both the CDF (http://www.carolinedf.org) and ICE (https://www.ice.gov/detain/prea) websites contain their respective protocols as it relates to PREA, and commitment to comply with those standards.

(e)(f) In their interviews with the Auditor, the Superintendent and A/PSA Compliance Manager each said that allegations would be immediately reported to the JIC, ICE OPR, and/or DHS OIG, as well as the appropriate ICE FOD. If the incident is potentially criminal and a staff member, contractor, volunteer, or detainee is alleged to be the perpetrator of sexual abuse, the incidents are reported to

the CCSO for investigation. The Auditor's review of the case files determined all notifications were made to JIC and ICE OPR within the prescribed timelines in policy and the review processes were thorough and complete. The Superintendent told the Auditor in his interview that the lead PREA investigator (the PSA Compliance Manager) is knowledgeable about the investigative process and familiar with notification protocols. He said that he and the PSA Compliance Manager (the A/PSA Compliance Manager in his absence) speak regularly about any open PREA investigations, and that the PSA and A/PSA Compliance Managers do an excellent job of keeping him apprised of all investigations. Each of the eight cases reviewed by the Auditor was organized, with acceptable investigative techniques and use of evidence (video surveillance footage) to help support the finding.

Does Not Meet (e): Based on a thorough review of the investigative files (detainee-on-detainee), coupled with interviews with the Superintendent and A/PSA Compliance Manager, the Auditor has determined that the facility did not refer two of the potentially criminal allegations to the CCSO as required. To become compliant, the facility must provide re-training to all investigators on DHS policies regarding the referral of criminal allegations and provide the Auditor proof that the training has occurred. Additionally, the facility must formally refer SAAPI cases #4139 and #3927 to the CCSO for investigation, provide the Auditor with a copy of the formal request for investigation along with the response and outcome from the CCSO.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) The facility has provided training to all employees and food service/commissary contractors, who may have contact with detainees. The Auditor reviewed the curriculum, and it provides the following content in regard to fulfilling their responsibilities under these standards; this training included: CDF's zero-tolerance policy for all forms of sexual abuse and assault; The right of detainees and staff to be free from sexual abuse or assault; Definitions and examples of prohibited and illegal behavior; Dynamics of sexual abuse and assault in confinement; Prohibitions on retaliation against individuals who report sexual abuse or assault; Recognition of physical, behavioral, and emotional signs of sexual abuse or assault, situations in which sexual abuse or assault may occur, and ways of preventing and responding to such occurrences, including common reactions of sexual abuse and assault victims; How to detect and respond to signs of threatened and actual sexual abuse or assault; Prevention, recognition, and appropriate response to allegations or suspicions of sexual abuse and assault involving detainees with mental or physical disabilities; and How to communicate effectively and professionally with victims and individuals reporting sexual abuse or assault; How to avoid inappropriate relationships with detainees; Accommodating limited English proficient individuals and individuals with mental or physical disabilities; Communicating effectively and professionally with lesbian, gay, bisexual, transgender, intersex, or gender non-conforming individuals, and members of other vulnerable populations; Procedures for fulfilling notification and reporting requirements; The investigation process; and The requirement to limit reporting of sexual abuse or assault to personnel with a need-to-know to make decisions concerning the victim's welfare and for law enforcement or investigative purposes.

(b) Training is completed each year, rather than the bi-annual requirement in this standard. The training was verified by the Auditor through interviews with the Training Manager and reviewing signed training certification forms, both electronic and hard-copy training files. The PREA training requirements are outlined in CDF Policy 2.11. Trinity staff are subject to the same training requirements as facility staff due to their direct contact with detainees.

(c) The facility documents the training on a roster; the training ensures staff members and contractors understand CDF's and ICE's current sexual abuse and assault policies and procedures. The Auditor reviewed the training materials which were provided to the Auditor during the pre-audit process and reviewed by the Auditor onsite. The Auditor further reviewed the training retention schedule for the facility, which indicates the records are retained for five years. Since the facility reopened in 2018, the five-year threshold for retention of records has not yet been met. The Auditor confirmed in his visit to the Training Center that all the hard-copy training records are maintained in locked filing cabinets in the facility's secure Training Center.

During the staff interviews, the Auditor verified that all interviewees (randomly selected staff and supervisory staff) had received the requisite PREA training. Each was able to verify that they had viewed the training, or received education in person, and were able to articulate their responsibilities under the standards. During the staff interviews, a detention officer stated that the training office uses a "trivia-type" game to staff, where quizzes are posted pertaining to various facility policies (including PREA) and points are awarded for correct quiz answers. Prizes are awarded to staff attaining the highest scores. This process was confirmed by the Training Manager. The Auditor found this an ingenious way to keep staff engaged and it was evident in the interviews. It was clear after the review of documentation and interviews that the facility has done an extraordinary job of educating its staff and maintaining proper documentation.

§115.32 - Other training.

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

Notes:

(a)(b)(c) CDF Policy 2.11 requires all volunteers and contractors who have contact with detainees be treated the same as staff as it pertains to PREA training. It requires that all be trained on their responsibilities under the facility's sexual abuse prevention, detection, intervention and response policies and procedures. In his interview with the Auditor, the A/PSA Compliance Manager stated that due to COVID-19 the facility is not employing any volunteers. The facility has trained all contractors who may have contact with detainees on their responsibilities under the facility's zero-tolerance policy, and their obligation to immediately report such incidents. The training is dependent upon the level of service they provide and the level of contact they have with the detainees. The training is

documented by the facility Training Manager, and the contractor acknowledges receipt of the training. During the interview with the Training Manager, he confirmed that the training took place and provided the Auditor with the signed acknowledgment forms. During the onsite audit, the Auditor interviewed the commissary contractor who confirmed they received the training and understood their responsibilities under the CDF Policy 2.11. The Auditor confirmed through observation that the commissary staff has only limited detainee contact and always under the supervision of security staff. The Auditor reviewed CDF's Volunteer/Contractor Orientation and Training Manual (provided pre-audit and reviewed onsite) and found it to be comprehensive, containing all required training topics per the PREA standards, and is a great resource guide for contractors and volunteers.

§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) CDF Policy 2.11 outlines the facility intake process that ensures all detainees are notified of the facility's zero-tolerance policies for all forms of sexual abuse. This process includes instruction on prevention and intervention strategies, self-protection and indicators, definitions, examples of detainee-on-detainee sexual abuse, and staff-on-detainee sexual abuse and coercive sexual activity. The facility also informs detainees of reporting methods which include reporting to staff, the DHS OIG, and the JIC. This includes the prohibition against retaliation, an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings, and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling.

CDF Policy 2.11 states that detainees shall be, "informed how to report an incident or situation regarding sexual abuse, or intimidation to any staff member, the DHS Office of Inspector General, and the Joint Intake Center. Each detainee is provided information about the Rappahannock Council Against Sexual Assault in the Detainee Handbook Supplement. Detainees are informed how RCASA assists victims of sexual assault. The telephone number and mailing address is provided. This information shall also be posted in each detainee living unit. Classification staff shall ensure each detainee who is limited English proficient or otherwise disabled benefits from the provided information." According to Intake staff, the vast majority of LEP detainees speak Spanish and the orientation video is produced in English and Spanish. In their interview with the Auditor, an intake staff member stated that in the event a detainee does not speak English or Spanish, or has a disability (cognitive, hearing, sight), a transcript of the video is provided in a manner the detainee can understand. In the event the detainee has a visual impairment, the transcript would be read to the detainee in a language they could understand, using telephonic interpretive services, if necessary.

(d) The facility has posted notices in all housing units of the DHS-PREA posters; the PSA Compliance Manager contact information; and name of local organizations (RCASA) that can assist detainees who have been victims of sexual abuse. These postings are in limited languages and cannot be read by detainees that do not read Spanish and English. However, this information is included in the transcript and provided to detainees who speak other languages through use of an interpreter as noted in provision (b) above.

(e)(f) The facility provides the DHS-prescribed Sexual Assault Awareness information pamphlet in nine languages, English, Spanish, Chinese, Arabic, French, Haitian Creole, Hindi, Portuguese, and Punjabi. During the onsite audit, all nine languages were available in pamphlet form. According to intake staff, if they did not have an ample supply of all the printed pamphlets, they have access to PDF files, which can be printed on an individual basis and distributed to detainees as needed.

In the 20 interviews with detainees, 19 said they had received the materials required in this standard. One detainee said he did not receive any materials at intake. The Auditor requested his detainee file, and it contained signed receipts for each of the required documents. There appears to be a disconnect with non-English speaking detainees in associating the term PREA, or the words "Prison Rape Elimination Act." The acronym and full phrase were not recognizable to six of the eight LEP detainees interviewed. When a deeper explanation was provided (through translation services), the information was understood, and the detainees acknowledged they had received the information.

The ICE National Detainee Handbook is available in 14 languages, many of which are kept on hand in the intake area. If a language is spoken by a detainee and the facility does not have a printed copy of the handbook in a language the detainee can understand, the facility has access to electronic PDF files which are available in the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) and can print a copy for the detainee. Of the eight LEP detainees, seven indicated they had received the detainee handbook in a language they could read. The one detainee who said he could not read in any language, stated he had received a handbook in Spanish, a language he can understand, but cannot read. He stated that he understood the information he received at orientation and if he needs information from the handbook, he has another Spanish-speaking detainee read it to him. Additionally, the Auditor reviewed this detainee's file and found documentation where the staff read the SAAPI information to the detainee using a language line. The Auditor randomly selected 10 detainee files (and three targeted based on detainee interviews) for inspection and found all to contain signatures acknowledging receipt of the DHS-prescribed Sexual Assault Awareness information pamphlet and the ICE National Detainee Handbook, which also contains sexual awareness information and the availability of support services.

§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) CDF Policy 2.11 requires allegations reported at the facility must be investigated by qualified facility investigators and that "[t]he facility will provide specialized training on sexual abuse and effective cross-agency coordination to facility investigators who conduct

investigations into allegations of sexual abuse." Each of the facilities four investigators participated in online training courses that provide them the information on how to investigate sexual assault and harassment, interacting with traumatized victims, and evidence collection, effective cross-agency coordination, and retention. The Training Manager provided certificates from both the facility and agency at the Auditor's request indicating completion of the training for each of the facility investigators. The Auditor interviewed one of the facility investigators during the onsite audit and viewed their training certificates. The A/PSA Compliance Manager had conducted two of the investigations reviewed by the Auditor, and the primary facility investigator had conducted the other six. The investigator understood the process of investigations, which was evident in the completed investigative reports reviewed by the Auditor. The A/PSA Compliance Manager, through the completion of his investigative reports, demonstrated what is required in the investigative process. Each of the reports was thorough, well organized and provided documentation and evidence to support the finding.

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 for this specialized training is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; 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 requirements.

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

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

Notes:

(a)(b)(c) IHSC Directive 03-01, Sexual Abuse and Assault Prevention and Intervention, requires that "all IHSC staff receive training on the SAAPI directive, PREA standards, and response protocol during initial orientation and annually thereafter throughout their employment with IHSC." Training for medical and mental health care staff cover at a minimum the following topics: how to detect and assess signs of sexual abuse; how to respond effectively and professionally to victims of sexual abuse; how and to whom to report allegations or suspicions of sexual abuse; and how to preserve physical evidence of sexual abuse. PREA Training for IHSC staff and contract medical staff is provided through DHS's Performance and Learning Management System (PALMS). The Auditor reviewed the curriculum in PALMS and found it to contain all the requirements of provision (b) of this standard. The Auditor randomly selected the training records for two IHSC personnel, and one contracted medical staff member. The Auditor found the training records to be complete and cover not only the topics required from general PREA training, but also the specialized material for medical and mental health staff. Based on their interviews with the Auditor, the medical and mental health staff had thorough knowledge of their duties and responsibilities relevant to PREA, the specialized training curriculum, and the facility's policies. The Superintendent stated that he meets regularly with the IHSC Health Services Administrator to ensure delivery of services to the detainee population.

§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) CDF Policy 2.11 states, "Classification staff shall conduct an assessment of all detainees upon intake to identify those likely to be sexual aggressors or sexual abuse victims. Detainees so identified shall be housed separately to prevent sexual abuse." CDF Policy 2.1, Admissions and Release, outlines the process utilized to assess a detainees' risk of victimization or abusiveness. The facility screens all detainees within 12 hours of arrival utilizing the CDF PREA Risk Assessment tool to identify those likely to be sexual aggressors or sexual victims, and houses detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. Based on interviews and informal conversations with intake and medical staff, the normal process is to have the detainee first screened by medical upon arrival at the facility prior to the initial intake process. If this does not occur, the detainees are kept separate from the general population until this process has taken place. The facility medical personnel confirmed during interviews that they utilize the ERO Language Services for LEP detainees to complete the risk screening documentation. The Auditor reviewed screening documentation for 10 detainees through file review and verified that the initial screening and classification are taking place within the specified timeframe. The Auditor also interviewed a total of 20 detainees, and all stated they had been assessed at intake.

(c)(d) The CDF PREA Risk Assessment tool takes into consideration the following: whether the detainee has a mental, physical, or developmental disability; the age of the detainee; the physical build and appearance of the detainee; whether the detainee has previously been incarcerated; the nature of the detainee's criminal history Whether the detainee has any convictions for sex offenses against an adult or child; whether the detainee has self- identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the detainee has self- identified as having previously experienced sexual victimization; and the detainee's concerns about his or her physical safety. The intake process also takes into consideration prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility. The initial screening documents used by intake staff were reviewed by the Auditor and contain specific questions regarding all aspects of subsections (c)(d). This was further confirmed through interviews by the Auditor with the Classification Manager. A review of 10 detainee files found the CDF PREA Risk Assessment tool was used appropriately to assess each detainee.

(e)(g) The A/PSA Compliance Manager and Classification Manager at the facility confirmed during their interviews that detainees are reassessed at 60, 90, and 120 days or if warranted based upon receipt of additional information. The Classification Manager maintains a spreadsheet of all detainees and provides classification personnel the names of detainees who are due for reassessment. Classification and intake personnel perform the reassessment and if any changes are noted, the Classification Manager is notified, and housing is reassessed based on the changes. The Classification Manager and intake/classification staff also confirmed that the responses to the screening questions are not available to the general staff, and is limited to medical, mental health, and case managers. The Auditor reviewed screening and reassessment documentation from 10 randomly selected detainee files during the onsite audit and verified that both are taking place within the specified timeframe. Of the 20 detainees interviewed, six had been at the facility for more than 60 days. Five of the six indicated in their interviews with the Auditor that a reassessment had been completed and one did not recall. The Auditor requested the file of the one detainee and confirmed that a reassessment had been conducted. During a review of the eight investigative files, the Auditor reviewed documentation that showed that each alleged victim and each abuser had been properly reassessed.

(f) The A/PSA Compliance Manager stated that no detainee is disciplined for refusing to answer, or for not disclosing complete information in the screening process.

§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) CDF Policy 2.2, Custody Classification System, requires that the information from the PREA Risk Assessment shall be utilized to determine the assignment of detainees to housing, recreation, activities, and voluntary work. The policy states, "Special consideration shall be given to any factor that would raise the risk of vulnerability, victimization or assault." The A/PSA Compliance Manager and Classification Manager stated in their interviews that these determinations are made on an individual basis. While onsite, the Auditor reviewed 10 completed screening tools and reassessment documentation in the detainee files and found all to be in order.

(b) CDF Policy 2.2 states, "When making classification and housing decisions for a transgender or intersex detainee, CDF employees will consider the detainee's gender self-identification, and an assessment of the effects of placement on the detainee's health and safety. A medical or mental health professional shall be consulted as soon as practicable on this assessment. Placement decisions should not be based solely on the identity documents or physical anatomy of the detainee, and a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. The placement shall be consistent with the safety and security considerations of the facility. Placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee." The A/PSA Compliance Manager stated that when making an assessment and housing decision for a transgender or intersex detainee, the facility considers the detainee's gender self-identification and how any placement will affect the detainee's health and safety at the facility. Detainees can be housed in the medical area until they can conduct a Transgender Care Committee meeting to determine the best housing option. The placement of a transgender or intersex detainee is reassessed at least twice each year, or when new information becomes available, to review any threats to safety experienced by the detainee. The facility has not housed any transgender or intersex detainees in the last 12 months where a reassessment needed to take place, which the A/PSA Compliance Manager confirmed this in his interview. The A/PSA Compliance Manager also confirmed that the placement is not based solely on the identity documents or physical anatomy of the detainee, and their self-identification of his/her gender and self- assessment of safety is always taken into consideration, and all placements are consistent with the facility's safety and security. The medical staff conducts initial assessments and consults with mental health; this was confirmed during interviews with medical and mental health staff. Intake also conducts assessments for the same information. All detainees will be screened by medical staff during the assessment process before being assigned housing. Based on interviews with intake staff and medical/mental health staff, there appears to be an excellent working relationship in place to properly assess and house detainees

(c) Through policy review and random staff interviews, the Auditor confirmed that a transgender or intersex detainee is allowed to shower separately from other detainees. They would have the detainee shower when other detainees were locked down (which is easily attainable, given the layout of the facility), or they have the option to allow the detainee to shower in medical. They also confirmed that they assign a female detention officer to the housing area, where a transgender detainee would be housed, when concerns of cross-gender viewing of any developed female anatomy may arise.

§115.43 - Protective custody.

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

Notes:

(a)(e) CDF Policy 2.12, Special Management Units, directs the management of the administrative segregation unit and those detainees placed in protective custody. These procedures were developed in consultation with the ERO FOD. The A/PSA Compliance Manager stated that the facility documents specific details for the placement of an individual in administrative segregation on the basis of vulnerability to sexual abuse or assault, and as per policy, notifies the ICE AFOD within 72 hours.

(b)(c) CDF Policy 2.12 states that the use of administrative segregation to protect vulnerable detainees is 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, and as a last resort." The facility would assign detainees to administrative segregation for protective custody only until an alternative means of separation from likely abusers can be arranged; this would not

last more than 30 days. The detainees would be provided access to programs, visitation, counsel, and other services available to the general population, as articulated by the A/PSA Compliance Manager in his interview. The Auditor interviewed an officer assigned to the administrative segregation unit at the facility. The officer was able to articulate in which circumstances a detainee would be housed in the unit, including detainees who may be vulnerable to sexual abuse.

(d) CDF policy 2.12, Special Management Units requires that an Administrative Segregation Assessment form is completed within 24 hours by a supervisor and emailed to the PSA Compliance Manager, and the status is reviewed within 72 hours by a security staff supervisor. The PSA Compliance Manager would conduct this review within 7 days, and every week after that for the first 30 days, and every 10 days after that. The Superintendent and A/PSA Compliance Manager were interviewed, and each had a thorough understanding of the administrative segregation as it pertains to this 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) CDF Policy 2.11 establishes the facility's procedures for detainees to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The facility provides instructions on how detainees may contact their consular official, the DHS OIG or, confidentially and, if desired, anonymously, report these incidents. The facility has also developed internal reporting avenues where the detainees can report directly to a staff member, through a request slip, medical slip, and grievance form. Although electronic tablets are available to all detainees, they do not yet allow for submissions of requests or grievances.

During the onsite audit, the Auditor observed consular posters prominently displayed in each housing unit. The Auditor also observed signage near the phones in every housing unit that included easy to follow instruction on how to call the ICE Detention Reporting and Information Line (DRIL), PREA Hotline, DHS OIG, and other services available to detainees. The information in the housing areas is provided in English and Spanish. For those detainees who do not speak English or Spanish, the same contact information is available in the ICE National Detainee Handbook in French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese. Additionally, the Auditor observed posters providing information from the RCASA organization in both English and Spanish. This information is also provided via transcript read to detainees who do not speak these languages or who suffer from some type of disability.

The Auditor tested the telephones in multiple housing areas and found them all operational. The Auditor was able to contact the DHS OIG, DRIL and PREA hotline representatives. In each case, the Auditor informed the representative on the purpose of the call. All representatives stated their understanding of accepting PREA allegations and/or complaints and each said that all can be made anonymously if requested by the detainee. The facility handbook, ICE National Detainee Handbook, and PREA posters all provide avenues for detainees to report incidents of sexual abuse or assault. In interviews with 20 detainees, 19 said they had seen the consular phone list, or knew how to reach their consular office. Of the 20, all acknowledged there were telephone numbers available to them, which are posted in the housing areas above each bank of phones to report PREA incidents.

(c) CDF Policy 2.11 states, "Staff accepts reports made verbally, in writing, anonymously, and from third parties and immediately puts into writing any verbal reports using an Incident Summary." The Auditor interviewed officers and supervisors and found they understood their obligation under this standard, and stated they would accept all reports made verbally, in writing, anonymously, and from third parties, and document any verbal reports made to them.

§115.52 - Grievances.

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

Notes:

(a)(b) CDF 6.2, Detainee Grievance System, and the facility handbook addresses the detainee grievance procedure regarding sexual abuse. The facility does not impose a time limit for the submission of the grievance; the grievance would be considered under the emergency grievance procedure, and no informal grievance procedures are applied. Detainees may file a formal grievance at any time during after, or in lieu of lodging an informal grievance. The A/PSA Compliance Manager stated during his interview that no barriers would be placed on a detainee who wished to file a grievance in any manner. Based on a memorandum provided by the facility, CDF has not had any grievances filed within the last 12 months for sexual abuse.

The Grievance Coordinator was interviewed and stated that there are no time limits for sexual abuse grievances, and if the facility receives a grievance of this nature, it would immediately be reported to the PSA Compliance Manager for investigation. A locked grievance box is located in each housing unit as observed by the Auditor during the onsite audit. The Grievance Coordinator stated that grievances from the locked boxes are picked up daily by supervisors and that he addresses any grievance he receives as soon as possible and responds at least informally within 24 hours to the detainee.

(c)(d) CDF Policy 6.2 outlines the written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. The Grievance Coordinator confirmed that the Superintendent and PSA Compliance Manager would be immediately notified, and they would then take immediate corrective action to protect the detainee. He further stated that any medical emergencies would be brought to the immediate attention of proper medical personnel. The Superintendent and the HSA confirmed this policy and practice in their interviews.

(e) The CDF grievance form states that a decision shall be issued within 5 days of receipt and that any appeal would be responded to within 30 days. The final grievance decision would be forwarded to the FOD. The Grievance Coordinator, who was the A/PSA Compliance Manager for this audit, confirmed this practice.

(f) Policy 6.2 and the facility handbook state that a detainee may utilize another detainee, the housing officer or other facility staff, family members, or legal representatives when filing a grievance. The interviewed staff understood their obligations to expedite a grievance, and to assist if necessary. All the security staff interviewed had knowledge of the grievance process and that there was an appeals process for detainees if they were not satisfied with the grievance determination. During the interview of 20 detainees, 17 stated they were aware they had the ability to file a grievance at the facility. The three (two English-speaking, and one French-speaking) detainees who stated they did not know how to file a grievance all acknowledged they had a facility handbook in their possession. The Auditor informed the detainees that instructions were in the handbook if they were necessary. One of the detainees interviewed said he had filed a grievance and that he received a response in a timely manner, although he did not agree with the response (the grievance was not PREA related).

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The facility has entered into an MOU with RCASA to provide expertise and support in the areas of crisis intervention, counseling, investigation, and prosecution of sexual abuse perpetrators. RCASA contact information, including mailing address and contact number, are posted in the housing units as observed by the Auditor during the onsite visit, and further provided to victims of sexual abuse. CDF Policy 2.11 establishes the procedures which include the outside agencies in the facility's sexual abuse prevention and intervention protocols. During the interview with the A/PSA Compliance Manager, he stated that all victims of sexual abuse are given the contact information for RCASA, and informed that they could contact them at any time. He further confirmed that at the same time they would be informed of the CDF procedures which govern monitoring of communications and when reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. In each of the facility housing areas and other common areas of the facility, the Auditor observed the ICE Zero Tolerance Posters, which are provided in eight languages. The poster informs detainees that all telephone calls are subject to monitoring and that "the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws."

In the 20 random detainee interviews, 19 said they were specifically aware of advocacy services available to them and had seen the postings in the housing area. The one detainee who denied knowledge of the services said the information may be available, but that he had no need to look for it. The Auditor reviewed the eight closed investigative files during the audit period, and all but one indicated that the detainees were given the contact information for RCASA, but due to confidentiality, it is unknown if they were utilized the services. In the one case where information was not provided, it was determined that the sexual assault reported had occurred many years prior and did not occur in custody and the allegation was logged due to an error in translation. During the onsite audit, the Auditor spoke to staff at RCASA via telephone and confirmed these procedures, including their mandatory reporting requirements.

§115.54 - Third-party reporting.

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

Notes:

The facility has established several methods for third-party reporting. The posters for the OIG, and ICE DRIL are posted in the visiting room and front entrance to the facility. CDF and ICE have placed reporting steps on their respective websites. The CDF website says: "The Caroline Detention Facility, takes accusations of sexual assault very seriously. Employees, contractors, and volunteers maintain a professional relationship with all persons under the supervision of the Caroline Detention Facility. If you have any knowledge of any type other than a professional relationship between any representative of the CDF and a detainee or detainees, please ask to speak to the Shift Commander or Superintendent immediately. To report suspicion of sexual misconduct at the Caroline Detention Facility, please use the third-party reporting form. [The CDF website (www.carolinedf.org) includes a hyperlink to a reporting form in English and Spanish]. This form may be submitted anonymously. Administrative investigations of sexual assault, abuse and/or harassment are conducted by the Caroline Detention Facility. Allegations of sexual assault, abuse and/or harassment which are criminal in nature are investigated by the Caroline County Sheriff's Office." The ICE website contains similar reporting information and steps in which to make third party reports at (https://www.ice.gov/detain/prea). The Auditor accessed the CDF and ICE websites and was easily able to access the information required in the standard. During interviews with the Superintendent, A/PSA Compliance Manager, and randomly selected staff members, all acknowledged third-party reporting mechanisms available to detainees. Nineteen of the 20 detainees interviewed acknowledged at least one method for third-party reports to be made. One detainee was unaware of any methods of third-party reporting. He was an English-speaking detainee who acknowledged possessing a facility handbook. He was informed that third-party reporting information was available in the handbook. The A/PSA Compliance Manager state there had been no allegations reported by a third-party during the audit period which was further confirmed by the Auditor's review of eight investigative files.

§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) CDF Policy 2.11 states, "All staff, contractors, and volunteers are required to immediately report any allegations, suspicions or knowledge of sexual assault and sexual harassment; retaliation against detainees or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." Reports must be immediately made both verbally and in writing. Staff, contractors, and volunteers may privately report said allegations outside of their normal chain of command by speaking with a staff member they trust, calling RCASA directly using their hotline, or contacting the Caroline County Sheriff's Office. They may also go directly to the Superintendent without disclosing to their immediate supervisor. An Incident Summary will be submitted as soon as possible to the Shift Commander or, in the case of private reporting, in a sealed envelope addressed to the Superintendent."

The CDF Policy 2.11 was reviewed and fully approved by the Superintendent in April 2020. The staffing plan documentation provided in 115.13 indicated that the facility had submitted all policies to ICE for review, but no documentation was provided that the agency has approved this policy. All staff members interviewed acknowledged they had avenues available to them to make reports and each stated they would make any report immediately upon having knowledge or information.

Recommendation (a): The Auditor recommends that the facility ensure this policy and other relevant policies are approved by the agency.

(c) CDF Policy 2.11 further states, "Staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, make medical treatment, investigation, law enforcement, or other security and management decisions." During the staff interviews, the Auditor confirmed that each understood their reporting requirements, reporting avenues available to them, and the requirement to not reveal any information.

(d) The facility does not house juveniles or family units. The A/PSA Compliance Manager confirmed that they would notify the appropriate state agency if a detainee who is considered a vulnerable adult was the victim of a sexual abuse. This is further outlined in CDF Policy 2.11. The A/PSA Compliance Manager also confirmed that they have not made any notification of this type during the audit period because there has been no incident involving a vulnerable adult.

§115.62 - Protection duties.

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

Notes:

CDF Policy 2.11 states, "If a facility staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee. Immediate action shall include, at a minimum: Separate the detainee in danger; Immediately inform his/her supervisor; Stay with the detainee until the supervisor arrives; and promptly submit an Incident Summary." During interviews with 10 random security staff, all stated that they would make the safety of the detainee their priority, ensure they were separated from the other detainees and contact their supervisor immediately.

During the two supervisor interviews, each stated that they could separate detainees through housing moves and or building moves. Any separation for these reasons would be immediately reported to the PSA Compliance Manager. In his interview, the A/PSA Compliance Manager stated that he would respond immediately or be available by phone to discuss the incident with the initial responders. The Superintendent was interviewed and acknowledged the importance of detainee safety. He confirmed that staff are trained to take immediate action to protect a detainee if that staff member has a reasonable belief the detainee is subject to a substantial risk of sexual abuse.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d) CDF Policy 2.11 outlines the facility's obligations to report sexual abuse and assault allegations which occurred at another confinement facility. In his interview with the Auditor, the A/PSA Compliance Manager stated, and was confirmed in policy, that the facility would document the allegations, and the Superintendent would immediately contact the facility head where the allegation took place. This notification would be made immediately, and the ICE Field Office would be notified as soon as possible, but not more than 72 hours later. The Superintendent would immediately document this notification, and copies would be forwarded to the PSA Compliance Manager. The A/PSA Compliance Manager confirmed in his interview that if an allegation were received from another facility, he would immediately begin an investigation as outlined in Policy 2.11 and notify the ICE Field Office. In their interviews, both the Superintendent and the A/PSA Compliance Manager acknowledged their responsibilities. The Superintendent said that first notification would be made telephonically to ensure the facility had information as quickly as possible. He said the phone call would be immediately followed with an email (he stated that an email group template had already been established for such notifications), which would document that conversation and the information shared. There were no allegations received that allegedly occurred at another facility during the audit period, nor were they notified by another facility regarding an allegation that occurred at CDF

§115.64 - Responder duties.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) CDF Policy 2.11A, along with training received by the staff outlines their response to a detainee who has alleged to have been sexually abused. The staff is instructed through policy and training to hold the detainee in a place of safety with sight and sound separation from other detainees and make immediate notification to their supervisor. Upon the arrival of assistance, policy states, "Any security staff receiving information regarding an incident of sexual assault or sexual harassment will immediately notify their supervisor. Security staff will attempt to identify the aggressor and separate the victim from the aggressor and place him/her in a secure area. If the abuse occurred within a time period which still allows for the collection of physical evidence (typically within 96 hours), request the alleged victim not take any actions which could destroy physical evidence, including, as appropriate: Not to shower or clean themselves in any way; Not to brush their teeth; Not to change clothes; Not to use the restroom; Not to eat or drink anything; Not to do anything which may destroy evidence of the assault." The training requires the Superintendent and A/PSA Compliance Manager be notified immediately; they would then contact the ICE Field Office and implement the PREA Coordinated Response Plan. All staff interviewed had a substantial understanding on their duties as first responders. These interviews confirmed that the Superintendent and A/PSA Compliance Manager would be notified immediately; after which they would contact the ICE Field Office and implement the PREA Coordinated Response Plan. Review of the investigative files further confirmed that first responders took appropriate action to protect the detainee and preserve evidence to the degree required by the incident in all cases.

(b) CDF Policy 2.11A requires that if first staff responder is not a security staff member, the responder shall be required to request that the alleged victim and abuser not take any actions that could destroy physical evidence and then notify security staff. A memorandum provided by CDF indicated that a detainee reported a PREA allegation to medical staff (non-security) during the audit period. The Auditor reviewed all documentation related to the incident, including the investigative file, and found that all protocols were followed, and all notifications were made in a timely manner. The Auditor interviewed one facility contractor, who was able to satisfactorily express their responsibilities if they were first to the scene of a sexual abuse or assault.

Based on an assessment of all information available to the Auditor through policy, interviews with staff, contractors, and detainees, coupled with a review of case files, and the incident reported to the nurse detailed above, the Auditor believes the facility exceeds the requirements of this standard in its responsibilities in preparing staff – including non-security staff – to respond to a PREA emergency.

§115.65 - Coordinated response.

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

Notes:

(a)(b) CDF has developed a coordinated response plan outlined in Policy 2.11A and IHSC Directive 03-01, with guidelines for the facility to respond to sexual abuse incidents. The plan utilizes a multi-disciplinary approach which includes the first responders, medical and mental health practitioners, investigators, the PSA Compliance Manager, Superintendent, and any other staff deemed necessary by the Superintendent.

each articulated their responsibilities in providing assistance and services to the facility. Based on a review of the facility's policies, coupled with interviews with staff and outside entities, the facility has developed an excellent coordinated response plan.

(c)(d) The A/PSA Compliance Manager confirmed that if a victim of sexual abuse is transferred between DHS immigration detention facilities covered by either subpart A or B of the DHS PREA Standards, or to a non-DHS facility, they notify the facility of the potential need for medical or social services unless the victim requests otherwise, which would only be the case for facilities not covered by DHS PREA Standards. The Superintendent was interviewed by the Auditor regarding this standard and was fluent regarding the facility's responsibilities in these specific cases, and the coordinated response required. The facility provided a memorandum stating that the facility did not have an instance where a response from CDF to another facility in reference to a transfer of a sexual abuse victim was needed, which was further confirmed by the A/PSA Compliance Manager during his interview.

In every telephone conversation the Auditor had with outside entities, such as the CCSO, RCASA, and the Mary Washington Hospital, each articulated their responsibilities in providing assistance and services to the facility. Based on a review of the facility's policies, coupled with interviews with staff and outside entities, the facility has developed an excellent coordinated response plan.

§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:

CDF Policy 2.11 states, "The Superintendent will ensure staff, contractors, and volunteers suspected of perpetrating sexual abuse or assault are removed from all duties requiring detainee contact pending the outcome of an investigation." The Superintendent explained a separation order requiring no contact will be documented by facility management via email or memorandum within 24 hours of the allegation. The A/PSA Compliance Manager and Superintendent both confirmed in their interviews with the Auditor that they have non-contact posts where individuals would be placed until an investigation was completed. The HRM also confirmed this policy and practice in her interview. These procedures were confirmed by the Auditor during interviews of random staff who demonstrated a clear understanding of this standard. The two allegations made against staff were unidentified, so the facility was unable to place anyone on no-contact status.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) CDF Policy 2.11 outlines the facility's protection against retaliation. The policy states that, "Detainees and staff who report sexual assault or sexual harassment or cooperate with investigations are protected from retaliation by other detainees or staff members as monitored by the Section Managers as to their employees assigned to them. CDF retaliation protection measures include housing changes or transfers for detainee victims or abusers, 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 assault or sexual harassment or for cooperating with investigators." The A/PSA Compliance Manager confirmed in his interview with the Auditor that they would utilize multiple protection measures, including housing changes, removal of staff, and emotional support services. The A/PSA Compliance Manager stated that for at least 90 days following a report of sexual abuse, the facility will monitor to see if there are facts that may suggest possible retaliation by detainees or staff. If this is indicated, the facility will act promptly to remedy any such retaliation. The A/PSA Compliance Manager confirmed they would follow CDF Policy 2.11, which outlines the monitoring process and indicates that detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff would all be monitored. If a need is indicated, the monitoring will continue beyond the 90 days. The Superintendent was interviewed by the Auditor and said that protection from retaliation was of paramount importance and that the facility took great strides to ensure detainee safety. Staff interviewed acknowledged that retaliation against any person who makes an allegation or participates in an investigation of sexual abuse is prohibited. The Auditor inspected eight closed investigative files from the audit period. In of the eight cases, no retaliation monitoring took place for affected detainees. One of the cases was opened and closed as a SAAPI case but was determined to be an incident that did not occur in custody, therefore did not require retaliation monitoring. The Superintendent acknowledged the error and stated there was confusion caused by the difference between the Department of Justice PREA standard and the DHS PREA standard. The Auditor reviewed the retaliation logs that were documented in the other two cases and found them to be thorough and completed within the required time frames of the standard.

Does Not Meet (c): The facility failed to monitor retaliation in five of the eight cases. The facility is required to monitor to see if there are facts that may suggest possible retaliation by detainees or staff for at least 90 days following a report of sexual abuse. Based on a review of all policies, investigative files, and interviews with the Superintendent and the A/PSA Compliance Manager, the Auditor has determined that the facility does not meet this standard. To become compliant, the facility must remove from existing policy any reference to retaliation monitoring being predicated by the case finding as the DHS PREA standards require retaliation monitoring regardless of the case finding; Provide proof to the Auditor of the amended policy; Provide training to all supervisory staff and investigators on the correct retaliation policy; Provide proof to the Auditor that training has been completed; Initiate retaliation monitoring for any detainee who alleged abuse that is still in the custody of the facility; Provide proof to the Auditor that retaliation monitoring for those detainees has occurred; and Provide proof to the Auditor that retaliation monitoring has occurred for any detainee who has alleged sexual abuse since the onsite audit.

§115.68 – Post-allegation protective custody.

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

Notes:

(a)(b)(c) CDF Policy 2.11 outlines the facility post-allegation protective custody process. The detainee would be placed in the least restrictive, and supportive environment subject to the requirements of DHS PREA Standard 115.43. They would not be held for more than five days in any type of administrative restriction, unless under unusual circumstances or at the request of the detainee. If a detainee were held in this manner, they would be reassessed before being returned to the general population. This information was confirmed by the A/PSA Compliance Manager in his interview with the Auditor. The A/PSA Compliance Manager in his interview with the Auditor understood the requirements for housing detainees under these circumstances; he further confirmed they had not had a detainee in post allegation protective custody during the audit period, which was confirmed through a memo from the facility. Although the facility had provided a memo stating no post-allegation segregation had occurred, the A/PSA Compliance Manager identified a case and provided documentation for a detainee who reported sexual abuse while at the facility. Based on his interview with mental health staff, he was placed in administrative segregation for his safety for approximately 24 hours. The allegations were investigated and determined to be unfounded. The Auditor reviewed the entirety of the case file, along with administrative segregation paperwork and determined all policies were followed regarding housing a detainee in protective custody. The detainee was provided a DHS-prescribed Sexual Assault Awareness information pamphlet and information on how to contact RCASA. The Auditor further confirmed his findings through an inspection of the eight closed administrative investigations. The Auditor interviewed the officer responsible for monitoring the Administrative Segregation Unit and he said that to his knowledge, no detainee had been held in the unit for the purposes stated in this standard.

(d) The policy further states that the "ICE Field Office Director will be notified no later than 72 hours after initial placement into segregation, whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault;" this notification requirement was also confirmed through interviews with the A/PSA Compliance Manager and Superintendent. There was one instance when a detainee was placed in protective custody post-allegation, and the Auditor confirmed through his review of the investigative file that all documentation was in order and all notifications were made in a timely manner.

§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) CDF Policy 2.11 outlines the facility investigator's responsibility to conduct prompt, thorough and objective administrative investigations into alleged sexual assault. The facility has four trained investigators to conduct administrative investigations. The A/PSA Compliance Manager, who is also a trained investigator, stated in his interview with the Auditor that all allegations are responded to immediately, and ICE is notified. If the allegation is criminal, they will stop the administrative investigation and let DHS OIG, or the sheriff's office conduct the criminal investigation. The Auditor confirmed through his interview with the A/PSA Compliance Manager that if a criminal investigation were either unsubstantiated or substantiated, they would still conduct an administrative investigation after consultation with the DHS OIG, ICE OPR, and/or the sheriff's office. The Auditor confirmed through his review of the eight investigations that each were prompt, thorough, objective and completed by a trained, qualified investigator.

(c) CDF Policy 2.11 outlines the investigative procedure for administrative investigations and states, "Facility investigators will: Preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interview alleged victims, suspected perpetrators, and witnesses; Review prior complaints and reports of sexual abuse involving the suspected perpetrator; Assess the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph; Make an effort to determine whether actions or failures to act at the facility contributed to the abuse; and document each investigation by a written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and retain such reports for as long as the alleged abuser is detained or employed by the facility, plus five years." The procedures in the policy govern the coordination of the administrative and criminal investigations, and procedures to ensure that the criminal investigation is not compromised by an internal administrative investigation. During his interview with the Auditor, the facility investigator confirmed the investigative procedures for the administrative investigations and reiterated that any administrative investigation would be coordinated with the criminal investigation as to not cause any interference that may jeopardize a potential criminal filing or prosecution.

(e)(f) CDF Policy 2.11 states that "the departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation." The A/PSA Compliance Manager confirmed that the investigation would be conducted. He further stated that if an outside entity conducted a criminal investigation, he would stay in contact with them to ascertain the progress of the investigation. This was further confirmed during the review of the investigative files, which confirmed that none were terminated due to either the alleged victim or abuser leaving employment, or control of the facility. The Superintendent was interviewed by the Auditor and demonstrated an excellent command of the investigative and notification process for PREA allegations. Each of the cases was organized and thorough. The investigators provided evidence in each case to support its ultimate finding and all notifications prescribed by ICE policy were made within requirements.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

CDF Policy 2.11 states that "The CDF shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated in an investigation." The A/PSA Compliance Manager, who is one of the facility investigators and was interviewed by the Auditor, stated that they do not impose any higher of a standard than a preponderance of the evidence. The Superintendent confirmed this standard in his interview with the Auditor. Based on the Auditor's review of the eight closed investigations, the facility is applying this standard of evidence appropriately.

§115.73 - Reporting to detainees.

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

Notes:

CDF Policy 2.11 outlines the procedure for reporting the results of an investigation to a detainee. The policy directs the facility investigator or designated staff to inform the detainee in writing whether the allegation has been substantiated, unsubstantiated, or unfounded. This process is completed utilizing the Notification of Outcome of Allegation form. The detainee will receive the notification in person by the PSA Compliance Manager, or the A/PSA Compliance Manager and sign the form. If a criminal investigation takes place and the determination is different, an updated form will be provided to the detainee. The detainee would keep the original, and a copy is placed in the investigative file. An updated form would be provided to the detainee after the outcome of a criminal investigation. The A/PSA Compliance Manager and Superintendent confirmed this procedure in their interviews with the Auditor. The Auditor reviewed the eight closed investigative files and found that all contained the required form, signed by the detainee. One of the investigations was investigated as criminal, but the same outcome of "unfounded" was determined. In their interviews with the Auditor, both the Superintendent and the A/PSA Compliance Manager said that if the detainee were no longer housed at CDF, but still in ICE custody, they would ensure notice would be made to the detainee at the new facility and ensure documentation was received of the detainee's receipt of notification and include it in the investigative file. They each said that if the detainee were no longer in ICE custody, they would attempt to identify an address where the notification could be mailed.

§115.76 - Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d) CDF Policy 2.11 outlines the facility response to staff discipline of a substantiated allegation for violating facility sexual abuse policies. The staff member would be subject to disciplinary or adverse action up to and including removal from their position and the Federal service. The A/PSA Compliance Manager and HRM confirmed in their interviews with the Auditor that removal from their position is the presumptive discipline for a violation of the policy. The A/PSA Compliance Manager confirmed that the facility would report all removals or resignations by staff prior to removal for violations of facility sexual abuse policies to the DHS OIG and the Caroline County Sheriff's Office, unless clearly not criminal, and confirmed if the staff member were licensed, the licensing body would be notified. In her interview with the Auditor, the HRM conveyed the same information as it relates to staff members. The facility provided the Auditor with a memo stating that no staff members have been disciplined within the audit period, which was confirmed by the A/PSA Compliance Manager in his interview. They also provided a sample letter in the event an employee was discharged based on a violation of PREA standards. The Auditor reviewed the eight closed investigative files for the audit period and confirmed that no investigation involving staff was substantiated. The Auditor interviewed the Superintendent, and he confirmed the process and his involvement on any decision regarding staff. He confirmed that a substantiated investigation against a staff member regarding a PREA incident would be grounds for discharge. The staffing plan documentation provided in §115.13 indicated that the facility had submitted all policies to ICE for review, but no documentation was provided that the agency has approved this policy.

Recommendation (b): Provision (b) requires agency review and approval of facility policies and procedures regarding disciplinary or adverse actions for staff. The Auditor recommends that the facility obtain documentation of the agency approval of CDF Policy 2.11.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a) CDF Policy 2.11 addresses any contractors or volunteers who have engaged in sexual abuse. The policy directs the facility to prohibit the contractor or volunteer from having any contact with detainees, and that the "Superintendent shall report to the Caroline County Sheriff's Office, unless the activity was clearly not criminal, and to relevant licensing bodies." In his interview with the Auditor, the A/PSA Compliance Manager stated that the facility would make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. These incidents, if criminal, will also be reported to law enforcement agencies.

(b)(c) The A/PSA Compliance Manager and HRM confirmed that contractors and volunteers suspected of perpetrating sexual abuse would be removed from all duties requiring detainee contact pending the outcome of an investigation. They further stated that as per CDF Policy 2.11, the facility would take appropriate remedial measures; and will consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse but have violated other provisions within these standards. The A/PSA Compliance Manager, Superintendent, and HRM confirmed in their interviews with the Auditor, that if a contractor or volunteer violated any provisions of the standards, their security clearance and access to the facility would be immediately revoked. The facility did not have any incidents of contractor or volunteer corrective action for the audit period, as confirmed in a memo provided by the A/PSA Compliance Manager, and his interview with the Auditor.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d) CDF Policy 2.11 and 3.1, Disciplinary System, address the facility disciplinary sanctions following an administrative or criminal investigation that finds a detainee engaged in sexual abuse. The disciplinary process outlined in policy 3.1 ensures that the discipline is commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future. The policy further outlines the progressive levels of reviews, appeals, procedures, and documentation procedure. During the Auditor's interview with the A/PSA Compliance Manager, it was confirmed that this discipline process would be utilized for disciplining any detainee found to have violated sexual abuse or harassment policies or facility rules. During the Auditor's interviews with medical and mental health staff, they stated that any detainee involved in an incident, whether victim or offender, would be evaluated. The A/PSA Compliance Manager reiterated in his interview, as per policy, they would consider any mental disabilities or mental illness that may have contributed to the detainee's behavior when determining what type of sanction, if any should be imposed. The facility provided a memo stating that no discipline had been imposed on a detainee who engaged in sexual abuse. The Auditor reviewed the eight closed investigations and confirmed no cases involved discipline being imposed due to a substantiated finding.

(e)(f) The A/PSA Compliance Manager stated that the facility would follow policies 2.11 and 3.1 for detainee discipline, which state that "the facility will not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact." He also confirmed that a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred would not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The Superintendent was interviewed by the Auditor, and he confirmed the facility's policies and practices as it relates to detainee discipline.

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

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

Notes:

(a)(b)(c) IHSC Directive 03-01 and the IHSC Behavioral Health Services Guide detail the medical and mental health screenings for a history of sexual abuse. If the detainee has experienced prior sexual victimization or perpetrated sexual abuse, they will be referred to a qualified medical or mental health practitioner for follow-up. The medical evaluation will occur immediately, but not more than 48 hours, and the mental health evaluation will occur within 72 hours. The detainees at the facility are screened under DHS PREA 115.41 by medical personnel. If they experienced prior sexual victimization or perpetrated sexual abuse, they would receive any immediate medical attention as deemed necessary. If mental health were available, they would see them immediately. If mental health staff are not immediately available, the detainee would be seen within 72 hours. The Auditor confirmed this process through his interviews with medical and mental health staff. These interviews also confirmed that they would notify the PSA Compliance Manager whenever a detainee was seen due to issues identified through this standard. The Auditor reviewed a sample of a mental health referral for a prior perpetrator based on the responses from the initial risk screening and the detainee was seen by a provider within 48 hours of the referral. The Auditor also reviewed three other files while onsite that involved a referral to medical/mental health based on the risk screening instrument and they were all evaluated within the required timeframe. The Auditor formally interviewed a mental health staff member, who demonstrated thorough knowledge of the referral policies related to this standard. A medical staff supervisor was interviewed by the Auditor and demonstrated the same level of knowledge regarding this standard. The Auditor also spoke informally with other medical staff members who articulated a clear understanding of the policies.

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

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

Notes:

(a)(b) CDF Policy 2.11 and IHSC Directive 03-01 outline this standard. CDF Policy 2.11 says, "Detainees victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature, and scope of which are determined by medical and mental health practitioners according to their professional judgement." The policy goes on to say, "Detainee victims are provided emergency medical and mental health services and ongoing care as appropriate, including testing for sexually transmitted diseases and infections, prophylactic treatment, emergency contraception, follow-up examinations for sexually transmitted diseases, and referrals for counselling (including crisis intervention counseling)." In their interviews with the Auditor, medical staff confirmed that the above procedures would be followed. CDF Policy 2.11 and IHSC Directive 03-01 also establish that emergency medical treatment services would be provided at no cost to the detainee, regardless of whether the victim names the abuser, or cooperates with any investigation arising out of the incident. The facility has an MOU with RCASA for victim advocacy, which was reviewed by the Auditor and confirmed with a phone call to the organization. The facility provided two medical evaluation records for alleged victims in an allegation of inappropriate touching. The alleged victims were immediately evaluated by facility medical staff.

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

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

Notes:

(a)(b)(c)(e)(f)(g) CDF Policy 2.11 and IHSC Directive 03-01 outline ongoing medical and mental health care following a sexual abuse allegation. The medical and mental health departments are part of the coordinated response to an incident and would be immediately involved with the detainee and make any treatment determinations. These determinations will include follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The medical and mental health services offered are consistent with the community level of care. The detainee is offered tests for sexually transmitted infections; all the treatment services are offered at no cost to the detainee. The facility also attempts to provide a mental health evaluation and offer treatment to all known detainee-on-detainee abusers within 60 days of learning of the abuse. During their interviews with the Auditor, this process was confirmed with the A/PSA Compliance Manager and medical and mental health staff.

A memo was provided to the Auditor indicating no substantiated cases occurred during the audit period, therefore, no ongoing services were provided to abusers, which was also confirmed through interview with the A/PSA Compliance Manager. During the medical and mental health staff interviews, the Auditor confirmed that mental health services would be offered to both the victim and abuser in a sexual abuse incident. The Auditor validated through review of the investigative files that in one case ongoing medical and mental health care were provided to an alleged victim.

(d) This provision is addressed in CDF Policy 2.11. It states that "Detainee victims of sexually abusive vaginal penetration by a male abuser while detained shall be offered a pregnancy test. 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."

Although the facility did not house female detainees at the time of the onsite audit, medical staff and the A/PSA Compliance Manager confirmed in their interviews that these services would be provided to female detainees.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) CDF Policy 2.11 states, "The CDF shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse unless the allegation was determined to be unfounded. The sexual abuse incident review will be conducted by an incident review team consisting of the following members: Compliance Manager, Investigator, Security Supervisor, Medical or Mental Health Professional, Security Chief. The incident review team will review the incident and prepare written report within 30 days of the conclusion of the investigation. The incident review team shall consider and document whether the incident or allegation was motivated by: Race, Ethnicity, [or]Gender." During the audit period, the facility had six unfounded investigations, and two unsubstantiated investigations. Only one of the investigations contained an incident review, which was acknowledged by the Superintendent. The one review was completed in a timely manner.

The policy states all investigations and reviews are forwarded to OPR who are directed by Agency policy 11062.2, to forward a copy to the ICE PSA Coordinator for review. This report indicates if any changes need to be made in policy or practice that could better prevent, detect, or respond to sexual abuse, they shall be made. In his interviews with the Superintendent and the A/PSA Compliance Manager, the Auditor confirmed the recommendations for improvement would be made if there were any. The review considers whether the incident or allegation was motivated by race, ethnicity, or 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. The Auditor reviewed the one incident review conducted and determined all notifications were made appropriately, timely, and that reviews of the incidents occurred within 30 days of the conclusion of the investigation. The Auditor inspected the one incident review, and no recommendations had been made as a result. The Auditor interviewed the facility HSA, who is a member of the Incident Review Team. He stated that the team assesses each case on its own merits and ensures that decisions made are in the best interest of staff and detainee safety.

Does Not Meet (a): After a thorough review of all investigations, a review of facility policy and an interview with the Superintendent, the Auditor has determined that the facility has not completed an incident review on seven of the closed investigations and does not meet the requirements of provision (a). To become compliant, the facility must conduct an incident review for the remaining seven cases that were closed during the audit period, and any cases that occurred after the onsite audit, and provide proof to the Auditor that the reviews have been completed.

Recommendation (a): The Auditor recommends that CDF Policy 2.11 be amended to state that all allegations of sexual abuse, regardless of determination, shall be reviewed within 30 days.

(c) The facility provided the Auditor with the 2021 Annual Review of Sexual Abuse Investigations and Corrective Actions report, which compares the facility data from 2019 and 2020. The Superintendent and A/PSA Compliance Manager confirmed to the Auditor that the incident and annual reports were submitted to the local PSA Manager, FOD, and the ICE PSA Coordinator, which is outlined in policy CDF 2.11.

§115.87 - Data collection.

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

Notes:

(a) CDF Policy 2.11 outlines the procedures for the facility data collection. The facility collects and retains data related to sexual abuse as directed by policy. The PSA Compliance Manager collects and retains all data including case records associated with claims of sexual abuse including investigative reports, detainee information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary.

The A/PSA Compliance Manager, in his interview with the Auditor, stated that the PSA Compliance Manager is responsible for compiling data collected on sexual activity and sexual abuse incidents. He forwards the DHS Monthly PREA Incident Tracking Log to the Superintendent each month. He also creates and submits a PREA Survey which is submitted to the Superintendent for every allegation of sexual abuse and sexual activity.

During his interview, the A/PSA Compliance Manager stated that all information is maintained in locked filing cabinets within the administration building with only the PSA Compliance Manager, A/PSA Compliance Manager and Superintendent having access. The Auditor observed the storage locations during the facility tour. The established facility retention schedule is ten years for these files.

§115.201 - Scope of audits.

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

Notes:

(d) During the audit tour, the facility provided the Auditor full access to all areas of the facility, and the ability to ensure policies and procedures were in daily practice.

(e) Before the audit, during the onsite audit, and during the post-audit phase, all relevant documentation was made available through the ICE ERAU SharePoint site. Additional documentation was requested by the Auditor onsite, which was provided promptly.

(i) The Auditor was permitted to conduct private interviews with the detainees and staff. These interviews were conducted in various offices throughout the facility, with ample privacy.

(j) PREA Audit Notifications were posted throughout the facility providing the Auditor contact information. The Auditor confirmed the prior presence of the audit posting notifications during his interviews with facility staff, contractors, and detainees. Knowledge by interviewees regarding when the postings had been placed ranged from a few days to more than a month. Based on the totality of interviews, ample notice was provided in order for detainees or staff to correspond concerns to the Auditor. No correspondence was received from staff, detainee, or any other concerned party.

AUDITOR CERTIFICATION

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	34
Number of standards not met:	4
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Mark McCorkle 9/21/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/21/2022

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/21/2022

Assistant Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Mark McCorkle	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
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AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Washington Field Office		
Field Office Director:	Russell Hott		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	14797 Murdock Street, Chantilly, VA 20151		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Caroline Detention Facility		
Physical address:	11093 S.W. Lewis Memorial Drive, Bowling Green, VA 22427		
Mailing address: *(if different from above)*	PO Box 1460, Bowling Green, VA 22427		
Telephone number:	(804) 633-0043		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Superintendent
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(804) 633-(b) (6), (b) (7)(C)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Administrative Security Chief
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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 the CDF met 34 standards, exceeded in two standards (115.31 and 115.64), had 1 standard that was non-applicable (115.14), and had 4 non-compliant standards (115.11, 115.22, 115.67 and 115.86). As a result, the facility was placed under a 180-day Corrective Action Plan (CAP) period of September 27, 2022 through March 26, 2023, to address the non-compliant standards.

On November 3, 2022, the Auditor reviewed the ICE PREA CAP and documentation provided by the facility for compliance review, in which the Auditor made the determination that the facility met standards 115.11, 115.22, and 115.67 in all material ways.

On December 5, 2022, the Auditor Reviewed the ICE PREA CAP and documentation provided by the facility for compliance review, in which the Auditor made the determination that the documentation provided by WCC satisfied what was necessary to demonstrate compliance and that the facility met standard 115.86 in all material ways.

Number of Standards Met: 4

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.67 Agency protection against retaliation
§115.86 Sexual abuse incident reviews

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

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

(c) CDF Policy 2.11, Security, Sexual Abuse and Assault Prevention and Intervention (SAAPI), mandates zero tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to incidents of sexual abuse and sexual harassment. The policies furthermore define sexual abuse and sexual harassment. The entirety of this policy was reviewed and fully approved by the Superintendent in April 2020. The staffing plan documentation provided in §115.13 indicated that the facility had submitted all policies to ICE for review, but no documentation was provided that the agency has approved this policy.

Does Not Meet (c): This standard requires that the facility policy be approved by the agency (ICE). The facility did not provide documentation indicating that the policy had been presented for review and approval by ICE, therefore the Auditor finds that the facility is not in compliance with this standard. To become compliant, the facility must show that the agency has reviewed and approved this policy.

Corrective Action Taken (c): The facility provided a memo from the AFOD approving CDF Policy 2.11 dated August 2, 2021. The Auditor reviewed the memo and has determined that the facility now meets this standard in all material ways.

§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:

(e)(f) In their interviews with the Auditor, the Superintendent and A/PSA Compliance Manager each said that allegations would be immediately reported to the JIC, ICE OPR, and/or DHS OIG, as well as the appropriate ICE FOD. If the incident is potentially criminal and a staff member, contractor, volunteer, or detainee is alleged to be the perpetrator of sexual abuse, the incidents are reported to the CCSO for investigation. The Auditor's review of the case files determined all notifications were made to JIC and ICE OPR within the prescribed timelines in policy and the review processes were thorough and complete. The Superintendent told the Auditor in his interview that the lead PREA investigator (the PSA Compliance Manager) is knowledgeable about the investigative process and familiar with notification protocols. He said that he and the PSA Compliance Manager (the A/PSA Compliance Manager in his absence) speak regularly about any open PREA investigations, and that the PSA and A/PSA Compliance Managers do an excellent job of keeping him apprised of all investigations. Each of the eight cases reviewed by the Auditor was organized, with acceptable investigative techniques and use of evidence (video surveillance footage) to help support the finding.

Does Not Meet (e): Based on a thorough review of the investigative files (detainee-on-detainee), coupled with interviews with the Superintendent and A/PSA Compliance Manager, the Auditor has determined that the facility did not refer two of the potentially criminal allegations to the CCSO as required. To become compliant, the facility must provide re-training to all investigators on DHS policies regarding the referral of criminal allegations and provide the Auditor proof that the training has occurred. Additionally, the facility must formally refer SAAPI cases #4139 and #3927 to the CCSO for investigation, provide the Auditor with a copy of the formal request for investigation along with the response and outcome from the CCSO.

Corrective Action Taken (e): CDF provided documentation which demonstrated that all facility investigators had been re-trained and that the two potentially criminal allegations had been referred to the sheriff's office for investigation. Based on a thorough review of all documentation provided, the Auditor has determined that the facility is now in compliance with this standard in all material ways.

§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) CDF Policy 2.11 outlines the facility's protection against retaliation. The policy states that, "Detainees and staff who report sexual assault or sexual harassment or cooperate with investigations are protected from retaliation by other detainees or staff members as monitored by the Section Managers as to their employees assigned to them. CDF retaliation protection measures include housing changes or transfers for detainee victims or abusers, 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 assault or sexual harassment or for cooperating with investigators." The A/PSA Compliance Manager confirmed in his interview with the Auditor that they would utilize multiple protection measures, including housing changes, removal of staff, and emotional support services. The A/PSA Compliance Manager stated that for at least 90 days following a report of sexual abuse, the facility will monitor to see if there are facts that may suggest possible retaliation by detainees or staff. If this is indicated, the facility will act promptly to remedy any such retaliation. The A/PSA Compliance Manager confirmed they would follow CDF Policy 2.11, which outlines the monitoring process and indicates that detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff would all be monitored. If a need is indicated, the monitoring will continue beyond the 90 days. The Superintendent was interviewed by the Auditor and said that protection from retaliation was of paramount importance and that the facility took great strides to ensure detainee safety.

Staff interviewed acknowledged that retaliation against any person who makes an allegation or participates in an investigation of sexual abuse is prohibited. The Auditor inspected eight closed investigative files from the audit period. In of the eight cases, no retaliation monitoring took place for affected detainees. One of the cases was opened and closed as a SAAPI case but was determined to be an incident that did not occur in custody, therefore did not require retaliation monitoring. The Superintendent acknowledged the error and stated there was confusion caused by the difference between the Department of Justice PREA standard and the DHS PREA standard. The Auditor reviewed the retaliation logs that were documented in the other two cases and found them to be thorough and completed within the required time frames of the standard.

Does Not Meet (c): The facility failed to monitor retaliation in five of the eight cases. The facility is required to monitor to see if there are facts that may suggest possible retaliation by detainees or staff for at least 90 days following a report of sexual abuse. Based on a review of all policies, investigative files, and interviews with the Superintendent and the A/PSA Compliance Manager, the Auditor has determined that the facility does not meet this standard. To become compliant, the facility must remove from existing policy any reference to retaliation monitoring being predicated by the case finding as the DHS PREA standards require retaliation monitoring regardless of the case finding; Provide proof to the Auditor of the amended policy; Provide training to all supervisory staff and investigators on the correct retaliation policy; Provide proof to the Auditor that training has been completed; Initiate retaliation monitoring for any detainee who alleged abuse that is still in the custody of the facility; Provide proof to the Auditor that retaliation monitoring for those detainees has occurred; and Provide proof to the Auditor that retaliation monitoring has occurred for any detainee who has alleged sexual abuse since the onsite audit.

Corrective Action Taken (c): CDF provided documentation showing that Policy 2.11 had been amended removing any reference to case disposition as it relates to the requirement to provide retaliation monitoring. Additionally, the facility provided documentation that supervisory staff and investigators had been re-trained on the revised retaliation policy. Lastly, CDF provided eight retaliation documentation forms showing that retaliation protocols had been completed for those detainees still in custody who had alleged sexual abuse. Based on a thorough review of all documentation provided by CDF, the Auditor has determined that the facility is now compliant with this standard in all material ways.

§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) CDF Policy 2.11 states, "The CDF shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse unless the allegation was determined to be unfounded. The sexual abuse incident review will be conducted by an incident review team consisting of the following members: Compliance Manager, Investigator, Security Supervisor, Medical or Mental Health Professional, Security Chief. The incident review team will review the incident and prepare written report within 30 days of the conclusion of the investigation. The incident review team shall consider and document whether the incident or allegation was motivated by: Race, Ethnicity, [or]Gender." During the audit period, the facility had six unfounded investigations, and two unsubstantiated investigations. Only one of the investigations contained an incident review, which was acknowledged by the Superintendent. The one review was completed in a timely manner.

The policy states all investigations and reviews are forwarded to OPR who are directed by Agency policy 11062.2, to forward a copy to the ICE PSA Coordinator for review. This report indicates if any changes need to be made in policy or practice that could better prevent, detect, or respond to sexual abuse, they shall be made. In his interviews with the Superintendent and the A/PSA Compliance Manager, the Auditor confirmed the recommendations for improvement would be made if there were any. The review considers whether the incident or allegation was motivated by race, ethnicity, or 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. The Auditor reviewed the one incident review conducted and determined all notifications were made appropriately, timely, and that reviews of the incidents occurred within 30 days of the conclusion of the investigation. The Auditor inspected the one incident review, and no

recommendations had been made as a result. The Auditor interviewed the facility HSA, who is a member of the Incident Review Team. He stated that the team assesses each case on its own merits and ensures that decisions made are in the best interest of staff and detainee safety.

Does Not Meet (a): After a thorough review of all investigations, a review of facility policy and an interview with the Superintendent, the Auditor has determined that the facility has not completed an incident review on seven of the closed investigations and does not meet the requirements of provision (a). To become compliant, the facility must conduct an incident review for the remaining seven cases that were closed during the audit period, and any cases that occurred after the onsite audit, and provide proof to the Auditor that the reviews have been completed.

Corrective Action Taken (a): CDF provided documentation that the facility had conducted the required incident reviews on the remaining seven cases and had considered the required factors per the standard in making its determinations on each case. Based on a thorough review of all documentation provided by CDF, the Auditor has determined that the facility is now in compliance with this standard in all material ways.

§115. Choose an item.
Outcome: Choose an item.
Notes:

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Notes:

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

Mark McCorkle December 13, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) December 18, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) December 19, 2022
Program Manager's Signature & Date