PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	8/24/2021	**To:**	8/26/2021
AUDITOR INFORMATION			
Name of auditor:	Douglas K. Sproat, Jr.	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	601-832-
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-381-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Denver Field Office
Field Office Director:	John Fabbricatore
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	12445 E. Caley Avenue, Centennial, CO 80111
Mailing address: (if different from above)	N/A

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Aurora ICE Processing Center		
Physical address:	3130 Oakland St., Aurora CO 80111		
Mailing address: (if different from above)	N/A		
Telephone number:	303.361.6612		
Facility type:	CDF		
PREA Incorporation Date:	**05/06/2014**		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	303.739
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	303.739

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NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the Aurora ICE Processing Center (AIPC), also known as the Denver Contract Detention Facility, was conducted on August 24-26, 2021, by U. S. Department of Justice (DOJ)- and U.S. Department of Homeland Security (DHS)-certified PREA auditor Douglas K. Sproat Jr., for Creative Corrections, LLC. The purpose of the audit was to determine compliance with the DHS PREA standards. This facility is operated by the GEO Group Inc. (GEO) and contracted by U. S. Immigration and Customs Enforcement (ICE) for the housing of adult male and female detainees to hold and process individuals who are awaiting the results of a judicial removal review. This was the second DHS PREA audit of the facility. The audit period was August 2020-August 2021. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C), and Assistant ICE PREA Program Manager, (b) (6), (b) (7)(C), both DOJ- and DHS-certified PREA auditors. The role of the Program Manager is to provide oversight to the ICE PREA audit process and liaison with the ICE External Review and Analysis Unit (ERAU) during the audit report review process. Due to unforeseen circumstances, this audit report was finalized by (b) (6), (b) (7)(C), a DOJ- and DHS-certified auditor and ICE PREA Assistant Program Manager.

AIPC is located in Aurora, Colorado, which is about 19 miles north of Denver. The facility is situated within two secure perimeter fences; there is a sterile zone between the fences with a shaker and a microwave system and razor ribbon at the top and bottom of the fences. The facility provides secure detention for high, medium and low custody adult male and female detainees. On the first day of the audit the facility held 809 adult male and 95 adult female detainees. The design capacity of the facility is 1,108 detainees. During the previous 12 months, 2,203 detainees were booked into AIPC; the average time in custody at the facility is 60.89 days. The average detainee population for the last twelve months was 332.43 for males and 20.56 for females. According to the Pre-Audit Questionnaire (PAQ), the countries most often represented by the detainees are Mexico, Nicaragua, and Brazil.

About 4 weeks before the audit, Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) Team Lead for the audit, (b) (6), (b) (7)(C), provided the Auditor with the facility's PAQ, facility policies, and other pertinent documents. The documentation was provided through ICE SharePoint. The various documents were compiled and organized in accordance with the PREA Pre-Audit Policy and Document Request DHS Immigration Detention Facilities form and arranged within folders for ease of auditing.

The first day of the audit began with an entry briefing. The Team Lead (b) (6), (b) (7)(C) opened the briefing at 8:15 A.M. In attendance were:

- (b) (6), (b) (7)(C), Inspection and Compliance Specialist (ICS), ICE/OPR/ERAU
- (b) (6), (b) (7)(C), Assistant Facility Administrator (AFA), GEO
- (b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
- (b) (6), (b) (7)(C), Deputy Field Office Director (DFOD), ICE/ERO
- (b) (6), (b) (7)(C), PSA Compliance Manager/Investigator, GEO
- (b) (6), (b) (7)(C), Chief of Security (COS), GEO
- (b) (6), (b) (7)(C), Officer in Charge (OIC), ICE/ERO
- (b) (6), (b) (7)(C), Detention Standards and Compliance Officer (DSCO), ICE/ERO
- Douglas K. Sproat, Certified DOJ/DHS PREA Auditor, Creative Corrections, LLC.

After a brief round of introductions, the Team Lead provided a detailed schedule for the audit. The Auditor then gave an overview of the audit process and methodology used to establish PREA compliance. He explained that the process is designed for accurately evaluating the facility's written policies and procedures for compliance with PREA, along with determining the degree to which these policies and procedures are a part of the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with PREA standards will be determined based on the review of policies and procedures, observations made during the facility tour, documents reviewed (both through SharePoint and while on-site), and interviews with staff, contractors, and detainees. The Auditor advised the group that he had not received any correspondence from either detainees or staff. Just prior to the tour, the Auditor noted that the tour needed to cover all areas that the detainees had access to.

The OIC led the facility tour, which included the following areas: the sally port, intake, medical, programs, recreation (indoor and outdoor), food service, laundry, commissary, warehouse, visitation, and the housing units. AIPC is comprised of a single large building which houses all the facility's operations. The detainee housing portion of the building has 12 multiple occupancy cell housing units, 14 open bay/ dorm housing units, and 48 segregation cells. The medical area contains nine medical housing cells, with one of those being for detainees on suicide watch. There are five negative pressure cells. The toilets in each cell in the medical area had privacy curtains, and each cell had a call button. (b) (7)(E) This area is monitored by 24-hour medical staff and a detention officer.

The building also contains all the administrative functions and all support services. The single entrance for staff and visitors at AIPC is through the part of the building that contains all administrative offices, central control, and visitation. In the lobby/reception area of this building, everyone--staff and visitors alike—sends all belongings (purses, briefcases, coats, etc.) though an X-ray machine, and everyone steps through a metal detector. An officer uses a wand for anyone who sets off the metal detector.

During the tour, the Auditor observed the program/service areas, housing units and their showers, the officer post sightlines, logbooks for unannounced rounds, and camera locations. All detainees are always under direct supervision. In each living unit, he entered the restroom and shower area to evaluate the effectiveness of privacy issues for detainees; he determined that the restrooms and shower areas offer adequate privacy for the detainees. The Auditor noted that each housing unit door had a sign stating, "Opposite gender must announce when entering." Additionally, he heard the opposite gender announcements consistently being made. Throughout the tour, the Auditor saw audit notices, PREA signage highlighting methods for reporting sexual abuse and assault, and information about zero tolerance. On the bulletin boards is information on how to contact a consulate and how to contact victim services provided at AIPC through Blue Bench. Telephones are available for detainees in all living units, and there are notices

above the phones noting that phone calls may be monitored at all times. Detainees in medical cells or restrictive housing have access to portable telephones.

The tour also included areas where detainees may volunteer to work food service, laundry, and the warehouse. Food service has 4 staff members and approximately 12 detainees. All meals are prepared in food service and delivered to the living units. Based on the Auditor's observations and information provided by the food service manager, the Auditor confirmed that the coolers and freezers are always locked and only accessed by staff. Detainees are always under direct supervision while in these areas. The detainee restroom is always locked and can be accessed only through the food service officer unlocking the door. (b) (7)(E) (b) (7)(E) Usually, one staff member and eight detainees work in the laundry area. Mirrors were installed after the previous audit for better viewing behind the washers. The facility has since added cyclone fencing and a locked gate leading to the area behind the washers. The detainee restroom is always locked, and detainees must ask staff for permission to use the restroom. Staff are the only individuals who can lock and unlock the door to the restroom. The warehouse is staffed by one staff member. This area is authorized for one detainee worker, who is directly supervised. (b) (7)(E) The detainee restroom in the warehouse is always locked and can only be accessed by staff.

Throughout the tour the Auditor also noted any issues that would need further review for PREA compliance later in the audit. The Auditor also spoke informally with 14 staff and 9 detainees regarding PREA issues during the tour. Everyone was very cooperative and informative in their responses. AIPC has 249 security staff (158 male and 91 female), 39 medical staff, and 4 mental health staff, in addition to a variety of other positions (additional staff and three contractors), such as those who carry out essential facility functions such as recreation, maintenance, commissary, warehouse, laundry, and food service.

The detainees arrive at the facility through a sallyport entrance before being delivered to the intake area in the part of the building dedicated to the detainee living areas and support services. The intake process at AIPC is the first step for all detainees arriving at the facility. Although the Auditor viewed the intake areas and discussed the process with the AFA and the PSA Compliance Manager/Investigator, the Auditor was unable to observe the intake process since no new detainees arrived at the facility during the three days of the audit. The intake/processing area has five holding cells. There are two large holding cells with a capacity of 77 detainees. There are also three smaller holding cells with a capacity of ten detainees. (b) (7)(E) The camera is monitored by central control and does not show the toilet area. The Auditor verified this by viewing this area on the monitor in central control. Detainees do not remain in the holding cells longer than 12 hours; this was verified through interviews with classification staff, intake staff, and detainees.

On the first day of the audit, Tuesday, August 24, 2021, the PSA Compliance Manager/Investigator gave the Auditor a detainee roster; the Auditor selected a sampling of 15 detainees for interviews on that day. From the detainee roster supplied by the PSA Compliance Manager/Investigator on the second day, the Auditor selected 17 for interviews. AIPC did not have any mentally or physically disabled detainees (including vision or hearing impairments), no detainees who had filed a grievance related to sexual abuse, and no detainees who had been placed in segregated housing for risk of sexual victimization after a PREA allegation. However, of the total of 32 detainees selected for interviews, there were representatives of the following targeted populations: 1 who was transgender, 2 who were gay, 2 who were classified as abusers, 3 who were classed as vulnerable to victimization, 18 who were limited English proficient (LEP), and 6 who spoke English. Of the 18 LEPs, 17 were random selections. The Auditor began interviewing detainees immediately after the tour. He interviewed all these detainees in two private offices, one in a male unit and the other in a female unit. The Auditor interviewed 5 female and 27 male detainees. The 18 LEPs in the group were interviewed utilizing Language Services Associates, a language interpretation company contracted through Creative Corrections LLC.

Of the 32 detainees interviewed, no one reported any problems with privacy issues, and no one feared for their personal safety. No detainee had been strip searched. Those who reported being pat searched said the search was done by an officer of the same gender in a respectful and appropriate manner. The transgender detainee said she had never been searched at all. Every detainee interviewed acknowledged receiving all the written materials at intake (such as the local and national detainee handbooks, as well as a sexual assault awareness pamphlet) and seeing the orientation video, both during intake and in their living units. Everyone acknowledged hearing the opposite gender announcements; only female officers work in the female living units, but the female detainees interviewed said that when male officers do have to come into a female unit, they always make the proper opposite-gender announcements.

When asked, the detainees told the Auditor that AIPC does a very good job of educating them about the protections PREA provides for them. The detainees also reported knowing their rights under PREA, including their right to be free of sexual abuse and assault, their right to report PREA violations anonymously, and their right to have someone else file a report on their behalf. All the detainees said they had seen various posters throughout the facility with information on how to make a report, including an anonymous report. The 32 detainees formally interviewed were from the following countries: Guatemala (1), Cuba (2), Liberia (1), Nicaragua (9), Ecuador (2), Iran (1), Ethiopia (1), Kenya (1), El Salvador (1), Soviet Union (1), Iraq (1), Mexico (6), Jamaica (1), Bangladesh (1), Somalia (1), Armenia (1), and Eritrea (1). The nine detainees interviewed informally told the Auditor information that was consistent with what the detainees formally interviewed reported.

There were four allegations of sexual abuse reported at AIPC during the audit period, with one of these allegations still being investigated. The Auditor reviewed the files for the three completed investigations and interviewed the PSA Compliance Manager/Investigator about the process used at the facility when allegations occur. The PSA Compliance Manager/Investigator said he notifies ICE and the Aurora Police Department (APD) when he is notified of an allegation. Then he prepares a brief synopsis for the OIC within two hours of an allegation; the OIC then refers the allegation to the AFOD. After all of the notifications, ERO will decide whether to accept or decline investigation of the allegation. If ERO declines, the case will be handled by APD. AIPC has a Memorandum of Understanding (MOU) with APD for investigations at the facility, and the norm is for APD to conduct the criminal investigations at AIPC. Of the PREA allegation materials reviewed by the Auditor for the timeframe preceding the audit period, one allegation was substantiated, one was unsubstantiated, and one was unfounded. The fourth allegation remained open at the end of the audit period.

The interviews for staff took place in a private office in the administration area on Wednesday after the final detainee interviews. The Auditor interviewed the OIC in his office on Tuesday after the facility tour and before the detainee interviews since he was leaving immediately after the facility tour. The 23 staff interviewed in person were:

Special Staff Interviews

- OIC
- AOIC
- Facility Administrator (FA)
- AFA
- PSA Compliance Manager/Investigator
- COS
- Human Resources Manager (HRM)
- Physician's Assistant (PA)
- One Classification Officer
- One Intake Officer
- Grievance Officer (GO)

Random Staff Interviews

- Three shift supervisors, one from each shift
- Six detention officers, two from each shift
- One Acting Supervisory Detention and Deportation Officer (Acting SDDO)
- One SDDO
- One contractor (Keefe) Commissary

The interviews gave the Auditor a comprehensive view of the daily operations at AIPC. The OIC and the Assistant OIC (AOIC) both made very positive comments about the professional working relationship between ICE and AIPC; they said they had an excellent relationship with the administration at the facility and they met with the FA and his staff on a daily basis. They were very complimentary about the facility's compliance with its various reporting duties, its submitting policies for review and approval, and its attention to various contract provisions. The Auditor noted the presence of upper-level management in all areas of the facility throughout the tour and during revisits to different areas of the facility.

On Thursday, August 26, 2021, the ERAU Team Lead opened the exit briefing at approximately 4:30 P.M. After expressing her appreciation for the cooperation of all involved in the audit process, she turned the briefing over to the Auditor. The following attended the exit briefing:

- (b) (6), (b) (7)(C), ICS, ICE/OPR/ERAU
- (b) (6), (b) (7)(C), DSCO, ICE/ERO
- (b) (6), (b) (7)(C), PSA Compliance Manager/Investigator, GEO
- (b) (6), (b) (7)(C), SDDO, ICE/ERO
- (b) (6), (b) (7)(C) Facility Administrator (FA), GEO
- (b) (6), (b) (7)(C), AFA, GEO
- (b) (6), (b) (7)(C), Health Services Administrator (HSA), GEO
- (b) (6), (b) (7)(C), COS, GEO
- (b) (6), (b) (7)(C), HRM, GEO
- (b) (6), (b) (7)(C), Administrative Executive Secretary, GEO
- Douglas K. Sproat, Certified DOJ/DHS PREA Auditor, Creative Corrections, LLC.

The Auditor also expressed his appreciation for the cooperation of everyone at AIPC during the three days of the audit, highlighting in particular the helpfulness of the facility's PSA Compliance Manager/Investigator in organizing the interviews for detainees and staff. He further noted the value of the on-site portion of the audit in providing him a better understanding of the operations at the facility. He stated that the 32 detainees interviewed--of which 26 were LEP's--all understood the protections PREA provides, and the staff interviewed were very knowledgeable about PREA and easily articulated how PREA benefits the detainees at AIPC. The Auditor noted that the staff appeared to be very well-informed about PREA; they all attributed their knowledge to the frequency of the PREA training provided at AIPC.

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: 4

§115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
§115.31 Staff training
§115.32 Other training
§115.33 Detainee Education

Number of Standards Met: 30
§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
§115.21 Evidence protocols and forensic medical examinations
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.34 Specialized Training: Investigations
§115.35 Specialized training: Medical and mental health care
§115.43 Protective custody
§115.51 Detainee reporting
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff and agency reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health screenings; 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: 5
§115.13 Detainee supervision and monitoring
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.52 Grievances
§115.86 Sexual abuse incident reviews

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

PROVISIONS

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

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(c) Policy 5.1.2.D-AUR, PREA Sexual Abuse Assault Prevention and Intervention (SAAPI) Program for Immigration Detention Facilities, outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and harassment. Policy 5.1.2.D-AUR dictates that "all AIPC employees, contractors, and volunteers have an affirmative duty to report all allegations or knowledge of Sexual Abuse, romantic, or sexual contact" that takes place at AIPC. In addition, Policy 5.1.2.D-AUR spells out "that the local ICE office will "review and approve" each AIPC policy, as well as any subsequent changes." The Auditor viewed documents reflecting the process of AIPC's sending all policies and any subsequent changes to the policies to the OIC, who has an office on site. The OIC then forwards these policies, and any changes to his immediate supervisor, the AFOD, whose office is located in Denver. The Auditor confirmed this process through interviews with the OIC and the AOIC. The detainee materials at the facility, whether the ICE National Detainee Handbook or the local detainee handbook, or the many posters and other informational material located throughout the facility, emphasize a commitment to a zero-tolerance environment. After interviews with staff and detainees, it was apparent the facility is committed to having zero tolerance for sexual abuse, sexual assault, and sexual harassment; staff members were able to spontaneously speak to various aspects of the facility's zero-tolerance approach. The zero-tolerance policy is publicly posted on the GEO website (www.geogroup.com/PREA). AIPC staff, contractors, and volunteers all learn of the facility's zero-tolerance policy through the facility's initial and refresher PREA training. Staff also receive a GEO Employee Handbook with a section on the zero-tolerance policy and are issued cards, which they carry, outlining their staff responsibilities, zero-tolerance, and first responder duties. Detainees learn of the zero-tolerance approach at AIPC policy through their orientation at intake and through the informational materials cited above.

(d) The Auditor's interviews with the FA and the PSA Compliance Manager/Investigator established the PSA Compliance Manager/Investigator reports directly to the FA. The PSA Compliance Manager/Investigator confirmed during the interview he has sufficient time and authority to oversee facility efforts to ensure compliance with PREA requirements, even though he also carries out the responsibilities of the facility's investigator. His compliance tasks include serving as the facility's point of contact for the ICE PSA Coordinator, collecting and analyzing PREA data, assisting with the development of initial and on-going training protocols, reviewing results of every investigation of sexual abuse, and preparing required reports, and collecting the AIPC Unannounced SAAPI Rounds forms. The PSA Compliance Manager/Investigator has several years of experience in this position, and he appears to be extremely knowledgeable about his responsibilities and duties.

The facility exceeds the requirement for this standard because of its consistent efforts to educate staff and detainees about PREA and its consistent efforts to promote and maintain a zero-tolerance environment. The positive and productive effect of these efforts was apparent through the interviews with both detainees and staff.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The Auditor reviewed the facility's staffing plan. All direct-care post assignments meet the requirements of the standard. Direct-care posts are those staffed by the officers having the responsibility for in-person supervision of detainees throughout every 24-hour period. The Pre-Audit Questionnaire (PAQ) reflected that the facility has 249 security staff, all of whom have daily contact with detainees. There are 158 male officers and 91 female officers deployed on three eight-hour shifts. Video cameras operate 24 hours a day, 7 days a week; they are monitored through central control. The Auditor confirmed the adequacy of the staffing numbers and deployment through a review of security staffing logs. The FA, PSA Compliance Manager/Investigator, and COS indicated during their interviews that the number of staff is determined by such things as the physical layout and size of the facility and the composition of the detainee population, along with contractual requirements. The Auditor's review of the facility's three completed incident reviews showed that no allegations related to any need to increase the number of staff, change staff deployment, or alter camera placement.

(b) Policy 5.1.2.D-AUR requires a "comprehensive written staffing plan that is reviewed at least annually." The Auditor reviewed the facility's written staffing plan; he confirmed through interviews and a review of documents that the plan is reviewed at least annually. The FA, PSA Compliance Manager/Investigator and the COS all confirmed during their interviews that the annual review of the staffing plan to evaluate the need for any deviations in the plan.

(c) The FA, PSA Compliance Manager/Investigator, and COS told the Auditor their practice at AIPC is to follow all components of Policy 5.1.2.D-AUR and the standard when examining their staffing practices. Some of the key portions of the policy are the requirement for the facility to "ensure it maintains sufficient supervision of detainees, including appropriate staffing levels and, where applicable, video monitoring to protect detainees against sexual abuse." As the administrators decide how to carry out their job of maintaining appropriate supervision of detainees and the extent to which video supervision is needed, the AIPC policy requires them to use these factors in their decision making: "1) Generally accepted detention and correctional practices; 2) Any judicial findings of inadequacy; 3) The physical layout; 4) The composition of the detainee population; 5) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; 6) The findings and recommendations of sexual abuse incident review reports; and 7) Any other relevant factors, including but not limited to the length of time detainees spend in AIPC custody." As noted in (a), a study of incident reviews for the period did not reflect any problems related to facility staffing. The facility submitted a copy of an undated staffing plan post on-site audit. In addition, they submitted an email confirming review of a 2021 staffing plan. However, neither document submitted confirmed that the facility in developing the most recent staffing plan considered the elements mandated by sub section (c) of the standard. The FA explained that the number of staff at AIPC is a contract requirement. (b) (7)(E) [redacted] These cameras operate 24 hours a day, seven days a week. The cameras have pan/tilt/zoom capabilities but do not record sound. All cameras are monitored by the main control room officers. Video footage is recorded and archived in an on-site secure server for at least 90 days.

Does Not Meet (c): The facility submitted an undated copy of a staffing plan post on-site audit. In addition, the facility submitted an email stating the staffing plan for 2021 had been reviewed with no recommended changes. Neither document confirmed that the facility took into consideration generally accepted practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relative factors, including but not limited to the length of time detainees spend in agency custody. To come into compliance, the facility must demonstrate that all factors mandated by the standard are considered when determining adequate staffing levels for 2022. Confirmation of compliance can be determined by the facility submitting their staffing plan review for 2022.

(d) Policy 5.1.2.D-AUR III outlines comprehensive guidelines regarding detainee supervision and unannounced security inspections. Staff, including supervisors, must conduct unannounced security inspections to identify and deter sexual abuse of detainees. Duty supervisors must "make rounds at least once per each shift and senior staff will make unannounced inspections randomly. Security checks by duty officers, senior staff and department heads will be documented in each housing unit logbook by the staff member performing the task." The Auditor reviewed three logbooks and verified that the unannounced rounds were being made on all three shifts and were documented in red as PREA rounds. The policy further requires that staff "are prohibited from alerting others that these security inspections are occurring, unless such an announcement is related to the legitimate operational function of the Aurora ICE Processing Center."

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

A July 8, 2021, memo from the PSA Compliance Manager states, "The Aurora ICE Processing Center does not house juvenile or family detainees." The PAQ indicates that AIPC does not house such detainees, and both the FA and the PSA Compliance Manager/Investigator confirmed during their interview that the facility does not house juveniles or family detainees.

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

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

Notes:

(b)(c)(d) Policy 5.1.2.D-AUR III (I) (SAAPI) states that "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 is required or in exigent circumstances." The policy further directs that "cross-gender pat-down searches of female detainees are prohibited, absent exigent circumstances and that all cross-gender pat searches, must be documented using the Cross-Gender Pat Search Log." Post and shift assignments are completed to ensure that there are always female officers on duty on all shifts. A memo from the PSA Compliance Manager/Investigator dated July 8, 2021, states, "The Aurora ICE Processing Center did not have any instances where cross-gender pat-down searches were conducted in the year preceding this audit." Both male and female security staff told the Auditor they had been trained to perform cross-gender searches; however, they stated there are always officers of the proper gender available to perform a search, and no officer interviewed had conducted a cross-gender search of any type during the audit period. Detainees who reported being pat searched said the search was done by an officer of the same gender in a respectful and appropriate manner. The transgender detainee said she had never been searched.

(e)(f) Policy 5.1.2.D-AUR III (SAAPI) prohibits "Cross-gender strip searches or cross-gender visual body cavity searches unless there are exigent circumstances, such as issues "of officer safety, or when performed by Medical Practitioners." Searches of this type must always be documented in the Cross-Gender Pat Search Log. A July 8, 2021, memo from PSA Compliance Manager/Investigator states, "The Aurora ICE Processing Center did not have any instances where strip searches or visual body cavity searches were conducted in the year preceding this audit." The PSA Compliance Manager/Investigator told the Auditor that security staff are well-trained to conduct such searches and to complete the required documentation.

(g) Policy 5.1.2.D-AUR III (SAAPI) also addresses the requirements of the standard to make provisions for "detainees to shower, change clothes, and perform bodily functions without employees of the opposite gender viewing them, absent Exigent Circumstances or instances when viewing is incidental to routine cell checks or otherwise appropriate in connection with a medical examination or monitored bowel movement." Another provision of Policy 5.1.2.D-AUR III (SAAPI) requires staff of the opposite gender to "announce their presence when entering housing units or any areas where detainees are likely to be showering, performing bodily functions, or changing clothes." During the tour of AIPC, through observation, the Auditor was able to verify there were no privacy issues which would expose a detainee to improper viewing while showering, changing clothes, or performing bodily functions. During the on-site audit, the Auditor went to central control and asked the officer to pull up certain areas in the detainee living units which further confirmed there were no privacy issues. There are signs on the doors to the living units reminding those entering to make the opposite gender announcements. The Auditor consistently heard these announcements being made. The Auditor interviewed both male and female detainees, and no one had any complaints about being improperly exposed to viewing by officers of the opposite gender when they were using the shower, performing bodily functions, or changing clothes. All the detainees interviewed acknowledged hearing the opposite-gender announcements.

(h): Since AIPC is not designated as a Family Residential Center; therefore, this subpart of the standard is not applicable.

(i): Policy 5.1.2.D-AUR III (SAAPI) dictates that "facilities shall not search or physically examine a Transgender or Intersex Detainee solely to determine the detainee's genital status. If the genital status is unknown, it may be determined during private conversations with the detainee, by reviewing medical records, or, by 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." Policy 5.1.2.D-AUR III (SAAPI) also incorporates a variety of very specific directions to guide staff in following facility-approved practices when searching detainees identified at intake as transgender or intersex. The only transgender detainee at AIPC during the on-site visit stated during her interview that she had never been pat-searched or strip-searched since arriving at the facility.

(j) In addition to the guidance provided in Policy 5.1.2.D-AUR III (SAAPI), AIPC conducts training to equip security staff for pat-down searches (both same sex and cross-gender) and proper searches of transgender and intersex detainees. The Auditor reviewed an ICE training bulletin, "Best Practices (February 2021) -- Cross-Gender, Transgender, and Intersex Searches," which covers practices addressed in both the standard and Policy 5.1.2.D-AUR III (SAAPI). It contains key definitions and techniques, including directives about documentation. Staff training supplements Policy 5.1.2.D-AUR III (SAAPI) in emphasizing that searches of various types are to be done "in a professional and respectful manner, and in the least intrusive manner possible, including consideration of officer safety." The Auditor verified specific training in search techniques by reviewing the training files of seven

detention officers. Interviews with six detention officers reflected they all were easily able to describe the process for conducting a cross-gender, transgender, or intersex search of a detainee.

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

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a) Policy 5.1.2.D-AUR III (SAAPI) details the facility's approach for ensuring that detainees with disabilities "have an equal opportunity to participate in or benefit from the Company's efforts to prevent, detect, and respond to Sexual Abuse and Assault." These efforts are designed to provide critical PREA information to detainees with a wide range of disabilities, such as detainees who have limited ability to speak or understand English, who are deaf or hearing-impaired, who are blind or visually impaired, who have limited reading skills, and those who have "intellectual, psychiatric or speech disabilities…" A section of the AIPC Detainee Handbook states, "Detainees with disabilities [will] be provided an equal opportunity to access, participate in, or benefit from in-custody programs, services, and activities; and be provided with auxiliary aids and services as necessary to allow for effective communication. Examples of aids and modified services includes but are not limited to…note takers, video remote interpreting services, tablets/readers, and materials or displays in Braille." An intake officer and a classification officer explained to the Auditor the steps that would be taken to communicate effectively with detainees who might have a variety of disabilities. For detainees who are deaf or hearing-impaired, the facility would provide a sign language interpreter through a video conference line to communicate information if video orientation materials are not offered in a closed caption format in a language the detainee understands. There is also a TTY in intake for use with detainees who are deaf or hearing-impaired. For detainees with vision impairments, the video's audio portion (English and Spanish) would convey necessary information to the detainee, with the option for the facility to use Language Line Services if the detainee speaks some other language. Intake staff also ensure that detainees with limited reading or comprehension skills have materials read to them in a one-on-one situation by staff who will repeat portions of materials or will simplify language as needed for a thorough understanding. The facility also has bilingual staff on all 3 shifts that can assist with interpretation or translation tasks in 38 languages; AIPC has an impressive "Staff interpreter List" with names, languages spoken, and job assignments for ease in locating an interpreter who speaks a given language. The PSA Compliance Manager/Investigator maintains this list; since he is also the PREA trainer for staff, he is in a position to supplement that list whenever a new bilingual staff member is present for PREA training. Some of the languages the current AIPC staff speak include Haitian Creole, Farsi, Tagalog, Serbo-Croatian, Punjabi, and Russian. There were no disabled detainees on-site when the Auditor was at AIPC.

(b)The Auditor reviewed the ICE National Detainee Handbook (English and Spanish) and a facility-specific handbook (English, Spanish, Portuguese). The ICE National Detainee Handbook is published in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Vietnamese, Turkish, Bengali, and Romanian). Although AIPC had the ICE National Detainee Handbook in the languages noted, the facility is authorized to produce copies of the handbook in any of these other languages. Although no detainees went through the intake process while the Auditor was on-site, the Auditor reviewed a blank intake packet which contained an "I SPEAK" language identification guide used to assist staff in identifying what language the detainee speaks. AIPC also distributes a DHS-prescribed Sexual Assault Awareness pamphlet in nine languages that provides detainees with critical information on how to recognize and report sexual abuse; these pamphlets are posted throughout the facility, in addition to being distributed directly to detainees. This pamphlet is available in English, Spanish, French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic. The PSA Compliance Manager/Investigator said when they need to address a language issue for conveying PREA information and no staff member speaks the detainee's language, they call the language line and have the material translated for the detainee in whatever language is needed. The Auditor interviewed 18 LEP detainees through the use of Language Services Associates; all of them told the Auditor they had received PREA information in a format they could understand.

(c) Under Policy 5.1.2.D-AUR III (SAAPI) AIPC will "provide in-person or telephonic interpretation services in issues related to sexual abuse or assault in order to ensure effective, accurate, and impartial interpretation by someone other than another detainee unless the detainee expresses a preference for a detainee interpreter and the AIPC determines that such interpretation is appropriate…. minors, alleged abusers, detainees who witnessed the alleged abuse and detainees who have a significant relationship with the alleged abuser shall not be utilized as interpreters in matters relating to allegations of sexual abuse and that when detainee interpreters are used in interpretation sexual abuse allegations the use shall be justified and fully documented." The Auditor reviewed all three of the closed allegation files from the audit period, and a telephonic interpretation service was used in each case.

A thorough review of the facility's preparedness to deal with a variety of disabilities and the facility's unique efforts to use staff members' language skills for communicating important information to detainees establish that the facility exceeds what is required under the standard.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(d) Through review of policy 5.1.2-D-AUR, it was determined that the facility has established a system of conducting criminal background checks for new employees, contractors, and volunteers who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The job application form requires the employee to answer questions of having not engaged in sexual abuse in a prison, jail, lock-up, community confinement facility, juvenile facility, or other institution and have not been civilly or administratively adjudicated or convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to refuse. The form was updated in March 2018 with the three questions. These forms are utilized for new hires and promotions. The Human Resources staff interviewed indicated this information is also checked on all applicants as part of the hiring process during the background stage. The facility will contact prior institutional employers to obtain information on substantiated allegations of sexual abuse or any resignation during an investigation. The facility utilizes a third-party company, Career Builder, for background checks. Background checks are also conducted through ICE prior to an employee or contractor being approved for hire or a volunteer approved to provide services. During a training session presented in September of 2020, a Unit Chief from OPR's Security Division explained that all ICE and contract employees must clear a background investigation through PSU before hiring or promoting any staff or contractor who may have contact with detainees. The contractor or staff complete an e-QIP and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE; if it is a contract employee, the office informs the contractor that the employee cannot perform work on behalf of ICE. The Unit Chief explained the sexual misconduct questions are

asked of the potential employee as part of the e-QIP. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a supervisor. The continuing affirmative duty to report is also accomplished annually during the annual performance review of employees. They must complete an acknowledgement form containing the questions prior to the completion of the evaluation. While on-site, the Auditor reviewed a sampling of five applications for employees, one contractor, and five volunteers; all the forms contained the PREA questions required by subpart (a). In addition, the facility submitted three signed copies of the PREA Disclosure and Authorization Annual Performance Review forms dated 2021 confirming compliance with subsection (b) of the standard.

(c) Policy 5.1.2-D-AUR requires a background investigation and criminal background record check for all new hires to ensure the candidate is suitable for hiring. A background and criminal background record check will be repeated for all employees at least every five years. The Human Resource staff interviewed indicated the facility utilizes a third-party company, Career Builder, for background checks. Background checks are also conducted through ICE prior to an employee being approved for hire and again within five years. The Auditor reviewed 12 personnel files to verify how the facility handles its background checks. The files contained initial background checks, five-year background rechecks, and a background recheck if the person had applied for a promotion or was a transfer from within the GEO system. The files reviewed showed that the background checks were thorough and had been performed in a timely manner consistent with this subpart of the standard. ICE conducts all AIPC's background investigations.

(e) The employment application contains a statement indicating the applicant agrees not to falsify or omit information. If the applicant does falsify or omit information, employment can be denied, or the person will be subject to immediate termination. The Human Resource staff interviewed confirmed the wording on the application and that a person would not be hired or terminated for falsifying information. During the review of the employee personnel files, the wording was verified on the employee application forms. The policy 5.1.2-D-AUR also states and supports the practice.

(f) Policy 5.1.2-D-AUR indicated "the facility shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work, unless prohibited by law." The Human Resource staff interviewed stated all information requests, internal and external, are forward to corporate for response. The information will be provided through the corporate office.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

(a)(b) This standard is non-applicable as AIPC has not acquired a new facility, made substantial expansion, or updated their video monitoring system during the audit period.

§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) According to the policy 5.1.2.D "when investigating a PREA allegation the facility must follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." This protocol must "be developed in coordination with DHS…." Through an interview with the OIC, the Auditor confirmed the involvement of the ICE ERO Field Office in the development of every policy and protocol at AIPC. The PREA Compliance Manager/Investigator further verified that ICE had been involved with the development of the facility's evidence protocol. Policy 5.1.2-D-AUR further outlines the facility's evidence and investigation protocols for sexual abuse allegations. Agency policy 11062.2 outlines the agency's evidence and investigation protocols. The facility utilizes the Department of Justice (DOJ's) National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents 2nd Edition for the uniform evidence protocol as indicated by the PSA Compliance Manager. The protocols are incorporated into the facility's SAAPI Coordinated Response Plan. The SAAPI Coordinated Response Plan provides an extensive guideline for staff to follow for investigations and/or referring an allegation for investigation. The protocols are approved by GEO Corporate and ICE as part of the annual policy review. The facility does not house juvenile detainees. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility incident review personnel in accordance with OPR policies and procedures. The OPR will coordinate with the FOD and facility staff to ensure evidence is appropriately secured and preserved pending an investigation.
The facility begins investigations immediately following an allegation. The allegations are also reported to the APD and ICE, including to the AFOD and ICE staff at the facility for investigation and further action. If the investigation is not conducted by the APD or ICE, the facility will complete the investigation by a specialized trained investigator. Of the three investigative files reviewed, all were investigated by trained facility investigators.
The OIC stated in his interview that once an allegation is initially reported through the PSA Compliance Manager/Investigator's broad notification process (which covers both ICE and APD), there is a two-hour window for the PSA Compliance Manager/Investigator to provide him with a synopsis of the allegation and other information available at the time. The OIC forwards this synopsis to ERO, and ERO uses that synopsis for its decision to accept or decline investigating the allegation/case. At that point, the allegation/case goes to APD to accept or decline.

(b)(d) (b/d) The facility has a memorandum of understanding (MOU) agreement with Blue Bench, the community rape crisis center and victim advocacy services. The MOU outlines that Blue Bench will provide immediate advocacy, support and crisis intervention via a published hotline; have a qualified advocate respond in person to the facility or other locations as requested to provide additional advocacy, emotional support, and information to victims; provide up to three follow-up visits and continued individual advocacy and support to victims at the facility; inform the victim of the option for a victim advocate to be present during the medical examination and investigative interviews; answer victims' questions about the forensic exam and accompany the victim during the exam if desired; provide all of the above specified services without cost to the facility; and communicate any questions or concerns to designated PREA Compliance Manager and facility office. The MOU was executed on March 30, 2018, with annual renewals. The interview with the PSA Compliance Manager indicated that the services are free of charge to the detainee and the hotline is available 24-hours a day for the detainees. The hotline number and victim advocacy services are provided to the detainees on a poster on the housing unit's bulletin boards. The PSA Compliance Manager also indicated that each alleged victim is provided a Blue Bench pamphlet and the Sexual Abuse and Assault Awareness brochure and must sign acknowledging receiving the information.

(c) Under the policy 5.1.2.D-AUR "services to detainee victims are to be without cost to the victim and without any obligation to name an abuser or cooperate with the investigation." Through this MOU, AIPC has ensured that outside victim support services are available to detainee victims, including support services in a hospital setting. The facility uses Denver Health Medical Center for any forensic examinations for alleged victims. A forensic examination would then be offered at that location by a Sexual Assault Nurse Examiner (SANE), although an alleged victim is always free to decline such an examination. Attempts to set up a telephone interview with the Director of Nursing for Emergency Department, who is in charge of the SANE

program for Denver Health Medical Center, were unsuccessful, but a letter of June 23, 2014, from the Correctional Care Coordinator verifies that Denver Health will provide emergency care and treatment to detainees from AIPC, including the services of a SANE. A second letter, dated July 1, 2014, further verifies the services of SANEs at Denver Health and states that the facility will determine whether a representative of Blue Bench can be with the detainee. According to the PAQ and as confirmed by the PSA Compliance Manager/Investigator, there were no forensic examinations at AIPC during the audit period.

(e) Subpart (e) of the standard states: "To the extent that the agency is not responsible for investigation allegations or sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of paragraphs (a) through (d) of this section." The facility does have a MOU with the APD. The MOU outlines all the requirements of the standard. To date, the APD has not investigated a case. Upon review of the investigation files, notifications were made to the APD, and case numbers were assigned.

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

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

Notes:

(a)(d) Policies 5.1.2-D-AUR and 5.1.2-E Investigating Allegations of Sexually Abusive Behavior (PREA) and Evidence Collection state all allegations are referred for investigation to a law enforcement agency with legal authority to conduct criminal investigations. A staff member will report the allegation to a supervisor who will make the required notifications which begins the investigation process. The facility will document all investigation referrals. The allegations are referred to the APD and ICE, including to the AFOD and ICE staff at the facility for investigation and further action. The Facility Investigator stated that OPR will review all cases to determine if an investigation is required by the agency. All allegations involving staff are investigated by OPR. Agency policy 11062.2 outlines the agency's evidence and investigation protocols. Once the investigation allegation is reviewed and accepted by the agency OPR investigator, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If the investigation is not conducted by the APD or ICE, the facility will complete the investigation by a specialized trained investigator. The facility does have a MOU with the APD. The MOU outlines all the requirements of the investigation. The Auditor's review of the three closed files for the audit period showed that the files were all referred to APD, even though APD did not necessarily conduct a criminal investigation into each case, depending on the nature of the allegation.

(b) The standard requires "each facility to establish a facility protocol policy to ensure that all allegations of sexual abuse are referred to an appropriate law enforcement agency authorized to conduct criminal investigation, unless the allegation does not involve potentially criminal behavior." The SAAPI Coordinated Response Plan outlines the responsibility of the facility and other investigative agencies. Policy 5.1.2-D-AUR (SAAPI) addresses the responsibilities and requirements for investigation. Policy 5.1.2-D-AUR (SAAPI) further covers data collection and data storage, publication, and destruction. The policy states "that all records associated with allegations of sexual abuse are securely retained for at least 10 years or longer if required by state statute." These records are securely maintained in a locked file cabinet in the PSA Compliance Manager/Investigator's Office, as reported by the PSA Compliance Manager/Investigator and verified by the Auditor.

(c) On the GEO website, www.geogroup.com/PREA, is a webpage dedicated to PREA. The webpage contains the company's policies 5.1.2-D and 5.1.2-E for public information. The page also contains the zero-tolerance policy, how to report sexual abuse or sexual harassment, and how an employee may report sexual abuse or sexual harassment. There is a paragraph that explains the investigation process that states if the allegation potentially involves criminal behavior, GEO will ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations. The policy 5.1.2-E-AUR also provides the protocols for sexual abuse investigations. The ICE website, www.ice.gov/prea, includes information on the agency's PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE Detainee Handbook, ICE PREA poster and ICE PREA pamphlet.

(e/f) Policies 5.1.2-D-AUR and 5.1.2-E-AUR require that all incidents are promptly reported to the Joint Intake Center (JIC), ICE OPR, and/or DHS OIG, as well as the appropriate ICE Field Office Director (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 SAAPI Coordinated Response Plan has a list of required notifications that includes the ICE after Hours Duty Office who will make the required notifications to the agency. The Investigator stated all notifications are made to the agency, APD, and GEO Corporate. The PSA Compliance Manager/Investigator said he was the person responsible for making the notifications when an PREA incident occurred, and the FA told the Auditor that the PSA Compliance Manager/Investigator could always be counted on to make all of the required notifications. The OIC further confirmed to the Auditor that the facility was always prompt in making appropriate notifications about all PREA allegations, whether the allegation was a detainee-on-detainee situation or an allegation of staff/contractor/volunteer-on-detainee incident. A review of three investigative files submitted following the on-site visit confirmed that the appropriate investigative entities were notified on all cases as dictated by the standard.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) Policy 5.1.2.D AUR requires that "all new employees must receive initial training on GEO's Sexual Abuse and Assault Prevention and Intervention Program (SAAPI). They must then receive annual SAAPI refresher training thereafter." Under Policy 5.12.D AUR, the training for employees who have contact with detainees covers a broad range of topics, covering each of the nine elements outlined in subpart (a) that are essential to helping AIPC meet its PREA responsibilities. The Auditor reviewed the impressive PREA training module, which included this statement: "The GEO Group and every staff member employed by us will strictly follow the DHS PREA standards. This means YOU will be held accountable for doing everything within your power to prevent sexual assault in our facilities." Some of the topics covered in the PREA training include the facility's "zero-tolerance policy for Sexual Abuse and Assault" and how to carry out the employees' "responsibilities under agency Sexual Abuse and Assault prevention, detection, reporting and response policies and Procedures, to include procedures for reporting knowledge or suspicions of Sexual Abuse." Other training topics enable them to recognize issues of sexual abuse and how to prevent, detect, and report actual or suspected sexual assault and abuse. The training also covers important issues such as how to avoid inappropriate relationships with detainees, how to communicate effectively and professionally with detainees (including LGBTI and gender non-conforming detainees), and how to limit reporting of PREA issues to personnel with a need-to-know. All annual refresher training will include updates to sexual abuse and assault policies. Everyone taking the training (whether initial or refresher training) must sign the AIPC "Prison Rape Elimination Act (PREA) In-Service Training Acknowledgement" form. The AIPC "Prison Rape Elimination Act (PREA) In-Service Training Acknowledgement" form that staff, contractors, and volunteers sign contains this language: "I

acknowledge on this date I received and understand the training on Prison Rape Elimination Act (PREA). I understand that the GEO, Group, Inc. maintains a zero tolerance in regard to sexual abuse and sexual harassment of individuals in a GEO facility or Program and I have a statutory obligation and affirmative duty to report ALL forms of sexual abuse and/or sexual harassment whether in a GEO facility or not." The Auditor reviewed training files for seven supervisors, seven medical staff, seven food service staff, and seven security staff and verified that all had received the initial PREA training, and the annual refresher training as required by AIPC policy. He also reviewed a sampling of PREA in-service training from the audit period.

The Auditor was unable to interview the Training Manager, who was providing in-service training for staff during the audit period. She allowed the Auditor to sit in and observe the in-service training session. She gave the PSA Compliance Manager/Investigator permission to access the training files for the Auditor to review. The PSA Compliance Manager/Investigator stated that staff, contractors, and volunteers receive the same initial and refresher SAAPI training described above. After a review of the training files for 28 staff, the Auditor was further able to establish that the facility was conducting training in accordance with its policy. Additionally, random staff interviews revealed that staff have a thorough understanding of the facility's sexual abuse prevention and response policies and procedures. The Auditor found that staff who were interviewed quickly answered all questions about PREA, and these employees attributed their familiarity with PREA and their responsibilities under PREA to the frequency of their training at AIPC. While on-site, the Auditor was able to explore the staff's understanding of their duties as either security or non-security first-responders. They all seemed to have a comprehensive understanding of their responsibilities, and they all credited their annual training for their knowledge of what to do when a PREA-related incident occurs.

Under Standard 115.31, staff refresher training is required every two years; AIPC's policy and practice exceeds this requirement since all staff receive refresher training annually.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) Policy 5.1.2.D AUR requires extensive PREA training for volunteers and contractors who have contact with detainees. While AIPC has no contractors as described in subpart (d) of the standard, it does use contractors for the Commissary and IT services; these contractors and facility volunteers receive the same PREA-related initial training as described above in Standard 115.31 for employees. Policy 5.1.2.D AUR states, "all employees, contractors, and volunteers must receive initial training on GEO's Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program." Like the AIPC staff, the volunteers and contractors must then receive annual SAAPI refresher training. This training covers a broad range of topics that are vital in helping AIPC meet its PREA responsibilities. The Auditor viewed a copy of the comprehensive PREA training curriculum and found the information to be compliant with the requirements of the standard. The PSA Compliance Manager/Investigator told the Auditor that the annual refresher training always includes any facility updates to sexual abuse and assault policies. All volunteers and contractors taking the training (whether initial or refresher training) must sign the "Prison Rape Elimination Act (PREA) In-Service Training Acknowledgement" form, which includes a reminder of both the facility's zero tolerance policy and of the affirmative duty of staff, contractors, and volunteers to report sexual abuse and harassment. The one contractor the Auditor interviewed was able to explain her responsibility as a non-security first responder to PREA related issues without the use of her on-person PREA help card. She said that the annual refresher training is the reason for her being able to respond as she did. She also stated that she had never had to respond to a PREA-related issue at AIPC. After a review of three volunteer and three contractor files, the Auditor verified that the facility conducted initial and refresher PREA training in accordance with its policy.

The facility's policy and practice exceed what is required by the standard since the standard does not require refresher training for contractors and volunteers.

§115.33 - Detainee education.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(d)(e)(f) The facility policy 5.1.2.D addresses the PREA education requirements for detainees. At intake into the facility, staff provide detainees information through the facility-specific handbook, ICE Detainee National Handbook, PREA pamphlet Sexual Assault Awareness Information, and the Detainee Orientation Video. The ICE Detainee National Handbook is readily available in 14 different languages including English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Vietnamese, Turkish, Bengali, and Romanian. PREA education at AIPC includes a video orientation program. The intake staff interviewed indicated the video is played on a loop in English and in Spanish. This video was the educational tool most frequently cited by the detainees during their interviews; they said the video is shown frequently and in a format they can understand. The Auditor reviewed the script of this English/Spanish orientation video to confirm that it does provide detainees with basic PREA information, including how to make a report. The PSA Compliance Manager/Investigator said the video plays on a continuous loop in the housing areas. The AFA, the PSA Compliance Manager/Investigator, and an intake officer explained that AIPC presents important material to detainees with vision impairments by offering its education program in an audio format; it provides similar information to hearing-impaired detainees through written materials. They further noted that in cases where a detainee appears to have any kind of reading challenges, a staff member will read all the orientation information, including PREA materials, to the detainee in a one-on-one situation. The facility also provides a facility specific handbook available in English, Spanish, and Portuguese. The video and handbook include information on sexual abuse prevention, sexual abuse reporting, and sexual abuse treatment and counseling. The Detainee Handbook contained information on the grievance process. Although no detainees went through the intake process while the Auditor was on-site, the Auditor reviewed a blank intake packet which contained an "I SPEAK" language identification guide used to assist staff in identifying what language the detainee speaks. AIPC also distributes a DHS-prescribed Sexual Assault Awareness pamphlet in nine languages that provides detainees with critical information on how to recognize and report sexual abuse; these pamphlets are posted throughout the facility, in addition to being distributed directly to detainees. This pamphlet is available in English, Spanish, French, Chinese, Punjabi, Portuguese, Hindi, Haitian-Creole, and Arabic. The facility specific handbook is also available in English, Spanish, and Portuguese. The PSA Compliance Manager/Investigator said when they need to address a language issue for conveying PREA information and no staff member speaks the detainee's language, they call the language line and have the material translated for the detainee in whatever language is needed. The Auditor interviewed 18 LEP detainees through the use of Language Services Associates. All of them told the Auditor they had received PREA information in a format they could understand. There were no hearing-impaired or visually impaired detainees on site to be interviewed. The policy requires vital information such as the DHS-prescribed sexual assault awareness notices be posted on all housing unit bulletin boards, along with the name of the PSA Compliance Manager and the name of local organizations that can help detainees who have been sexually abused. The Auditor also reviewed PREA posters, the DHS-prescribed Sexual Assault Awareness Information pamphlet, and the DHS-prescribed sexual assault awareness notices. The posters included the name of the facility's PSA Compliance Manager and how to make a report to him, along with how to use a hotline number to contact a local victim advocacy

group (Blue Bench). The Auditor saw PREA signage posters on the bulletin boards in the living units, in visitation, in staff break rooms, and in all common areas of the facility. The Auditor also viewed DHS/ICE PREA posters in English and Spanish, containing the name of the facility PSA Compliance Manager posted throughout the facility, including on all bulletin boards in the housing units.

(c) Participation in this intake orientation program is to be documented, with that documentation to be kept in their individual files. The Auditor reviewed a sampling of ten detainee files, and each file contained detailed documentation of the materials (such as the AIPC Detainee Handbook) received by the detainee and the viewing of the orientation video as a part of the PREA education process, along with the detainee's signature. The detainee's signature also affirms his/her awareness of "the right to be free from sexual abuse, assault and harassment." This process was also verified through detainee interviews. The form the detainee signs, "Detainee PREA," also records whether the detainee was "English proficient," "staff language proficient," or whether a translation line or TTY was used. A particularly valuable aspect of the form is the spelling out of eight specific things the officer responsible for the detainee's orientation must do or say related to PREA—and the officer signs to verify that he or she has said or done all of those things. Having such a detailed list of important PREA information helps to ensure consistent and comprehensive PREA education when the detainee first arrives at AIPC.

The facility does an excellent job of detainee education, both in how it presents PREA information during the orientation process and in how well it provides information through the detainee handbook and various facility postings about its zero-tolerance environment and how detainees can make reports.

§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) Policy 5.1.2.D AUR specifies that "investigators shall conduct investigations into every allegation of sexual abuse at AIPC. Investigators shall be trained in conducting investigations on sexual abuse and effective cross-agency coordination. All investigations into alleged sexual abuse must be conducted by qualified investigators." Policy 5.1.2.D AUR further sets out that "investigators must receive this specialized training" in addition to the SAAPI training referenced in the narrative to Standard 115.31, which is required for all new employees. They must also take the annual SAAPI refresher training. Specialized training includes, but is not limited to, the following topics: interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, and criteria and evidence required for administrative action or prosecutorial referral. The Auditor verified this process when interviewing the PSA Compliance Manager/Investigator and reviewing his certification and the special investigative training curriculum he had completed.

ICE policy 11062.2 (SAAPI) states, "OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as Office of Detention Oversight staff, and other OPR staff, as appropriate." The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; 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 the Auditor's review; this documentation is in accordance with the standard's requirements. Even though no AIPC investigations during the audit period were conducted by OPR staff, the notices of allegations are always sent to ICE initially, and if OPR should opt to conduct the investigation, specially trained investigators would be required to handle the investigation.

(b) AIPC is required to maintain documentation of specialized investigator training for any facility investigator. The Auditor reviewed various certificates naming the specialized investigator training courses completed by the PSA Compliance Manager/Investigator. His specialized training met the requirements of this standard.

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

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

Notes:

(a)(b) Does not apply since the are no DHS or ICE employees on the medical staff at AIPC.

(c): The PSA Compliance Manager/Investigator and the PA both stated during their interviews that ICE has reviewed and approved the facility's policy regarding the specialized training of medical and mental health professionals working at AIPC. Policy 5.1.2D AUR III. (E) requires that "all full-time and part-time Medical and Mental Health Care Practitioners who work regularly" at AIPC must receive specialized training that includes the following topics: "… detecting signs of Sexual Abuse and Assault, preserving physical evidence of Sexual Abuse, responding professionally to victims of Sexual Abuse and proper reporting of allegations or suspicions of Sexual Abuse and Assault." However, the preservation of evidence by AIPC health care staff would exclude the performing of forensic exams; the PA told the Auditor such exams are performed by a SANE at Denver Health. The specialized training for medical and mental health staff is "in addition to the general mandated for employees…or contractors…depending on their status at the facility." The Auditor reviewed the curriculum for the medical and mental health specialized training and determined that the curriculum covered the requirements of the policy and the standard. The Auditor reviewed seven medical and mental health staff training files; such review confirmed the initial and refresher PREA training and the specialized medical and mental health training for the staff.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) The screening process for the risk of victimization and abusiveness is outlined in Policy 5.1.2.D AUR. The facility uses a PREA Risk Assessment tool at intake to assess 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 been previously incarcerated or detained; 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 LGBTI, (gay, lesbian, bisexual, transgender, intersex) or Gender Nonconforming; whether the detainee has self-identified as having previously experienced sexual victimization;" and the detainee's own concerns about his/her physical safety. Policy 5.1.2.D AUR, reviewed by the Auditor, conforms to the standard regarding the timing of the assessment and the requirements for maintaining separation among detainees for their protection until the assessment is done. Under this standard, the "initial classification and initial housing assignment should be completed within 12 hours of admission to the facility." The risk assessment is completed on all detainees upon admission to AIPC by the intake classification staff. Random interviews with detainees consistently confirmed this assessment occurred prior to their placement in the general population. The Auditor reviewed the PREA Risk Assessment tool and found it to assess the same information set forth in the standard. The Auditor reviewed ten detainee files, and each file included a risk assessment and that the initial housing placement was made within 12 hours as required by the standard. Both the assessments and the housing placements are recorded on the ICE Custody Classification Worksheet. During their interviews, an intake officer, a classification officer, and the PSA Compliance Manager/Investigator all confirmed the 12-hour time period for completing the intake process.

(d). Policy 5.1.2.D AUR directs that the intake assessment must "consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the Facility, in assessing the risk of being sexually abusive…." A review of the PREA Risk Assessment tool confirms that it contains the following entries that cover the requirements of this subpart: (1) "criminal history of sex offenses with adult/child victim," (2) "sex offender with adult/child victims," (3) "incident reports for sexual misconduct while incarcerated," (4) "history of prior sexual abuse perpetration while incarcerated," (5) "prior crimes of violence (excluding sex offenses, domestic violence)," and "history of domestic violence as a perpetrator." The intake officer and the classification officer confirmed that all of these elements are part of the risk assessment process and the answers to each of these questions play a significant role in housing, programming, and volunteer work assignments.

(e) Policy 5.1.2.D AUR requires, "any time after the initial assessment, a detainee shall be reassessed for risk of victimization or abusiveness when warranted based upon the receipt of additional, relevant information or following an incident [of]…abuse or victimization." The SAAPI Vulnerability Reassessment Questionnaire is used to conduct the reassessment. The questionnaire is brief, but a "yes" answer to certain questions requires a referral to a "PREA Committee/Classification Member" for review and follow up. The average length of stay at AIPC is 60.89 days. The Auditor reviewed two routine reassessments, both completed after a 60-day period. The PSA Compliance Manager/Investigator informed the Auditor that additional reassessments will also take place whenever needed, such as when there has been an incident of victimization. He advised that the reassessments for alleged detainee victims, such as those from the audit period, are normally done by mental health staff. The Auditor requested post on-site audit that the facility provide the SAAPI Vulnerability Reassessment Questionnaire completed following the three sexual abuse investigations conducted during the audit period. The facility failed to provide the documentation; therefore, the Auditor could not confirm compliance with subsection (e) of the standard as it relates to this specific requirement.

Does Not Meet (e): Both subsection (e) of the standard and AUR Policy 5.1.2.D require that a detainee shall be reassessed following an incident of sexual abuse or victimization. In an interview with the PSA Compliance Manager/Investigator, it was determined that the facility utilizes the SAAPI Vulnerability Reassessment Questionnaire to conduct the reassessment. However, upon request from the Auditor, the facility could not provide copies of the reassessment form for detainees involved in the three sexual abuse investigations completed during the audit period; therefore, compliance could not be confirmed. To confirm compliance, the facility must provide copies of the SAAPI Vulnerability Reassessment Questionnaire for all sexual abuse allegation investigations that occur during the CAP process.

(f) Policy 5.1.2.D AUR requires that the facility will not "discipline detainees for refusing to answer or for not providing complete information in response to certain screening questions." However, the policy does not specify which questions the detainee cannot be disciplined for if they refuse to answer. Following the on-site visit, the Auditor requested additional documentation that would further explain their policy regarding discipline for a detainee should he/she refuse to provide complete information, and/or refuse to answer questions pursuit to subsection (c) 1, 7, 8, 9 of the standard. As of the writing of this report, the facility has neglected to provide the requested information; therefore, there is not enough documentation to find this section of the standard compliant.

Does Not Meet (f): Policy 5.1.2.D AUR does not specify which questions the detainee cannot be disciplined for if they refuse to answer, and the facility did not provide an explanation after request to clarify their policy and confirm which questions the detainee would not be subject to discipline for should they refuse to answer. To become compliant, the facility must update their policy to be more exact as to what questions the detainee would not be disciplined for should they refuse to answer or provide complete information for them. If available, the facility must provide any documentation confirming a detainee was not disciplined for refusing to answer, and/or provide complete information when asked the questions outlined by (c) 1, 7, 8, 9 of the standard. Finally, the facility must provide documented training to both Intake and Classification staff regarding the new policy.

(g) Policy 5.1.2.D AUR states, "AIPC shall implement appropriate controls on dissemination of responses to questions related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees." Following the on-site visit, the Auditor requested further documentation that would explain how the facility guarantees that the faculty has appropriate controls on the dissemination within the facility of responses to questions asked pursuant to standard 115.41. As of the writing of this report the facility, has neglected to provide any documentation that would confirm that they have an appropriate system in place; and therefore, they have not confirmed compliance with this section of the standard.

Does Not Meet (g): Following the on-site visit, the Auditor requested further documentation regarding the facility's practice when disseminating within the facility responses to questions asked pursuant to this standard in order to ensure the sensitive information is not exploited to the detainee's detriment by staff or other detainees. The facility has neglected to provide this information; therefore, compliance with this subsection of the standard cannot be confirmed. To become compliant, the facility must provide a clear explanation as to how the information obtained pursuant to this standard is disseminated. The facility must also provide documentation to prove their process is being followed; this documentation can be presented in the form of a copy of the dissemination list in conjunction with five examples of the correspondence to the "need to know" staff listed in the dissemination list.

§115.42 - Use of assessment information.

Outcome: Does Not Meet

Notes:

(a) Policy 5.1.2.D AUR states, "Screening information form standard 115.41 shall be used to inform the assignment of detainees to housing, recreation and other activities, and voluntary work. Placements are decided on an individualized basis in order to ensure the safety of each detainee."

During their interviews, the PSA Compliance Manager/Investigator and a classification officer gave the Auditor an overview of how the risk assessment information is used to determine what is best for the detainee in terms of housing and other issues. They explained that they maintain an "at risk log" of potential victims and potential abusers, with these categories determined from the information on the SAAPI/PREA Risk Assessment tool. The Auditor also gained information about the use of assessment information from an intake officer he interviewed. The Auditor reviewed the AIPC SAAPI/PREA At-Risk Assessment Tracking Logs, which contained important information such as the date of arrival, PREA classification risk level for vulnerability or abusiveness (either high or medium high), offenses potential abusers have been charged with, housing assignments, and dates of completed 60–90-day reassessments. Following the on-site visit, the Auditor requested further documentation regarding how the facility utilizes the information when determining the detainee's recreation, other activities, and voluntary work. The Auditor requested that this information include a medical clearance or other work clearance of a detainee documenting the use of the screening information. As of the writing of this report, the documentation has not been received; and therefore, the Auditor could not confirm compliance.

Does Not Meet (a): Following the on-site visit, the Auditor requested further documentation regarding the facility's practice of using information received during the risk assessment to determine recreation and other activities, and volunteer work assignments. As of the writing of this report, the facility has neglected to provide this information; therefore, compliance with this subsection of the standard cannot be confirmed**.** To become compliant. the facility must provide the Auditor with five examples as to how the facility utilizes information obtained through the risk assessment for these other activities and assignments. An example of appropriate documentation to provide is how this information is used when determining kitchen work of other work or program assignment.

(b): Policy 5.1.2.D AUR requires, "the facility must consider the detainee's gender self-identification when making assessment and housing decisions for a transgender or intersex detainee, along with assessing how a placement might affect the detainee's health and safety and that AIPC must also consult a medical or mental health professional as soon as practicable when making an assessment." Policy 5.1.2.D AUR further states, "the placement of a transgender must not be based solely on the identity documents or physical anatomy but on the detainee's self-identification of his/her gender, along with the detainee's perceptions of his/her safety needs and must be consistent with the safety and security considerations of the facility…." Policy 5.1.2.D AUR requires transgender and intersex detainees be reassessed at least twice a year and that reassessments be completed through the use of the SAAPI Vulnerability Reassessment Questionnaire. Interviews with the intake officer and the classification officer confirmed this process. Following the post on-site visit, the facility provided to the Auditor a copy of the Intake Risk Assessment and two follow-up reassessments that confirmed the facility is in compliance with subsection (b) of the standard.

(c) Policy 5.1.2.D AUR, "allows transgender and intersex detainees the opportunity to shower separately from other detainees, when operationally feasible." The PSA Compliance Manger/Investigator told the Auditor if a transgender is in an open population dorm with private individual shower stalls and requests to shower separately by use of the Statement of Search/Shower/Pronoun Preference form that the detainee fills out upon arrival., the officers will set up a shower schedule to accommodate the detainee. The detainee would then be the only detainee showering at that time each day. There was one transgender detainee housed at AIPC during the on-site audit who self-identified at intake as being transgender. During her interview with the Auditor, she said she had no privacy issues because she was placed in an unoccupied twelve-bed housing unit by herself, after she requested not to be placed in an all-male unit.

§115.43 - Protective custody.

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

Notes:

(a)(b)(d)(e) Policy 5.1.2.D AUR requires that "in the event a vulnerable detainee must be placed in administrative segregation for protection, this placement will be as a last resort and for the least amount of time practicable." Policy 5.1.2.D AUR further states that AIPC "will document the reasonable efforts that were made and the alternatives that were considered and that the placement in administrative segregation for protection does not exceed 30 days." Policy 5.1.2.D AUR establishes the written procedures for the review of the placement of any detainee placed in administrative segregation for his or her safety, including requiring a review within 72 hours by supervisory staff to decide if the placement in segregation should continue. Policy 5.1.2.D AUR further requires that "supervisory staff must conduct an identical review no later than a week after the detainee is placed in administrative segregation and every seven days thereafter for the first two months, and every 10 days thereafter." According to policy 5.1.2.D AUR "The FOD must be notified within 72 hours of the initial placement in protective custody." Policy 5.1.2.D AUR further requires "procedures for the management of the administrative segregation unit should be developed in consultation with the ICE FOD having jurisdiction for the facility." The Auditor verified with the FA, the PSA Compliance Manager/Investigator, and the OIC that AIPC developed the administrative segregation procedures in consultation with ICE.

(c) Policy 5.1.2.D AUR states, "If a detainee is placed in segregated housing for protection because of sexual vulnerability, the detainee must have access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable." The FA, the COS, and the PSA Compliance Manager/Investigator all stated that if a detainee was in segregated housing to ensure his or her protection under PREA, the detainee would be able have access to all of the programs and services available to detainees in the general population to the maximum extent practicable.

According to the FA, the COS, and the PSA Compliance Manager/Investigator, no detainee had been placed in protective custody on the basis of vulnerability to sexual abuse during the audit period. The PSA Compliance Manager/Investigator stated in a memo that since there were no placements in protective custody/administrative segregation during the audit period, there were no notifications to the FOD required.

§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). Policy 5.1.2.D AUR requires AIPC "to provide detainees multiple ways to report to a public or private entity the occurrence of sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents." Policy 5.1.2.D AUR also requires "the facility must educate the detainee on how to make these reports, which can be oral, written, anonymous, or through a third party." Educating detainees on how to make reports actually begins at intake. AIPC provides instructions on how to contact a consular official, the DHS OIG, or other appropriate outside offices. The facility informs detainees of their right "to confidentially and, if desired, anonymously report these incidents." Detainees are also given instructions on how to contact outside entities that are not a part of the facility or agency, or what to do if they want to report these issues to a staff member, contractor, or volunteer at AIPC. The Auditor verified that this reporting information is provided in both the facility-specific detainee handbook and in the ICE National Detainee Handbook. The facility-specific handbook provides a method for making an anonymous report by dialing 9 on a telephone in the living unit and entering 000000# as the pin. The information also appears on signage throughout the facility. Both the handbooks, as well as the signage, contain names and telephone numbers for reporting sexual abuse. The Auditor verified the functioning of the ICE Detention Reporting and Information Line (DRIL). The detainees interviewed by the Auditor were all aware there were multiple ways to file reports, such as reporting to a staff member or making a call to a hotline, even though they all denied having ever made a report. They also knew that the report could be oral or written and could be anonymous. A few of the detainees, however, were unaware that they could have an outside person make an anonymous third-party report on their behalf.

(c) Policy 5.1.2.D AUR requires "AIPC staff to accept reports whether they are verbal, written, anonymous or third-party reports, and to document their receipt of a report." Although all of the staff interviewed by the Auditor said they had never actually received a report, all three of the closed allegations reported during the audit period came as a result of a detainee making the allegation to staff.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d) Policy 5.1.2.D AUR states, AIPC shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint and "the facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse." Policy 5.1.2.D AUR further dictates "in the case of any time-sensitive grievance, AIPC can address an emergency grievance expeditiously to address any immediate threat to detainee health, safety, or welfare related to a grievance about sexual abuse or assault. If there is a medical emergency, staff must immediately alert medical personnel for further assessment." Detainees can place grievances about PREA-related allegations into locked grievance boxes in the units. The Grievance Officer (GO) is the only person who can access these boxes.

(e) Policy 5.1.2.D AUR states, "The response time for AIPC to respond to the grievance is 5 days and a response time for addressing an appeal of the grievance is a maximum of 30 days, and all grievances related to sexual abuse and the facility's responses to those grievances be sent to the appropriate FOD at the end of the grievance process." The PSA Compliance Manager/Investigator stated in a memo that the facility had issued a decision on a PREA-related grievance within five days, while another memo stated there had been no appeals of decisions about PREA-related grievances during the audit period. The GO advised the Auditor that all responses to such grievances are done according to the timeframe set out in Policy 5.1.2.D AUR. She said that the FA is the final authority if there is an appeal of a decision regarding a PREA-related grievance. The Auditor reviewed a copy of a grievance that resulted in an investigation of staff-on-detainee sexual abuse. Although the grievance resulted in an investigation, the sections of the grievance titled, "Grievance Findings; Department Head Signature/Date; and Revied by/Date (Assistant Facility Administrator)" were all blank; and therefore, the Auditor could not confirm if the detainee received a decision to the grievance within the mandated five-day timeline. A further review of the investigation file confirmed that ICE officials were notified.

Does Not Meet (e): Subsection (e) of the standard requires the facility issue a decision on the grievance within five days of receipt. A grievance submitted by a detainee alleging sexual abuse by a staff member was incomplete including the section titled, "Grievance Findings," thus, subsection (e) of the standard could not be confirmed as compliant. To confirm compliance, the facility must submit, if available, a grievance alleging sexual abuse that is properly completed to allow the Auditor to verify the detainee is issued a decision with the timeframe allotted by the standard.

(f) Policy 5.1.2.D AUR policy outlines various ways a detainee can seek help for preparing a grievance, such as "from another detainee, the housing officer or other facility staff, family members, or legal representatives." The Auditor reviewed the information about grievances in the facility-specific and the ICE National Detainee Handbooks. Both handbooks explain that all detainees "can request help from staff, another detainee, family, friends, and others in filing a grievance." All of the detainees interviewed said they knew they could get help from facility staff or from an outside source like family to file a grievance. Staff members told the Auditor they were aware they could help a detainee file a PREA-related grievance, although no staff member interviewed had ever been asked for such help.

No detainee interviewed said he or she had ever filed a PREA-related grievance.

§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) Policy 5.1.2.D AUR requires the facility to "maintain or attempt to enter into a memoranda of understanding or other agreement with community service providers who can offer detainees confidential emotional support services related to sexual abuse while in custody; in the alternative, per policy, "if local providers are not available, AIPC is then required to seek national organizations that can provide legal advocacy and confidential emotional support services for immigrant victims of crime." Policy 5.1.2.D AUR further requires AIPC to keep copies of any such agreements, as well as maintain documentation of any unsuccessful attempt to enter into an agreement. Through an MOU with Blue Bench, which the Auditor reviewed, AIPC has ensured that outside victim support services are available to detainee victims, including support services in a hospital setting. The Auditor verified the facility-specific detainee handbook contained Blue Bench contact information and that posters throughout the facility also had the Blue Bench contact information. The MOU was renewed on March 31, 2021, with a one-year suspense date. The Auditor made two unsuccessful attempts to contact a representative of Blue Bench while he was on-site so he could learn more about their services. The PSA Compliance Manager/Investigator told the Auditor that Blue Bench was always reliable and responsive when he has needed them.

(d) Policy 5.1.2.D AUR states, "AIPC shall enable reasonable communication between detainees and organizations as well as inform detainees (prior to giving them access) of the extent to which policy governs monitoring of their communications and when reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." There are notices by all of the detainee phones that communications are subject to being monitored. The posters for Blue Bench and the DRIL line advise that these resources will take anonymous reports. The facility-specific handbook

provides a method for making an anonymous report by dialing 9 on a telephone in the living unit and entering 000000# as the pin. The MOU with Blue Bench refers to confidentiality of information, stating that such information will not be shared without the consent of the detainee; however, the MOU also refers to being governed by the laws of Colorado, so it is unclear if there are mandatory reporting laws limiting confidentiality for certain situations. While the facility does substantially comply with the requirement to let detainees know their phone calls to outside resources may be monitored, such as with their use of the telephones in the units, there is a lack of information for the detainees from AIPC about any limits to confidentiality when contacts with outside resources, such as with a victim advocate, are in person, and mandatory reporting situations.

Recommendation: Although there is a broad warning to detainees about telephone calls being subject to monitoring, there seems to be little information provided by AIPC about the degree of confidentiality a detainee can expect in contacting Blue Bench staff or other similar outside resources. The 2021 facility-specific handbook would seem the perfect place to convey that information, but the Auditor found nothing in the handbook about such confidentiality and the possible limits because of mandatory reporting laws in Colorado. It is recommended that the handbook be updated to include such information, or, in the alternative, that signage be created and displayed at APIC that would offer greater details to detainees regarding possible limits to confidentiality based on mandatory reporting laws.

§115.54 - Third-party reporting.

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

AIPC has established a method to receive third-party reports of detainee sexual abuse, and it is available to the public through its website and through postings in public areas of the facility. The Auditor accessed the GEO website http://geogroup.com/prea and verified it contains information on how to make a third-party report. He also accessed the ICE website, https://ice.gov/prea and verified that it also provides information on third-party reporting, which is accomplished by using the ICE ERO DRIL.

Through the Auditor's review of the three investigative files available for the audit period, the Auditor learned there had been no third-party reports.

§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) Policy 5.1.2.D AUR requires "staff to immediately report in accordance with Corporate policy any knowledge, suspicion, or information regarding any incident of sexual abuse/assault that occurred in a facility, whether or not it is a GEO facility." Policy 5.1.2.D AUR further directs that "staff must also report any retaliation against individuals or employees who reported such an incident or participated in an investigation of the incident, as well as any employee neglect or violation of responsibilities that may have contributed to an incident of sexual abuse/assault or retaliation." One section of policy 5.1.2.D AUR sets out a variety of ways for staff to make reports, such as reporting through the use of an employee hotline or reporting directly and privately to the Chief of Security, facility management, or the GEO Corporate PREA Coordinator. It is clear from policy 5.1.2.D AUR that "staff do not have to follow their chain of command when making a report." While at AIPC, the Auditor confirmed with both the FA, PSA Compliance Manager/Investigator, and the OIC that all of AIPC's policies and any changes to these policies are approved by ICE. The policy was approved by the Chief of Security and the ICE FOD during the annual policy review

Interviews with the PSA Compliance Manager/Investigator and random staff confirmed their awareness of the specifics of the policy and their duty to report as required by this standard. The Auditor's review of the three sexual abuse investigations allegations confirmed that all allegations during the audit period were presented to a staff member who immediately reported the allegation as required.

(c) Policy 5.1.2.D AUR informs employees about "the need to keep information about a sexual abuse report confidential and when it is permissible to divulge the information." The GEO Employee Handbook also has a section regarding the confidentiality of various types of sensitive information. All staff interviewed were aware of the need to maintain strict confidentiality about information regarding allegations of sexual abuse.

(d) Policy 5.1.2.D AUR also requires that "all allegations of sexual abuse or assault shall be immediately reported to a supervisor and the supervisor will then report the incident to ERO, and any other required entities based on the nature of the allegation." This subpart of the standard addresses reporting to State or local entities if the alleged victim of sexual abuse is under the age of 18; this subpart does not apply to AIPC since the facility does not house juveniles. According to the Auditor's interview with the PSA Compliance Manager/Investigator, if the alleged victim is a vulnerable adult the incident would be referred to the APD and any designated state and local agencies under mandatory reporting laws. The FA indicated that all mandatory reporting laws would be followed, including reporting to ICE and the corporate office.

§115.62 - Protection duties.

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

Policy 5.1.2.D AUR states, "Employees shall report and respond to all allegations of Sexually Abusive Behavior and employees are to assume that all reports of sexual victimization, regardless of the source of the report (i.e., "third party") are credible and respond accordingly. Additionally, policy 5.1.2.D AUR requires staff to handle the information about the situation throughout the investigation in a confidential manner, because of the need to respect the victim's security, identity and privacy and that conversations and contacts with the victim should be sensitive, supportive, and non-judgmental." While at AIPC, the Auditor interviewed the FA regarding the confidentiality of information. He stated they were keenly aware of the sensitive nature of the information they deal with daily regarding the detainee population. A review of the three investigative files submitted by the facility following the on-site visit confirmed that each detainee victim was properly separated from their alleged abuser immediately upon the facility receiving the allegation.

§115.63 - Report to other confinement facilities.

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

(a)(b) Policy 5.1.2.D AUR states, "If a detainee at AIPC alleges that an incident of sexual abuse occurred when he or she was at another facility, the FA or the AFA is to notify the FA (or designee) of the other facility within 72 hours and that ICE must be notified within that same timeframe. During the audit period, a detainee reported at intake an incident of sexual abuse at a previous facility. A July 8, 2021, memo from the PSA Compliance Manager/Investigator states the notification was made to the other facility within the required 72-hour timeframe. The PSA Compliance Manager told

the Auditor that he himself had made the notification to the other facility by telephone, followed by an email for documentation, as is the normal facility practice. He also notified the ERO OIC. A copy of the email sent by the PSA Compliance Manager to the Auditor post on-site visit confirmed compliance with this section of the standard. Policy 5.1.2.D AUR further policy requires that "all related documents to such a situation are to be sent to both the PSA Compliance Manager/Investigator and to the Corporate PREA Coordinator."

(c)(d) Whenever AIPC receives notification from another facility that a detainee alleged an act of sexual assault or abuse occurred when he or she was detained at AIPC, policy 5.1.2.D AUR requires an "investigation by qualified investigators and that a report be made to the appropriate ICE FOD." Policy 5.1.2.D AUR further requires, "any facility that receives notification of alleged abuse [must also] report [it] to the appropriate ICE Field Office Director, and to ensure the allegation is investigated in accordance with PREA standards."

§115.64 - Responder duties.

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

Notes:

(a) Policy 5.1.2.D AUR requires that "security first responders carry out the following tasks: "a. Separate the alleged victim and abuser; b. Immediately notify the on-duty security supervisor and remain on the scene until relieved by responding personnel; c. Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence; d. If the sexual abuse occurred within 96 hours, ensure that the alleged victim and abuser do not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating; e. The alleged victim and abuser should be placed (separately) in a dry cell or area where they cannot perform the following: washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating; until the forensic examination can be performed; f. A Security Staff member of the same sex shall be placed outside the cell or area for direct observation to ensure these actions are not performed." The Auditor interviewed six detention officers about their duties as first responders. Although staff carry a card with the first responder protocols on their person, the staff interviewed did not need to look at the cards when asked about their duties in the event of a report of sexual abuse. The staff credited their ability to be able to quickly recite the duties as a first responder was due to their annual training.

(b) A portion of the facility's policy addresses what should happen when the first responder is not a security staff member. Policy 5.1.2.D AUR states, "the non-security first responder must request that the alleged victim not take any actions that could destroy physical evidence, remain with the alleged victim, and notify security staff." Policy 5.1.2.D AUR further states, "the non-security first responder does not have any responsibility for directly ordering victims/abusers to take or not take certain actions, nor does the non-security staff have any responsibility for directing the placement of victims/abusers in another location." The only contractor the Auditor was able to interview stated she was a trained non-security first responder. She easily recited the duties that would be required of her without reference to her PREA informational card. She said the annual PREA training was very important in helping to keep the information fresh in her mind.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The AIPC "Sexual Abuse Response Team Protocol" (SARTP) (dated July 17, 2018, with a recent review date of May 5, 2021) sets out the roles and responsibilities of a multidisciplinary team in the event of an incident of sexual abuse. These roles would include, among other things, protecting the victim, preserving the scene and/or evidence, and making proper notifications at the facility, local, and agency level. The protocol directs that "staff are to treat all reports of sexual victimization, regardless of the source of the report…[as] credible" and to "treat information as confidential." The FA, the AFA, and the PSA Compliance Manager/Investigator told the Auditor that the coordinated response plan is covered in pre-service training (new staff), in-service training (retraining of staff), and shift briefings. The facility protocol outlines the coordinated actions for staff members with a variety of daily responsibilities so there is a multi-disciplinary approach to the incident. Those involved will include, but not necessarily be limited to, facility leadership, security supervisors, the PSA Compliance Manager, the investigator, and medical and mental health practitioners. Community crisis intervention personnel may also be involved, as well as hospital personnel such as a Sexual Assault Forensic Examiner (SAFE) or SANE.

(c)(d) Policy 5.1.2.D AUR requires "the facility, as permitted by law, to notify the receiving facility of the incident and the victim's potential need for medical or social services." This includes both DHS Immigration Detention Faculties and non-DHS facilities. A memo dated July 8, 2021, from the PSA Compliance Manager/Investigator stated, "During the year preceding the audit, the Aurora ICE Processing Center did not have any instances that required notification to the receiving facility that a victim of sexual abuse was transferred;" therefore, there were no documents from the audit period to review regarding the facility's practice. The PSA Compliance Manager/Investigator stated that AIPC would definitely ask a detainee victim his or her preference regarding disclosure of sexual abuse if the facility had knowledge the victim was being transferred to a non-DHS facility. However, he stated that ICE picks up detainees to be transported elsewhere, AIPC itself rarely has knowledge of exactly where the detainee is being transported. In an email received post audit, the facility advised the Auditor that if a detainee was being released from Aurora on bond, full-release, or deported, they may be unaware of where the detainee is going. However, if a detainee is being transferred to another facility, they would be notified of the detainee's destination and would forward a memorandum, along with the detainee's paperwork, to the AFA or PSA Compliance Manager of the receiving facility. Although there were no detainees transferred who were involved in an incident of sexual abuse during the audit period, the facility provided a copy of a blank memorandum that would accompany the detainee upon transfer should a situation occur.

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

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

Notes:

Policy 5.1.2.D AUR states, "if an employee, contractor, or volunteer is the alleged abuser, the individual will be removed from all duties requiring detainee contact pending the outcome of an investigation." Policy 5.1.2.D AUR also states that "GEO will not enter into or renew any collective bargaining agreement or other agreement that would limit the facility's ability to remove alleged employee abusers from detainee contact pending the outcome of an investigation or a determination of whether and to what extent discipline is warranted." The spreadsheet of allegations reviewed by the Auditor showed that two of the three closed sexual abuse allegations at AIPC during the audit period involved detainee-on-detainee allegations, with the third allegation involving a contractor. The Auditor interviewed the FA and the PSA Compliance Manager/Investigator, who confirmed that the facility always acts promptly to protect any detainee from an alleged abuser when an allegation is made.

The Auditor reviewed the contractor-on-detainee investigative file, which contained an order to immediately remove the contractor from detainee contact. This non-contact order remained in effect until the allegation was determined to be unfounded.

§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) Policy 5.1.2.D AUR prohibits "retaliation by staff, contractors, and volunteers against anyone, including a detainee, who reports, complains about, or participates in an investigation into an allegation of Sexual Abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." Policy 5.1.2.D AUR, like the standard, lists several options available to the facility for addressing the concerns of detainees and employees who are afraid of retaliation for reporting sexual abuse or for cooperating with investigations. Policy 5.1.2.D AUR requires "AIPC use multiple protection measures like changing housing assignments, removing the victim from contact with the alleged abuser, and providing emotional support services for detainees and employees…." There is a stringent monitoring process designed to remedy any possible problems that may arise related to retaliation. Policy 5.1.2.D AUR requires the PSA Compliance Manager or mental health personnel conduct the monitoring activities. A review of three closed investigation files submitted post on-site visit confirmed that the facility conducts monitoring of detainees and includes all elements required by the standard.

(c) The standard requires that the monitoring process last for "at least 90 days following a report of sexual abuse." The PSA Compliance Manager/Investigator told the Auditor he primarily performs this monitoring function for a minimum of 90 days unless certain conditions arise, such as transfer/discharge of the victim or the allegation is determined to be unfounded. The Auditor reviewed retaliation logs for the three victims from the closed cases during the audit period to confirm the facility's practices. The retaliation logs note the measures the facility took to protect the person, such as a change in housing or programs. Items that must be monitored include "disciplinary reports and housing or program changes…." Language at the bottom of the retaliation monitoring form states, "Mental health staff or PSA Compliance Manager shall meet weekly (beginning the week following the incident) with the alleged victim in private to ensure that sensitive information is not exploited by staff or others." A review of three closed investigation files submitted post on-site visit confirmed that the facility conducts monitoring of detainees for at least 90 days as required by the standard. An email provided by the facility post on-site audit confirmed that if a staff member alleges sexual abuse against a detainee, the PSA Compliance Manager, or a mental health professional would meet with that staff member weekly for a minimum of 90 days to monitor retaliation and that the meetings would be documented.

§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) Policy 5.1.2.D AUR states, "detainee victims of sexual abuse needing protection can be placed in a supportive environment that represents the least restrictive housing option possible…." The PSA Compliance Manager/Investigator explained that AIPC does not have a dedicated unit that could be considered "least restrictive" for the purpose of protective custody, although there is an administrative segregation unit. Therefore, placing the detainee victim in an environment that is supportive and where he or she feels safe may involve placing that person back in the general population after the abuser has been moved elsewhere, such as to administrative segregation. Should the victim not feel comfortable being returned to his or her original housing unit after the abuser has been removed, the detainee could possibly be offered a move to another open population unit to be away from the abuser. A memo from the PSA Compliance Manager/Investigator stated there had been no instances during the audit period where a detainee victim was placed in segregated housing to protect them from sexual abuse.

(c) Policy 5.1.2.D AUR also requires that "detainee victims must not be held for longer than five (5) days in any type of administrative segregation, except in unusual circumstances or at the request of the detainee…." Although there were no instances during the audit period where a detainee victim was paced in segregated housing to protect them from sexual abuse, the Auditor was furnished with a blank administrative detention order that would be used for such confinements, and it did contain a place to indicate if the confinement was at the request of the detainee. Policy 5.1.2.D AUR further dictates that "detainee victims placed in protective custody after having been subjected to sexual abuse must not be placed back in the general population until a proper reassessment is completed. If there are detainee victims held in protective custody for any length of time, reassessments must be done before the detainee is returned to the general population." The PSA Compliance Manager/Investigator stated in a memo there had been no victims of sexual abuse placed in protective custody for their safety and, the Auditor's review of three sexual abuse investigations files further confirmed that no detainee had been placed in protective custody related to an allegation of sexual abuse. Therefore, there was no documentation to review for compliance, either for reassessments. During their interviews, the FA, the COS, and the PSA Compliance Manager all indicated that the policy would be followed if a situation arose where post-allegation protective custody was considered or used.

(d) Policy 5.1.2.D AUR states that "a facility must notify the ICE FOD whenever any detainee victim has been held in administrative segregation for 72 hours." Since there were no detainee victims placed in protective custody for their protection during the audit period, there was no circumstance requiring a notification to the FOD.

§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)(d) Policy 5.1.2.D AUR dictates that, "An administrative investigation must be completed for all allegations of Sexual Abuse at GEO facilities. Such investigations are conducted by the PSA Compliance Manager/Investigator, who is a qualified, specially-trained investigator" and that "administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS and the assigned criminal investigative entity." The PSA Compliance Manager/Investigator seeks approval from ICE to begin an administrative investigation through an email request or a call followed by an email. Furthermore, the ICE OIC told the Auditor that all AIPC policies are approved by ICE, and the PSA Compliance Manager/Investigator told the Auditor that administrative investigations never proceed until after any criminal investigation is over and after he consults with the OIC. The Auditor reviewed the files for all three of the closed PREA cases for the audit period. The investigations were prompt and appeared to be thorough and objective. Even though all of the files reflected only an administrative investigation, documentation showed that the allegations were first referred to the APD. If a case is declined by APD, then the case belongs to AIPC and will be considered for an administrative investigation. The AIPC files the Auditor reviewed reflected any actions taken by APD on a case, such as assigning a case number file.

(c) Policy 5.1.2.D AUR states that "reports of an administrative investigation must include an effort to determine whether staff actions or failures to act contributed to the abuse; and…shall be in a written report format that includes at a minimum, a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings." Policy 5.1.2.D AUR further states, "investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall

interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of Sexual Abuse involving the suspected perpetrator," and, "AIPC shall retain all written reports…for as long as the alleged abuser is incarcerated or employed by the agency, plus five years; however, for any circumstance, files shall be retained no less than ten years." Interviews with the FA and the PSA Compliance Manager/Investigator reflected that AIPC is aware of the need for the coordination and sequencing of investigations to ensure criminal investigations by local law enforcement are not compromised by internal investigations. During his review of the allegation files from the audit period, the Auditor noted that each file contained material that met all or substantially all of the required provisions of subpart (c), such as preservation of evidence, witness statements, and review of prior complaints.

(e) Policy 5.1.2.D AUR requires that, "the departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for ending an investigation." The PSA Compliance Manager/Investigator confirmed that investigations would continue regardless of the departure of either the alleged abuser or alleged victim from AIPC. A review of three closed investigative files confirmed that the investigations continued following the detainee's release from custody.

(f) Notifications of allegations of sexual abuse involving potential criminal behavior are sent to both ICE and APD, although APD is the usual investigating entity. When outside agencies investigate, AIPC staff are expected to be cooperative; they are also expected to remain informed about the progress of the investigation. When the investigation is over, the facility will request a copy of the completed investigative file and then send the file to the GEO Corporate PREA Director for review and closure. The Auditor reviewed the MOU between the AIPC and APD that covers the parameters of the role of APD at the facility. The PSA Compliance Manager/Investigator noted that there is an excellent working relationship between AIPD and APD, and cooperation between the two entities is never a problem. A review of three closed investigative files confirmed compliance with subpart (f) of the standard.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

Policy 5.1.2.D AUR states that "a facility can impose no standard higher than a preponderance of the evidence in determining whether an administrative investigation can have a finding of substantiated." The Auditor's interview with the PSA Compliance Manager/Investigator verified that the facility will not impose a standard "higher than a preponderance of the evidence in determining whether allegations of sexual abuse are substantiated." The Auditor also reviewed the three closed investigative files and determined the PSA Compliance Manager/Investigator had used the preponderance of the evidence standard in making his determination at the conclusion of the cases.

§115.73 - Reporting to detainees.

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

Notes:

Policy 5.1.2-E-AUR outlines the reporting of investigation outcomes to detainees. The detainee is notified whether the allegation was determined substantiated, unsubstantiated, or unfounded through a written notification by the FA or designated staff member on the Notification of Outcome of Allegation Form. The detainee receives the original and a copy is maintained as part of the investigative file. Of the three cases closed at AIPC during the audit period, the PSA Compliance Manager/Investigator was able to deliver a notification to two of the detainees making an allegation. In the third case, the facility had indicated that the detainee was released prior to the conclusion of the investigation. The PSA Compliance Manager/Investigator explained that when a detainee is released from custody prior to the investigation being closed, he will forward the notification to the detainee if he has a forwarding address, and if he has no forwarding address, he will contact ICE to acquire further information about where to send the detainee notification. He said that ICE was unable to provide forwarding information in the third case and the file was documented to reflect the lack of forwarding information. The Auditor was unable to interview any detainees concerning a detainee notification because none of the detainees were still housed at AIPC during the on-site visit. The fact that two of the three detainees were notified regarding the outcome of their sexual abuse allegations and the third detainee reported no forwarding address making agency notification not feasible, the Auditor finds the standard to be in compliance.

§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) Policy 5.1.2.D AUR states that, "staff shall be subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiated allegations of Sexual Abuse or for violating agency or facility Sexual abuse policies." Policy 5.1.2.D AUR further states that "for staff who are the subject of a substantiated allegation, as well as staff who have violated agency Sexual Abuse rules, policies, or standards, termination is the presumptive disciplinary sanction…." A July 8, 2021, memo from the PSA Compliance Manager/Investigator stated that AIPC "did not have any staff terminations, resignations, or other sanctions for violating sexual abuse policies;" however, the facility provided a blank "Disciplinary Action Form" that AIPC uses for employee discipline. The Auditor verified through his interview with the ERO OIC that all facility policies and policy changes are approved by ICE.

(c) Policy 5.1.2.D AUR states, "the facility is required to report all removals or resignations in lieu of removal for violations of Agency or facility Sexual Abuse policies to appropriate law enforcement agencies, unless the activity was clearly not criminal." The HRM said during her interview that there had been no such situations during the audit period, but AIPC would report such situations if they occurred. A July 8, 2021, memo from the PSA Compliance Manager/Investigator states, "In the year preceding the audit, Aurora ICE Processing Center did not have any instances of notification of a licensing body."

(d): Policy 5.1.2.D AUR requires the facility to "make reasonable efforts to report removals or resignations in lieu of removal for violations of Agency or facility Sexual Abuse policies to any relevant licensing bodies to the extent known." The FA and the PSA Compliance Manager/Investigator stated in their interviews that AIPC would make a concerted effort to notify any relevant licensing bodies of staff removals or resignations in lieu of removal. As indicated earlier, in the year preceding the audit, AIPC did not have any instances of notification of a licensing body.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b) Policy 5.1.2.D AUR requires, "any contractor or volunteer who has engaged in Sexual Abuse shall be prohibited from contract with detainees. Each facility shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated Sexual Abuse by a contractor or Volunteer. Such incidents shall also be reported to law enforcement agencies, unless the activity was clearly not criminal." Policy 5.1.2.D AUR also directs that "a suspicion that a volunteer or contractor has committed sexual abuse is sufficient cause for removing that person from all duties requiring detainee contact pending the outcome of an investigation." The Auditor interviewed the PSA Compliance Manager/Investigator regarding this standard. He confirmed that there were no PREA-related infractions by either contractors or volunteers during the audit period and there were no instances where a report had to be made to any relevant licensing body or law enforcement entity. The PSA Compliance Manager/Investigator also provided a memo further explaining the process of making a report to a licensing board. Even though AIPC had no occasion to need to make such a report, the memo explained that the facility does not use a form to make a report to a licensing body. As he noted in the memo, "Such a notification to a licensing body would be conducted through the Colorado Department of Regulatory Agencies Division of Professions and Occupations website." Although there were no reports made to any outside bodies regarding volunteers or contractors during the audit period, the Auditor noted a "no contact" order in the allegation file from the audit period where the allegation involved an alleged contractor-on-detainee incident.

(c) Policy 5.2.1.D AUR dictates, "AIPC shall take appropriate remedial measures, and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in Sexual Abuse but have violated other provisions within these standards." Although there were no reports made to any outside bodies regarding volunteers or contractors during the audit period, the Auditor noted a "no contact" order in the allegation file from the audit period where the allegation involved an alleged contractor on detainee incident.

§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) Per Policy 5.1.2.E, "detainees are subject to disciplinary sanctions only after there has been a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse. The disciplinary process must include progressive levels of reviews, appeals, procedure, and documentation procedure[s]. If there are any sanctions, they have to be commensurate with the severity of the offense."

(d) Policy 5.1.2.E AUR requires "the disciplinary process must include a consideration of whether a mental illness or mental disability influenced the detainee's behavior, prior to the imposition of any sanctions." The PSA Compliance Manager/Investigator said AIPC would follow this policy, and the decision-makers would give due consideration to the possibility that a mental illness or mental disability might have affected the detainee's actions

(e)(f) Policy 5.1.2.E AUR states, "a facility is not allowed to discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact and a report of Sexual Abuse made in good faith and based upon a reasonable belief that the alleged conduct occurred does not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation."

The Auditor interviewed the FA and the PSA Compliance Manager/Investigator about the disciplinary process at AIPC when a detainee is found to have engaged in sexual abuse. They confirmed the process outlined in the above policy. A memo from the PSA Compliance Manager/Investigator stated that "During the year preceding audit, the Aurora ICE Processing Center did not have any instances of disciplinary sanctions for a detainee found to have engaged in sexual abuse." A review of three investigative files confirmed that AIPC did not have an instance of disciplinary sanctions for a detainee found to have engaged in sexual abuse.

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

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

Notes:

(a)(b)(c) Policy 5.1.2.D AUR dictates "if a detainee during intake assessment is determined by the intake staff to be at risk for either sexual victimization or abusiveness, or if the detainee has experienced prior victimization or has perpetrated sexual abuse, the detainee's assessment form shall be marked for immediate referral to a Qualified Medical and/or Mental Heal practitioner for medical and/or mental health follow-up as

appropriate." Policy 5.1.2.D AUR further states, "All intake Medical and Mental Health Screening forms shall be reviewed by medical daily for referrals. If the referral is for mental health services, the detainee must receive a mental health evaluation no later than 72 hours after the referral. Medical follow-up visits must occur no later than two (2) working days from the date of the referral." The timeframes set out in the AIPC policy conform to those in this standard.

The Auditor interviewed the AFA, the PA and the PSA Compliance Manager/Investigator and confirmed that the process for medical and mental health referrals followed the provisions of the facility's policy.

The Auditor reviewed a file for a detainee who was referred at intake for medical and/or mental health services. His review of the file established mental health referrals made at intake resulted in appointments within the time prescribed by the standard and the facility policy. In addition, the Auditor reviewed two intake risk assessments and the corresponding medical records further confirming standard compliance with the required medical and mental health evaluation timeframes.

§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) Policy 5.1.2.D AUR requires, "victims of sexual abuse in custody shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by medical and mental health practitioners." During his interviews with detainees, the Auditor asked if any of them had been referred for medical and/or mental health services. Although several of the detainees acknowledged being referred for mental health services—and some who even acknowledged being offered services through Blue Bench—no one would admit to receiving any mental health services. For those who said they had been referred for medical treatment, there was no hesitancy in admitting they received medical services and that such services had been effective. Review of three investigative files submitted post on-site confirmed that there were no incidents of sexual abuse that required the detainee be transported to an outside hospital for emergency medical care due to an incident of sexual abuse.

(b) Policy 5.1.2.D AUR states, "there is to be no financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." Both the PA and the PSA Compliance Manager/Investigator verified that the facility operates in accordance with the provisions of this standard.

§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) Policy 5.1.2.D AUR states, "AIPC shall offer medical and mental health evaluations (and treatment where appropriate) to all victims of Sexual Abuse while in immigration detention." The PA told the Auditor that alleged victims receive medical and mental health treatment as needed. Based on the three closed files reviewed by the Auditor, all three of the detainees who made allegations during the audit period were offered both medical and mental health services; these services were provided on the dates the allegations were reported.

(b) Under Policy 5.1.2.D AUR, "[t]he evaluation and treatment should include follow-up services, treatment plans, and (when necessary) referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Whether the victim is sent to a community hospital for further treatment or a forensic examination or whether the victim does not require treatment outside the facility, the facility will assume the responsibility for treatment plans—whether medical or mental health, or both—and follow-up services." The PA said that if the victims needed follow-up services after leaving AIPC—either upon release or transfer to another facility—the facility would work to provide sufficient information about the need for follow-up services, either to the receiving facility or to the victim him/herself if the detainee is being released to the street. A review of the three closed investigative reports verified that two contained the PREA Mental Health Incident Report; the report contained a checklist of all requirements noted in the standard. The third investigative report contained the detainee victim's mental health progress notes that corresponded to the alleged incident. All three pieces of documentation were carefully filled out and contained all elements of the standard.

(c) Policy 5.1.2.D AUR requires the services covered by this standard "be provided in a manner that is consistent with the level of care the individual would receive in the community." Both the PSA Compliance Manager and the PA told the Auditor that the services provided at AIPC are consistent with the level of care the detainee would receive in the community—if not better.

(d) Policy 5.1.2.D AUR dictates that, "victims of sexually abusive vaginal penetration by a male abuser while incarcerated will be offered pregnancy tests. If a pregnancy results from an instance of sexual abuse, the victim will receive timely and comprehensive information about lawful pregnancy-related medical services." According to the PA, if the facility had a situation with "abusive vaginal penetration by a male abuser" and/or a resulting pregnancy, AIPC would provide all services required by the facility's policy and the standard. He reported that there had been no such situations during the audit period.

(e) Policy 5.1.2.D AUR states, "victims will also be offered tests for sexually transmitted infections as medically appropriate." The PA said when victims go to the hospital for a forensic exam, they are routinely tested for such infections while they are there. The facility would provide treatment as needed when the victim returns to the facility. If a victim does not go to a hospital, the facility conducts the testing and provides treatment as needed. According to the PA, there have been no instances of a victim needing treatment for a sexually transmitted infection arising from a PREA incident during the audit period.

(f) Under Policy 5.1.2.D AUR, "there is to be no financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Medical services are to be provided at no cost to the victims, and the victims are not required to name the abusers or cooperate in any way with an investigation." Both the PSA Compliance Manager and the PA told the Auditor that detainee victims are never required to pay for any medical or mental health services. A review of the three closed investigative files confirmed there were zero incidents in which the detainee victim was transported to an outside hospital.

(g) Under Policy 5.1.2.D AUR, "the facility will attempt to conduct a mental health evaluation on all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by mental health practitioners." The documents reviewed by the Auditor consisted of a sample of clinical notes which included detainee referrals to mental health because of the probability of committing a sexual offense. The

Auditor also reviewed the "ICE At-Risk PREA Tracking Log," which lists the dates when detainees with a high risk of being abusive are offered mental health evaluations and whether or not they refused such evaluations.

When the Auditor was on-site, he reviewed 10 detainee medical/mental health files. The documentation in these files established that the detainee victims received appropriate care and treatment according to the standard. In a review of the three closed investigative files, one allegation was substantiated, and the detainee abuser was referred, and seen, by Mental Health as required by the standard.

§115.86 - Sexual abuse incident reviews.

Outcome Does not Meet Standard (requires corrective action)Choose an item.

Notes:

(a)(b) Policy 5.1.2.D AUR states, "within 30 days after the completion of every sexual abuse investigation, AIPC will conduct an incident review of all incidents--not just those that are substantiated or unsubstantiated. A review team will be comprised of upper-level management officials, the PSA Compliance Manager, [and] Medical and Mental Health Practitioners. The Corporate PREA Coordinator may attend either in person or via telephone. A written report (DHS Sexual Abuse or Assault Incident Review form) reflects the review team's findings and is "submitted to the local PSA Compliance Manager and the Corporate PREA Coordinator no later than 10 working days after the completion of the review. AIPC shall implement the recommendations for improvement or document its reasons for not doing so. The review team's reports, which cover findings and recommendations, if any, are also submitted to the ICE FOD or a designee" even though such submission is not required by the standard. The policy does not cover the standard requirement to forward a copy of the facility's report and response to the agency PREA Coordinator.

The Auditor confirmed the facility's practices as outlined in its policies through an interview with the PSA Compliance Manager/Investigator and through review of the three incident review reports completed for the allegations reported and closed during the audit period to verify that that they were done within the required timeframe. He confirmed the reports showed the review teams considered all of the elements required in subpart (b) of this standard. The reports the Auditor reviewed did not contain any recommendations for changes in the facility's policies or operations. A memo from the PSA Compliance Manager/Investigator stated that there had not been any instances where necessary changes in policy or practices were recommended. Therefore, no implementations were conducted. However, the facility's policy conforms to the standard in requiring a written response for the reasons for not implementing any recommendations a review team might make recommendations. The Auditor further reviewed the reports to confirm that they were forwarded to the agency PSA Coordinator as required by subsection (a) of the standard. The review confirmed that they were only forwarded to the FA and the Corporate PREA Compliance Manager.

Does Not Meet (a): The Auditor's review of the facility policy 5.1.2.D AUR does not require the facility to forward the incident report and response to the agency PREA Coordinator as required by subsection (a) of the standard. A review of the three investigative files confirmed that the facility forwards the incident report and response only to the facility FA and the Corporate PREA Compliance Manager; therefore, AIPC is non-compliant with this section of the standard. To become compliant the facility must also provide the Auditor with any incident reviews that occur during the CAP period documenting that their routing included the Agency PSA Coordinator. In addition, the Auditor recommends that the facility update policy to include the agency PSA Coordinator as part of the routing of the incident review and response for consistency with the standard requirement.

(c): The Auditor reviewed an unsigned PREA Annual Report submitted with the PAQ. The submitted documentation established that there is an annual review of sexual abuse investigations and incident reviews; this document also established that the results of the annual reviews are provided to the FA, FOD or his or her designee, and the agency PSA Coordinator, as noted in the standard. The review of the annual PREA Report along with the FA and the PSA Compliance Manager/Investigator interviews confirmed that the incident reviews from the audit period contained no recommendations for changes.

§115.87 - Data collection.

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

Notes:

The facility collects and retains data related to sexual abuse as directed by the corporate PREA Coordinator. Under policy 5.1.2.D AUR, "the data includes records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case dispositions, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary, and/or counseling in accordance with the PREA standards and applicable agency polices and established schedules." The facility's PSA Compliance Manager/Investigator told the Auditor he is responsible for compiling the data collected on sexual abuse incidents. Each month he forwards the DHS PREA Incident Tracking Log, a statistical report, to the corporate PREA Coordinator. The PSA Compliance Manager/Investigator creates and updates the PREA survey, which records basic information "for every allegation of sexual abuse and sexual activity as required." He submits these PREA surveys to GEO electronically through what is called its "PREA portal" so that the data from the surveys can be aggregated, and he also submits these surveys whenever an allegation occurs. Policy 5.1.2.D AUR further states "that data collected pursuant to this procedure shall be securely retained for at least 10 years of longer if required by state statute. Before making aggregated Sexual Abuse publicly available, all personal identifiers shall be removed."

The Auditor reviewed a sampling of the DHS monthly PREA incident tracking logs. The Auditor also reviewed records associated with allegations of sexual abuse, including incident reports, investigative reports, detainee information, case disposition, medical and mental health findings, and recommendations for post-release treatment. The PSA Compliance Manager/Investigator showed the Auditor that materials such as the case records of claims of sexual abuse are kept in a locked file cabinet in his office at AIPC, where he is the only person with access to these hard copy case records. Electronic files are on a protected server.

§115.201 - Scope of audits.

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

Notes:

(d): The Auditor was able to tour AIPC without restrictions.

(e): The Auditor was able to revisit various areas as needed, and facility staff promptly provided any documentation requested for the Auditor's comprehensive review of the facility's PREA practices.

(i): The Auditor was able to conduct private interviews with detainees and staff.

(j): The audit notice in English and Spanish was posted in all living units, but the Auditor did not receive any correspondence from either detainees or staff.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	4
Number of standards met:	30
Number of standards not met:	5
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Douglas K. Sproat, Jr. 9/19/2021

Auditor's Signature & Date

(b) (6), (b) (7)(C)

PREA Assistant Program Manager's Signature & Date 11/19/2021

(b) (6), (b) (7)(C)

PREA Program Manager's Signature & Date 11/19/2021

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

Homeland Security

SAUDITOR INFORMATION			
Name of Auditor:	Douglas K. Sproat, Jr.	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	601-832-[redacted]
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-[redacted]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Denver Field Office		
Field Office Director:	John Fabbricatore		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	12445 E. Caley Avenue, Centennial, CO 80111		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Aurora ICE Processing Center		
Physical address:	3130 Oakland St., Aurora CO 80111		
Mailing address: *(if different from above)*			
Telephone number:	303-361-6612		
Facility type:	CDF		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	303-739-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	303-739-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) audit of Aurora ICE Processing Center (AIPC), also known as the Denver Contract Detention Facility, was conducted on August 24 - August 26, 2021, by U. S. Department of Justice (DOJ) and U.S. Department of Homeland Security (DHS) certified PREA auditor Douglas K. Sproat Jr., for Creative Corrections, LLC. The Auditor was provided guidance during the report writing and review process by the U.S. Immigration and Customs Enforcement (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 facility is operated by the GEO Group Inc. (GEO) and contracted by ICE for the housing of adult male and female detainees to hold and process individuals who are awaiting the results of a judicial removal review. The purpose of the audit was to determine compliance with the DHS PREA standards. The PREA Incorporation date was May 6, 2014. This was the second DHS PREA audit of the facility. The audit period was August 2020 - August 2021. Due to unforeseen circumstances, this audit report was finalized by APM (b) (6), (b) (7)(C).

Upon completion of the audit, AIPC was found to be non-compliant with five standards. The facility's Corrective Action Period (CAP) began November 23, 2021 and ended May 22, 2022. The facility submitted documentation, through the Agency, for the CAP on March 8, 2022, through May 22, 2022. The Auditor reviewed the CAP and provided responses to the proposed corrective actions. The Auditor reviewed the final documentation submitted on May 22, 2022. The review of this documentation confirmed that all five standards are compliant in all material ways.

PROVISIONS

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

§115. 13 - Detainee supervision and monitoring

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

Notes:

(c): The Facility Administrator (FA), Prevention of Sexual Assault (PSA) Compliance Manager/Investigator, and Chief of Security (COS) told the Auditor their practice at AIPC is to follow all components of Policy 5.1.2.D-AUR and the standard when examining their staffing practices. Some of the key portions of the policy are the requirement for the facility to, "ensure it maintains sufficient supervision of detainees, including appropriate staffing levels and, where applicable, video monitoring to protect detainees against sexual abuse." As the administrators decide how to carry out their job of maintaining appropriate supervision of detainees and the extent to which video supervision is needed, the AIPC policy requires them to use these factors in their decision making: "1) Generally accepted detention and correctional practices; 2) Any judicial findings of inadequacy; 3) The physical layout; 4) The composition of the detainee population; 5) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; 6) The findings and recommendations of sexual abuse incident review reports; and 7) Any other relevant factors, including but not limited to the length of time detainees spend in AIPC custody." As noted in (a), a study of incident reviews for the period did not reflect any problems related to facility staffing. The facility submitted a copy of an undated staffing plan post on-site audit. In addition, they submitted an email confirming review of a 2021 staffing plan. However, neither document submitted confirmed that the facility, in developing the most recent staffing plan, considered the elements mandated by sub section (c) of the standard. The FA explained that the number of staff at AIPC is a contract requirement. (b) (7)(E) [redacted] These cameras operate 24 hours a day, 7 days a week. The cameras have pan/tilt/zoom capabilities but do not record sound. All cameras are monitored by the main control room officers. Video footage is recorded and archived in an on-site secure server for at least 90 days. the period did not reflect any problems related to facility staffing.

Does Not Meet (c): The facility submitted an undated copy of a staffing plan post on-site audit. In addition, the facility submitted an email stating the staffing plan for 2021 had been reviewed with no recommended changes. Neither document confirmed that the facility took into consideration generally accepted practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relative factors, including but not limited to the length of time detainees spend in agency custody. To come into compliance, the facility must demonstrate that all factors mandated by the standard are considered when determining adequate staffing levels for 2022. Confirmation of compliance can be determined by the facility submitting their staffing plan review for 2022.

Corrective Action Taken (c): The facility submitted the "Annual PREA Facility Assessment-Adult Prisons & Jails" staffing plan with a corresponding memo signed by the Facility Administrator. The plan took into consideration generally accepted practices, any judicial findings of inadequacy, the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, or any other relative factors, including but not limited to, the length of time detainees spend in agency custody. The plan was submitted on September 1, 2021, to the Agency PREA Coordinator; however, was not presented to the Auditor as requested, and therefore, the Auditor could not confirm compliance prior to the CAP period. Upon review of the submitted documentation, the Auditor finds that the facility is in compliance with subsection (c) of the standard.

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

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

Notes:

(e): Policy 5.1.2.D AUR requires, "any time after the initial assessment, a detainee shall be reassessed for risk of victimization or abusiveness when warranted based upon the receipt of additional, relevant information or following an incident [of]…abuse or victimization." The SAAPI Vulnerability Reassessment Questionnaire is used to conduct the reassessment. The questionnaire is brief, but a "yes" answer to certain questions requires a referral to a "PREA Committee/Classification Member" for review and follow up. The average length of stay at AIPC is 60.89 days. The Auditor reviewed two routine reassessments, both completed after a 60-day period. The PSA Compliance Manager/Investigator

informed the Auditor that additional reassessments will also take place whenever needed, such as when there has been an incident of victimization. He advised that the reassessments for alleged detainee victims, such as those from the audit period, are normally done by mental health staff. The Auditor requested post on-site audit that the facility provide the SAAPI Vulnerability Reassessment Questionnaire completed following the three sexual abuse investigations conducted during the audit period. The facility failed to provide the documentation; therefore, the Auditor could not confirm compliance with subsection (e) of the standard as it relates to this specific requirement.

Does Not Meet (e): Both subsection (e) of the standard and AUR Policy 5.1.2.D require that a detainee shall be reassessed following an incident of sexual abuse or victimization. In an interview with the PSA Compliance Manager/Investigator, it was determined that the facility utilizes the SAAPI Vulnerability Reassessment Questionnaire to conduct the reassessment. However, upon request from the Auditor, the facility could not provide copies of the reassessment form for detainees involved in the three sexual abuse investigations completed during the audit period; therefore, compliance could not be confirmed. To confirm compliance, the facility must provide copies of the SAAPI Vulnerability Reassessment Questionnaire for all sexual abuse allegation investigations that occur during the CAP process.

Corrective Action Taken (e): The facility submitted a "SAAPI Vulnerability Reassessment Questionnaire," dated December 27, 2021, that was completed following an allegation for sexual abuse. Upon review of the submitted documentation, the Auditor finds that the facility is in compliance with subsection (e) of the standard.

(f): Policy 5.1.2.D AUR requires that the facility will not, "discipline detainees for refusing to answer or for not providing complete information in response to certain screening questions." However, the policy does not specify which questions the detainee cannot be disciplined for if they refuse to answer. Following the on-site visit, the Auditor requested additional documentation that would further explain their policy regarding discipline for a detainee should he/she refuse to provide complete information, and/or refuse to answer questions pursuit to subsection (c) 1, 7, 8, 9 of the standard. As of the writing of this report, the facility has neglected to provide the requested information; therefore, there is not enough documentation to find this section of the standard compliant.

Does Not Meet (f): Policy 5.1.2.D AUR does not specify which questions the detainee cannot be disciplined for if they refuse to answer, and the facility did not provide an explanation after request to clarify their policy and confirm which questions the detainee would not be subject to discipline for should they refuse to answer. To become compliant, the facility must update their policy to be more exact as to what questions the detainee would not be disciplined for should they refuse to answer or provide complete information for them. If available, the facility must provide any documentation confirming a detainee was not disciplined for refusing to answer, and/or provide complete information when asked the questions outlined by (c) 1, 7, 8, 9 of the standard. Finally, the facility must provide documented training to both Intake and Classification staff regarding the new policy.

Corrective Action Taken (f): The facility submitted updated policy 5.1.2 D AUR section (c)(1)(h) which states, "Detainees shall not be disciplined for refusing to answer, or not disclosing complete information in response to the following questions on the risk assessment form: (a) whether the detainee has a mental, physical, or developmental disability; (b) whether the detainee has any convictions for sex offenses against an adult or child; (c) whether the detainee self-identifies as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; and (d) whether the detainee has concerns about his or her physical safety." In addition, the facility provided training sign-in sheets documenting that Intake and Classification staff received training on the updated policy. Per the facility, there were no detainees who refused to answer the PREA Intake question during the CAP period. Upon review of the submitted documentation, the Auditor finds that the facility is in compliance with subsection (f) of the standard.

(g): Policy 5.1.2.D AUR states, "AIPC shall implement appropriate controls on dissemination of responses to questions related to sexual victimization or abusiveness in order to ensure that sensitive information is not exploited by employees or other detainees." Following the on-site visit, the Auditor requested further documentation that would explain how the facility guarantees that the faculty has appropriate controls on the dissemination within the facility of responses to questions asked pursuant to standard 115.41. As of the writing of this report, the facility has neglected to provide any documentation that would confirm that they have an appropriate system in place; and therefore, they have not confirmed compliance with this section of the standard.

Does Not Meet (g): Following the on-site visit, the Auditor requested further documentation regarding the facility's practice when disseminating within the facility responses to questions asked pursuant to this standard in order to ensure the sensitive information is not exploited to the detainee's detriment by staff or other detainees. The facility has neglected to provide this information; therefore, compliance with this subsection of the standard cannot be confirmed. To become compliant, the facility must provide a clear explanation as to how the information obtained pursuant to this standard

is disseminated. The facility must also provide documentation to prove their process is being followed; this documentation can be presented in the form of a copy of the dissemination list in conjunction with five examples of the correspondence to the "need to know" staff listed in the dissemination list.

Corrective Action Taken (g): The facility submitted updated policy 5.1.2 AUR (C) (1) (c)(i)(j), which outlines the facility dissemination of sensitive detainee information. In addition, the facility submitted a memo, which contained the facility dissemination list and examples of correspondence to the members of the dissemination list utilizing a secured email system. Upon review of the submitted documentation, the Auditor finds that the facility is in compliance with subsection (g) of the standard.

§115. 42 - Use of assessment information

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

Notes:

(a): Policy 5.1.2.D AUR states, "Screening information form standard 115.41 shall be used to inform the assignment of detainees to housing, recreation and other activities, and voluntary work. Placements are decided on an individualized basis in order to ensure the safety of each detainee."

During their interviews, the PSA Compliance Manager/Investigator and a classification officer gave the Auditor an overview of how the risk assessment information is used to determine what is best for the detainee in terms of housing and other issues. They explained that they maintain an "at risk log" of potential victims and potential abusers, with these categories determined from the information on the SAAPI/PREA Risk Assessment tool. The Auditor also gained information about the use of assessment information from an intake officer he interviewed. The Auditor reviewed the AIPC SAAPI/PREA At Risk Assessment Tracking Logs, which contained important information such as the date of arrival, PREA classification risk level for vulnerability or abusiveness (either high or medium high), offenses potential abusers have been charged with, housing assignments, and dates of completed 60–90-day reassessments. Following the on-site visit, the Auditor requested further documentation regarding how the facility utilizes the information when determining the detainee's recreation, other activities, and voluntary work. The Auditor requested that this information include a medical clearance or other work clearance of a detainee documenting the use of the screening information. As of the writing of this report, the documentation has not been received; and therefore, the Auditor could not confirm compliance.

Does Not Meet (a): Following the on-site visit, the Auditor requested further documentation regarding the facility's practice of using information received during the risk assessment to determine recreation and other activities, and volunteer work assignments. As of the writing of this report, the facility has neglected to provide this information; therefore, compliance with this subsection of the standard cannot be confirmed. To become compliant, the facility must provide the Auditor with five examples as to how the facility utilizes information obtained through the risk assessment for these other activities and assignments. An example of appropriate documentation to provide is how this information is used when determining kitchen or other work, or a specific program assignment.

Corrective Action Taken (a): The facility provided an email to the Team Lead that states, "The detainee is in a cohort and will only be assigned to recreation and other activities and voluntary work in areas where only detainees in that same classification level are assigned." In addition, the facility provided a copy of the facility form, "Resident Voluntary Work/Activities Program Application," which supplements the ICE Custody Classification Worksheet (CCW). A review of the "Resident Voluntary Work/Activities Program Application, in conjunction with the CCW, confirms that the facility considers all information gathered during the initial risk assessment when determining recreation, and other activities, and volunteer work. As the new document was developed on or about May 13, 2022, the facility could not provide five examples of how the facility utilizes information obtained through the risk assessment when determining recreation, and other activities and/or volunteer work; however, based on the new practice, which meets all elements of subsection (a) of the standard, the Auditor finds that the facility is now in compliance with standard 115.42.

§115. 52 - Grievances

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

Notes:

(e): Policy 5.1.2.D AUR states, "The response time for AIPC to respond to the grievance is 5 days and a response time for addressing an appeal of the grievance is a maximum of 30 days, and all grievances related to sexual abuse and the facility's responses to those grievances be sent to the appropriate FOD at the end of the grievance process." The PSA Compliance Manager/Investigator stated in a memo that the facility had issued a decision on a PREA-related grievance within five days, while another memo stated there had been no appeals of decisions about PREA-related grievances during the audit period. The Grievance Officer (GO) advised the Auditor that all responses to such grievances are done according to the timeframe set out in Policy 5.1.2.D AUR. She said that the FA is the final authority if there is an appeal of a decision regarding a PREA-related grievance. The Auditor reviewed a copy of a grievance that resulted in an investigation of staff-on-detainee sexual

abuse. Although the grievance resulted in an investigation, the sections of the grievance titled, "Grievance Findings; Department Head Signature/Date; and Revied by/Date (Assistant Facility Administrator)" were all blank; and therefore, the Auditor could not confirm if the detainee received a decision to the grievance within the mandated five-day timeline. A further review of the investigation file confirmed that ICE officials were notified.

Does Not Meet (e): Subsection (e) of the standard requires the facility issue a decision on the grievance within five days of receipt. A grievance submitted by a detainee alleging sexual abuse by a staff member was incomplete including the section titled, "Grievance Findings," thus, subsection (e) of the standard could not be confirmed as compliant. To confirm compliance, the facility must submit, if available, a grievance alleging sexual abuse that is properly completed to allow the Auditor to verify the detainee is issued a decision with the timeframe allotted by the standard.

Corrective Action Taken (e): The facility provided a copy of a grievance submitted by a detainee, dated 5/4/22, that alleged an incident of sexual abuse. In addition, the facility provided a copy of the grievance response dated 5/5/22. Upon review of the submitted documentation, the Auditor finds that the facility is in compliance with subsection (e) of the standard.

§115. 86 - Sexual abuse incident reviews
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b): Policy 5.1.2.D AUR states, "Within 30 days after the completion of every sexual abuse investigation, AIPC will conduct an incident review of all incidents--not just those that are substantiated or unsubstantiated. A review team will be comprised of upper-level management officials, the PSA Compliance Manager, [and] Medical and Mental Health Practitioners. The Corporate PREA Coordinator may attend either in person or via telephone. A written report (DHS Sexual Abuse or Assault Incident Review form) reflects the review team's findings and is, "submitted to the local PSA Compliance Manager and the Corporate PREA Coordinator no later than 10 working days after the completion of the review. AIPC shall implement the recommendations for improvement or document its reasons for not doing so. The review team's reports, which cover findings and recommendations, if any, are also submitted to the ICE FOD or a designee even though such submission is not required by the standard." The policy does not cover the standard requirement to forward a copy of the facility's report and response to the agency PREA Coordinator.

The Auditor confirmed the facility's practices as outlined in its policies through an interview with the PSA Compliance Manager/Investigator and through review of the three incident review reports completed for the allegations reported and closed during the audit period to verify that that they were completed within the required timeframe. He confirmed the reports showed the review teams considered all of the elements required in subpart (b) of this standard. The reports the Auditor reviewed did not contain any recommendations for changes in the facility's policies or operations. A memo from the PSA Compliance Manager/Investigator stated that there had not been any instances where necessary changes in policy or practices were recommended. Therefore, no implementations were conducted. However, the facility's policy conforms to the standard in requiring a written response for the reasons for not implementing any recommendations a review team might make recommendations. The Auditor further reviewed the reports to confirm that they were forwarded to the agency PSA Coordinator as required by subsection (a) of the standard. The review confirmed that they were only forwarded to the FA and the Corporate PREA Compliance Manager.

Does Not Meet (a): The Auditor's review of the facility policy 5.1.2.D AUR does not require the facility to forward the incident report and response to the agency PREA Coordinator as required by subsection (a) of the standard. A review of the three investigative files confirmed that the facility forwards the incident report and response only to the facility FA and the Corporate PREA Compliance Manager; therefore, AIPC is non-compliant with this section of the standard. To become compliant the facility must also provide the Auditor with any incident reviews that occur during the CAP period documenting that their routing included the Agency PSA Coordinator. In addition, the Auditor recommends that the facility update policy to include the agency PSA Coordinator as part of the routing of the incident review and response for consistency with the standard requirement.

Corrective Action Taken (a): The facility submitted an email to the Agency PSA Coordinator with an incident review attached. Upon review of the submitted documentation, the Auditor finds that the facility is in compliance with subsection (a) of the standard.

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

Sabina Kaplan June 7, 2022
Auditor's Signature & Date

(b) (6), (b) (7)(C) June 14, 2022
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) June 14, 2022
Program Manager's Signature & Date