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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Joseph Martin	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	270 625-(b) (6), (b)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	El Paso Field Office
ICE Field Office Director:	William P. Joyce
PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	11541 Montana Ave, El Paso, TX 79936
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	ICE El Paso Hold Room		
Physical address:	11541 Montana Ave. El Paso, TX 79936		
Mailing address: *(if different from above)*			
Telephone number:	(915) 856-5504		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Field Office Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(915) 269-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Supervisory Detention and Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(915) 298-(b) (6), (b)

AUDIT FINDINGS

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS:

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

The Prison Rape Elimination Act (PREA) audit of the El Paso Hold room (EPHR) was conducted on June 12th and 13th, 2018, by Joseph Martin, a certified PREA Auditor contracted through Creative Corrections, LLC. This is the second PREA audit of the facility which is designated as a United States Immigration and Customs Enforcement (ICE) holding facility that temporarily holds male and female illegal immigrants for less than 12 hours.

The point of contact established for EPHR was through the External Reviews and Analysis Unit (ERAU) Team Lead (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) advised the Auditor prior to the on-site visit of the required standard documentation and Pre-Audit Questionnaire (PAQ) completion and upload on May 16, 2018 for review on the Department of Homeland Security (DHS) ERAU share point. The Auditor received no letters as a result of the audit notifications that were posted before the on-site visit. The Auditor observed these postings throughout the facility.

On June 12th, 2018 at approximately 8:00 a.m., an entry briefing was held with the following in attendance:

(b) (6), (b) (7)(C)	Team Lead, Office of Professional Responsibility(OPR)/ERAU
(b) (6), (b) (7)(C)	PREA Auditor, Creative Corrections LLC
(b) (6), (b) (7)(C)	Supervisory Detention and Deportation Officer(SDDO)
(b) (6), (b) (7)(C)	Deputy Field Office Director
(b) (6), (b) (7)(C)	Assistant Field Office Director(AFOD)
(b) (6), (b) (7)(C)	Assistant Field Office Director
(b) (6), (b) (7)(C)	SDDO

Following the Entry Briefing, Assistant Field Office Director (b) (6), (b) (7)(C) led the Auditor, (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) on a tour of the facility. Areas toured included the staff office areas, video monitoring room, sallyport, and processing area which included three holding rooms. The holding rooms have capacities that are 15, 34 and 3 for a total of 52. The Auditor spoke informally with staff during the tour.

(b) (7)(E) The facility has a total of (b) (7) cameras that include sound, pan, tilt and zoom capabilities. Each hold room has a toilet in the back with the larger hold room having two. Privacy partition walls are positioned between the toilet area and the sitting area in each hold room that provides sufficient coverage for detainees to perform bodily functions in privacy. Camera video was observed by the Auditor that ensured the restroom areas were not included on the live video monitoring. The Auditor also observed ICE Sexual Abuse & Assault information to include the agency's zero tolerance, reporting hotlines and information about crisis intervention services posted inside of each holding room in English and Spanish.

The El Paso Hold Room reported zero allegations of sexual abuse within the preceeding 12 months therefore, 36 months of data was used and there were no allegations during this timeframe. The total number of detainees booked in the last 12 months were 353 with 248 being male and 105 being female. The average stay of a detainee is two to three hours before they are transferred to another ICE facility, jail, deported or released. The facility employs 47 personnel with 40 being male and 7 being female. All staff that the Auditor had contact with were fluent in English and Spanish. Five of the 47 are supervisory personnel. The facility operates with three shifts that are scheduled from (b) (7)(E) - (b) (7)(E) . Sufficient number of staff are present on each shift to ensure adequate personnel are available for detainee supervision. The staffing plan ensures at least two staff are present in the processing/hold room area when detainees are present.

Immediately following the tour, the Auditor began the interview process. On the first day of the on-site visit, there was one male detainee. The facility staff advised the Auditor that the detainee was being unruly and advised against intervewing him. On the second day, the Auditor interviewed a male and female detainee using the Random Detainee interview guide. The male could speak English, and the female spoke Spanish. The Auditor used the Creative Corrections Interpreter Service, Language Service Associates, by using a telephone to perform the interview.

SDDO (b) (6), (b) (7)(C) served as the designee to be interviewed for 18 of the specialized interviews. Any reference throughout the report to the Designee for a particular standard will be SDDO (b) (6), (b) (7)(C) Specialized designee interviews were not completed on the following subjects, as they were non-applicable for the facility: contractor and volunteer training on sexual abuse, corrective action for contractors and volunteers, and case records associated with sexual abuse allegations. The facility employs no contractors or volunteers, and the facility is not responsible for maintaining case records related to sexual abuse allegations that occurred at the facility. In addition, 12 random samples of staff, contractor, and volunteer interviews were conducted, which included ICE staff of 7 that worked the (b) (7)(E) shift, 2 that worked the (b) (7)(E) shift and 3 that worked the (b) (7)(E) shift.

SUMMARY OF OVERALL FINDINGS:

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

On June 13th, 2018 an exit briefing was held with the following in attendance:

(b) (6), (b) (7)(C)	Team Lead, OPR/ERAU
(b) (6), (b) (7)(C)	PREA Auditor, Creative Corrections LLC
(b) (6), (b) (7)(C)	AFOD
(b) (6), (b) (7)(C)	Deputy Field Office Director
(b) (6), (b) (7)(C)	AFOD
(b) (6), (b) (7)(C)	SDDO
(b) (6), (b) (7)(C)	SDDO

The Auditor described the process for determination of compliance for the standards and expressed appreciation for the professionalism displayed by all staff throughout the audit process.

The Auditor found that EPHR met the following standards:
115.113, 115.118, 115.122, 115.131, 115.132, 115.134, 115.151, 115.154, 115.161, 115.162, 115.163, 115.164, 115.165, 115.166, 115.167, 115.171, 115.172, 115.176, 115.177, 115.182, 115.186, 115.201.

The Auditor found that EPHR did not meet the following standards:
115.115, 115.116, 115.117, 115.121, 115.141

The Auditor found the following standards N/A for EPHR:
115.114, 115.187

The justications for compliance, non-compliance or non-applicability are detailed below in each standard provision.

SUMMARY OF AUDIT FINDINGS	
Number of standards exceeded:	0
Number of standards met:	22
Number of standards not met:	5
Number of standards N/A:	2

PROVISIONS

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

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

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

Notes:

ICE policy 11062.2 Sexual Abuse and Assault Prevention and Intervention, mandates zero tolerance toward all forms of sexual abuse and outlines the approach to preventing, detecting and responding to sexual abuse. EPHR reported zero allegations of sexual abuse within the audit period. The staff interview of the Designee on Detainee Supervision and Monitoring indicated that staff members conduct regular security checks.

§115.113 – Detainee supervision and monitoring.

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

Notes:

(a) ICE policy 11087.1 Operations of ERO Holding Facilities, directs that sufficient supervision of detainees must be used in the operation of each facility. EPHR ensures a mandatory minimum number of two staff are on duty to supervise detainees. Video monitoring is used to assist in this supervision. EPHR operates three shifts and utilizes rosters and schedules to ensure sufficient staff are present at the facility.

(b) ICE policy 11087.1 directs comprehensive detainee supervision guidelines. EPHR uses these guidelines and utilizes the agency Holding Facility Self-Assessment Tool annually. The Auditor reviewed this tool that was provided as documentation. The last review was conducted on 12/13/2017.

(c) The designee on detainee supervision and monitoring interview indicated that adequate levels of staff are used on each of the three shifts in operating the facility. The physical layout of the facility allows for staff to see directly into each of the holding rooms due to large windows in between the holding rooms and the officer's station which is located within a few feet of each other. (b) (7)(E) [redacted] EPHR reported zero allegations of sexual abuse within the audit period.

§115.114 – Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

EPHR does not house juvenile detainees.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b) ICE policy 11087.1 states that cross-gender strip searches or cross-gender visual body cavity searches are not conducted except in exigent circumstances, including consideration of officer safety or by Medical Practitioners. The Designee on Viewing and Searching Detainees by Staff of the Opposite Gender interview indicated there are no cross-gender strip searches or visual body cavity searches done at the facility. EPHR does not house juvenile detainees.

(c) ICE policy 11087.1 states that all strip searches and visual body cavity searches shall be documented. EPHR does not perform these searches and there were zero occurrences within the audit period as indicated on the PAQ and as indicated by the Designee on Viewing and Searching Detainees by Staff of the Opposite Gender interview.

(d) ICE policy 11087.1 states that the Field Officer Director (FOD) shall ensure that detainees are permitted to shower, perform bodily functions and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine hold room checks, or is otherwise appropriate in connection with a medical exam or monitored bowel movement under medical supervision. The Auditor observed the holding rooms and the toilet area in each. Partial privacy walls provide sufficient coverage to allow detainees to perform bodily functions without being viewed by any staff. The Auditor also observed the camera angles and visually ensured they do not view the toilet areas. Detainees housed at EPHR do not shower or change clothing in the facility. EPHR reports no allegations of staff voyeurism within the audit period. Random staff interviews indicated that staff announce their presence when entering into any of the hold rooms.

(e) ICE policy 11087.1 states the detainees shall not be searched or physically examined for the sole purpose of determing the detainee's gender. The policy further states that conversations with the detainee, reviewing medical records or a broader medical exam by a medical practitioner may be used. The designee on viewing and searching detainees by staff of the opposite gender and random sample of staff interviews indicated knowledge of this policy and what options were allowable. EPHR has no medical staff employed but random sample staff interviews indicated that medical staff from the ICE detention facility nearby could be called if needed.

(f) The designee on viewing and searching detainees by staff of the opposite gender and random sample of staff interviews indicated staff had been trained on how to search detainees using the technique of male or female. However, through these interviews the Auditor determined that staff had not received training on how to search transgender and intersex detainees. Therefore, this section of the standard is non-compliant. The corrective action is to train staff to ensure they understand the differences in searching transgender and intersex detainees and document such training.

§115.116 – Accommodating detainees with disabilities and detainees who are limited English proficient.
Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) ICE policy 11081.1 states that detainees with disabilities including deaf or hard of hearing, blind or low vision, or those who have intellectual, psychiatric or speech disabilities have the opportunity to participate in or benefit from the agency's effort to prevent, detect and respond to sexual abuse. EPHR has PREA information posted in the processing area and in each of the holding rooms that includes information about the agency's zero tolerance for sexual abuse and assault, how to report sexual abuse by using a toll-free hotline, understanding victim reactions and crisis intervention services that are available. This information is posted in English and Spanish, and the reporting information is in several languages. The random staff interviews indicated that this information is not discussed when detainees are brought into the facility unless a detainee asks. The staff interviews also indicated that low vision detainees have been brought into the facility and have stated they were not in possession of their eye glasses and couldn't see to read without them. The Auditor asked if the PREA information was read to him or her and the common answer was no. For all detainees to benefit from this agency information, those who can't see to read, the information should be supplied in a different format so they also get the information that is posted. Therefore, this section of the standard is non-compliant. The corrective action could be that when staff gain knowledge that a detainee has low-vision or is blind that prevents them from reading the information posted in English or Spanish that the information should be read to them and documented so each and every detainee understands. This could be accomplished by staff reading the information to them and if the detainee does not understand English or Spanish that staff could use the interpretive services that the facility already has in place.

(b, c) ICE policy 11087.1 states that each facility shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect and respond to sexual abuse to detainees who are LEP. The Auditor found that the random staff interviews indicated that detainees who do not understand English or Spanish do not benefit from the posted PREA information as staff do not use the interpretive service to read the information to them. Therefore, this section of the standard is non-compliant. A corrective action could be to train staff to understand that when detainees come in who do not understand English or Spanish that the PREA information is read to them through the interpretive service that the facility already uses to communicate with them about their processing information. The designee on accomodating detainees with disabilities or who are LEP and random staff interviews indicated there have been no occurrences within the audit period. But if it was to occur, the interpreter translator service would be used when applicable and that other detainees may be used but detainees who were minors, alleged abusers, detainees who witnessed the abuse or detainees who have a significant relationship with the alleged abuser would not. The random staff and designee on accommodating detainees with disabilities interviews indicated each would help a detainee with disabilities that include those who are blind, deaf or illiterate in reporting allegations of sexual abuse. The Auditor received no indication that assistance devices such as TTY machine or Braile materials were available. The interview responses from the staff indicated for detainees that had disabilities such as deaf, hard of hearing, intellectual or psychiatric disabilities the PREA information would be relayed to them in a method they could understand by using any available means necessary. As stated above in section a, staff interviews indicated that detainees who were low vision were not read the PREA information upon intake to the facility. As noted above a corrective action could be for staff to read the PREA information to detainees who are low-vision or blind upon intake and document such was completed.

§115.117 – Hiring and promotion decisions.
Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a,b) ICE policy 6-7.0 ICE Personnel Security and Suitability Program directs the requirements of this standard to include asking required questions to applicants for new-hires or promotions. Any new-hire for the agency to include contractors and volunteers who may have contact with detainees are investigated to ensure they have not engaged in any acts that are prohibited in this standard. EPHR has had no promotions in the last 12 months. The Auditor used e-mail communication with (b) (6), (b) (7)(C) who is Unit Chief of the Personnel Security Unit of the OPR to corroborate the practice of asking the required questions to new-hires and promotions and background investigations being performed on new-hires, contractors and volunteers.

(c) ICE policy 6-7.0 states all new employees shall receive the required background investigation and shall be updated every five years. Two random staff were chosen to show initial background investigations and to show compliance with an updated investigation being conducted within the five year timeframe. The Auditor used e-mail communication with (b) (6), (b) (7)(C) who is the Unit Chief of the PSU of the OPR . (b) (6), (b) (7)(C) provided documentation of two EPHR staff with dates of their initial background investigation and with dates of their updated five year. One of the staff members showed the initial and updated background investigation with a timeframe of five years and two months and the other showed the staff member being submitted for processing on his five year aniiversary but the updated investigation was not completed. Upon further communication with (b) (6), (b) (7)(C) he explained the staff member was submitted for the updated 5 year to be completed which is a process that takes up to 195 days. Therefore, with this Auditor's understanding of the requirement of this standard to include the required five year timeframe and it being "conducted" this section of the standard is non-compliant. The process that takes up to 195 days is less than a reasonable timeframe to show compliance with the standard as it goes well beyond the five-years. A Corretive action could be to send names of applicable employees needing an updated five year background check at around the 54 month mark. This would allow the process to be complete at or near the five year period.

(d) ICE policy 6-8.0 ICE Suitability Screening Requirments for Contractor Personnel states that background investigations are conducted on contracted staff before they have contact with detainees. EPHR does not employ any contracted staff. Due to the policy 6-8.0 giving required procedures for contracted staff and the fact the facility does not employ any contracted staff this section is found to be compliant.

(e) The ICE background investigation process includes written information to the applicant that material ommissions or providing false information shall be grounds for termination or withdrawal of an offer of employment. Due to this agency process this section is found to be compliant.

(f) The Auditor contacted (b) (6), (b) (7)(C) Unit Chief of the Personnel Security Unit of the OPR, who stated that if a federal agency request background investigation material involving a former employee then it is provided. The Auditor contacted (b) (6), (b) (7)(C) ICE OPR Prevention of Sexual Assault Coordinator and she stated there is a protocol in place to provide such information to facilities that are non-federal agencies. A institutional employer would need to send a request and the information on substantiated allegations of sexual abuse would be provided.

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

Notes:

(a,b) EPHR is approximately two years old. It is obvious with the design of the facility that keeping detainees safe was considered when being constructed. The physical structures allow for direct and constant visual observation as the sallyport, processing area and hold rooms all have video monitoring to assist with direct observation to keep detainees safe from sexual abuse. The designee on upgrades to the holding facility and its technologies interview indicated the facility hasn't modified or expanded its physical build to include no new or updated video surveillance systems or monitoring technology has been added.

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

Notes:

(a, b) ICE policy 11062.2 Sexual Abuse and Assault Prevention and Intervention directs that sexual abuse allegations are coordinated by facility staff with the FOD, OPR , OIG and local law enforcement. Allegations that appear to be criminal are referred to the local police department. There were no investigations for the Auditor to reference for investigation practices. The Auditor determined that there is a process in place to ensure that sexual abuse allegations that occur at EPHR are handled within the guidelines of these sections of the standard.

(c,d) The designee on provision for forensic medical examinations interview indicated that detainee victims of sexual abuse would be taken to a local hospital for a forensic medical examination at no cost to the detainee when evidentarily or medically appropriate and that SAFE's or SANE's are employed at the local hospital which provides crisis intervention services. There was no evidence presented that indicated the facility has established a MOU with any local hospital or has had any contact to establish one. There have been no sexual abuse allegations within the audit period. It is recommended by the Auditor for the facility to establish contact with the hospital and to possibly reach an understanding detainees would be taken there in the need of a forensic exam.

(e) EPHR provided no documentation that it has requested the local law enforcement agency who peforms criminal investigations at the facility to adhere to the requirements of this standard specifically sections a through d. Therefore, this section of the standard is non-compliant. A corrective action would be for the facility to contact the agency and form written communication that requests them to follow the guidelines of this section.

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

Notes:

(a) ICE policy 11062.2 states immediately following notice of an alleged sexual abuse the FOD shall ensure the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator, notify the ICE Enforcement and Removal Operations (ERO) Assistant Director for Field Operations telephonically within two hours of the alleged abuse or as soon as practical, notify the ICE Joint Intake Center (JIC) telephonically within two hours and in writing within 24 hours through the ICE Notification Database.

(b) The Office of Professional Responsibility (OPR) shall coordinate with the FOD and facility staff to ensure evidence is appropriately secured and preserved pending the investigation. OPR shall coordinate with the Office of Inspector General (OIG) to effect timely acceptance of the case by OIG or referred to OPR for investigation. The designee on referring sexual abuse allegations for investigation interview corroborated this required protocol. There have been no allegations of sexual abuse within the audit period.

(c, d, e) ICE policy 11062.2 states that all allegations of sexual abuse are reported to OPR, the Joint Intake Center (JIC), local law enforcement when involving criminal behavior, and the ICE PSA Coordinator.In addition this policy directs that any alleged detainee victim of sexual abuse that is criminal in nature is provided timely access to relevant informational materials printed by U.S. Citizenship and Immigration Services.

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

Notes:

(a) ICE policy 11062.2 includes all the components of this section as required training. The random staff interviews indicated all have received the this training. EPHR employs no contractors or volunteers. The PAQ corroborated that all employees have received this training.

(b, c) The Auditor observed two staff certificate examples of PREA training that had been completed as outlined in section a. ICE conducts computer based PREA training for staff on an annual basis. EPHR employes no contractors or volunteers.

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

Notes:

ICE makes public its zero-tolerance policy by means of it's website (www.ice.gov). The Auditor observed the website to ensure it was easily accessible. EPHR has key information continuously and readily available to detainees by posting information in the processing area and hold rooms that contains information about the agency's zero-tolerance policy, information on reporting sexual abuse and crisis intervention services being readily available. This information is posted in English and Spanish.

§115.134 – Specialized training: Investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a) ICE policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as Office of Detention Oversight staff, and other OPR staff, as appropriate. The training should cover at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The Auditor reviewed the agency qualified investigator checklist which includes the definition of

a qualified investigator as an agency employee who has successfully completed both the general and specialized sexual abuse and assault trainings recognized by the agency, as well as any additional trainings identified by the agency or program office, in order to satisfactorily meet the agency's PREA mission. The Auditor reviewed the specialized investigator training curriculum and it includes topics of; implementing DHS PREA Investigative Requirements, Introduction to Advanced Forensic Techniques in Crime Scene Investigations, Investigating Incidents of Sexual Abuse and Assault, Legal Issues in PREA Administrative Investigations, Lesson Learned Through Postive PREA Outcomes, Preventing, Detecting and Responding to Sexual Abuse and Assault, and Requirements and Best Practices-LEP and Disability Accomodations and PREA.

(b) The OPR maintains documentation of staff that receive this specialized training. EPHR had no allegations or sexual abuse investigations in this audit period for the Auditor to reference the investigator's name to ensure the investigator had received specialized training.

§115.141 – Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) ICE policy 11087.1 states the requirements of agency staff to consider if a detainee may be high risk of being sexually abused and when necessariy taking steps to mitigate such danger. The designee on detainee risk assessment and random sample of staff interviews indicated staff conduct risk assessments by using personal observations, asking direct questions, using a standardized form for assessing detainees risk levels and by records check.

(b) EPHR does not house detainees overnight however in most cases the facility uses a standardized form for assessing detainees risk of sexual victimization and uses the information to hold separate from detainees who are violent or has a history of abusive acts.

(c) EPHR provided one example of documentation during the pre on-site visit phase. EPHR uses a standardized form that covers all the components of this section (1-9). However Random Staff interviews indicated that the standardized form for the Risk Assessment Classification (RCA) is only used for detainees that are being transferred to other ICE facilities for detention. Staff consistently said that if the detainee was going to be taken back to Mexico then the standardized form would not be used. In this case criminal records history and other documentation they would have, would cover most of the components except for section (7) which allows for the detainee to self-identify as being gay, lesbian, bisexual, transgender, intersex, or gender noncomforming. Therefore this section is non-compliant. All detainees should be able to self-identify upon admission to the facility and that information should be used in assessing detainees for risk of sexual victimization. Corrective action could be to train all staff to use the standardized form for all detainees or to ask this question in addition to other information available to gather all pertinent information in assessing for sexual victimization.

(d) ICE policy 11087.1 states the requirement of this section. The designee on detainee risk assessment and random staff interviews indicated staff use a heightened protection once a detainee is considered to be high-risk for sexual victimization. Staff stated they would more than likely sit the detainee outside of the holding rooms on a bench to keep him or her separate from other detainees or place him or her in a holding room alone.

(e) ICE policy 11087.1 states the requirements of the dissemination of sensitive information provided by the detainees. Random staff interviews indicated each knew his or her responsibility in keeping sensitive information private.

§115.151 – Detainee reporting.

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

Notes:

(a) ICE policy 11087.1 states the FOD shall ensure detainees have multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. This policy also states the FOD shall ensure instructions are provided to detainees on how to contact the DHS Office of Inspector General (OIG) to confidentially and , if desired, anonymously report these incidents. EPHR has posted information on how to report incidents involving a detainee or a staff person by, notifying a staff person, telling an ICE official or calling a toll free number that allows anonymous reporting. The designee on detainee reporting of sexual abuse and random staff interviews indicated verbal reports made to staff are reported immediately to the appropriate supervisor and first responder duties would be immediately conducted.

(b) ICE uses the OIG as an external entity for detainees to report sexual abuse by way of toll-free telephone numbers or by writing that allow for the caller to remain anonymous. The Auditor observed this information posted in the processing area and each of the holding rooms. This poster contains information on reporting sexual abuse and provides this information in seven different languages to assist detainees who are LEP. This reporting mechanism is posted in each holding room and on the bulletin board in the processing area. The random staff and designee on detainee reporting of sexual abuse interviews indicated any detainee would be allowed to call or write the OIG confidentially.

(c) ICE policy 11087.1 states that ICE Enforcement and Removal Operations (ERO) staff shall accept reports made verbally, in writing, anonymously, and from third parties and to promplty document verbal reports. The random sample of staff interviews indicated each of these reporting methods would be accepted and acted upon immediately to include ensuring verbal reports are documented.

§115.154 – Third-party reporting.

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

Notes:

ICE has established a method to receive third-party reports by using a toll-free hotline called the Detention Reporting and Information Line (DRIL). This hotline reporting method is published on the ICE website for public viewing and use when needed.

§115.161 – Staff reporting duties.

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

Notes:

(a, b) ICE policy 11062.2 requires staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred to any detainee; retaliation against detainees or staff who reported or participated in an investigation; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. ICE memorandum released from July 2, 2004 instructs all staff that they must report employee misconduct to the DHS, OIG, Joint Intake Center (JIC), or to an ICE OPR Field Office. These avenues of reporting offer staff a method of reporting outside of their chain of command. Random staff interviews indicated each understood his or her responsibility of reporting under the requirements of this standard.
EPHR reports zero allegations within the audit period.

(c) ICE policy 11062.2 states the requirements of this section to include staff not revealing any information related to sexual abuse other than anyone necessary. The designee on staff reporting duties and the random sample of staff interviews indicated each knew the requirements of confidentiality in regards to allegations of sexual abuse. EPHR reported no sexual abuse allegations within the last audit period.

(d) This section is N/A as EPHR does not house juveniles.

§115.162 – Agency protection duties.

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

Notes:

ICE policy 11062.2 states that if an ICE employee has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse he or she shall take immediate action to protect the detainee. The random sample of staff interviews indicated each knew their responsibility in protecting detainees and that each would take immediate action in doing so.

§115.163 – Report to other confinement facilities.

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

Notes:

(a,b,c,) ICE policy 11062.2 states that if an alleged assault occurred at a different facility from the one where it was reported, the administrator at the facility where the assault is alleged to have occurred is notified as soon as possible, but no later than 72 hours after receiving the allegation, and document such notification. The designee on receiving allegations from, and reporting to, other confinement facilities interview indicated if such an allegation were to occur at EPHR the OPR would be notified and OPR would notify the facility administrator where the alleged incident took place.

(d) ICE policy 11062.2 states that immediately following notice of an alleged sexual abuse or assault allegation when the incident occurs in ERO custody the FOD shall ensure the appropriate law enforcement agency having jurisdiction for the investigation has been notified; the FOD shall ensure the Assistant Director for Field Operations and JIC are notified. The designee on receiving allegations from, and reporting to, other confinement facilities interview indicated that if EPHR was to receive such a notification then it would be reported immediately following agency protocol.

§115.164 – Responder duties.

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

Notes:

(a) ICE policy 11087.1 directs the requirements of this standard ensuring separation of the alleged victim and abuser, preserving and protecting the crime scene, and preserving physical evidence on the alleged victim and abuser. The random sample of staff interviews indicated they knew to separate the alleged victim from the abuser and most knew to preserve and protect the crime scene. Some of the staff interviewed indicated he or she knew to request the alleged victim not to take any actions that could destroy physical evidence and to ensure the alleged abuser doesn't take any actions that could destroy physical evidence. Due to not all staff interviews indicating he or she knew all four steps of this section, the Auditor finds more training needs to be given on the requirements of requesting the alleged victim not to take any actions that could destroy physical evidence and ensuring the alleged abuser doesn't either. EPHR reports no allegations of sexual abuse within the last 12 months. The Auditor recommends training could include first responder protocol cards that each staff member could carry with him or her that could serve as a quick guide if needed.

(b) ICE policy 11087.1 directs that if a first responder is not a law enforcement staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify law enforcement staff. EPHR does not employ any non law enforcement staff members.

§115.165 – Coordinated response.

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

Notes:

(a, b, c) ICE policy 11087.1 states the FOD shall ensure a coordinated, multidisciplinary team approach to responding to allegations of sexual abuse and assault occurring in holding facilities. This approach includes detailing first responder duties, outlines FOD responsibilities to ensure access to Medical and Mental Health Care as well as Community and Victim Services and Forensic Medical Examinations. It also describes the role of other agency staff in response to such an allegation. This policy also states if a detainee victim is transferred from a holding facility to a detention facility or to a non-ICE facility the FOD shall inform the receiving facility of the incident and the victim's potential need for medical or mental health care or victim services. EPHR reports no sexual abuse allegations within the audit period. The designee on the facility's coordinated, multidisciplinary response to sexual abuse interview indicated the facility communicates verbally and electronically following the established policy protocol for allegations of sexual abuse. In addition, if detainee victims of sexual abuse are transferred the receiving facility would receive information about the allegation and the victim's potential need for medical or social services.

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

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

Notes:

ICE policy 11062.2 states the FOD shall ensure that an ICE employee, facility employee, contractor, or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring detainee contact pending the outcome of an investigation. The designee on protecting detainees from contact with alleged abusers interview indicated that immediate separation would occur between the alleged victim and alleged abuser. EPHR reported no allegations in the audit period. involving staff, contractors or volunteers.

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

Notes:

ICE policy 11062.2 states that agency employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. The designee on preventing or responding to retaliation interview indicated that supervisors would be responsible for ensuring no retaliation for reporting, complaining about, or participating in an investigation into a sexual abuse allegation.

§115.171 – Criminal and administrative investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a,b) ICE policy 11062.2 states the FOD shall ensure that Sexual Abuse investigatons are prompt, thorough and objective. This policy directs that the investigations are to be performed by qualified OPR staff in coordination with facility staff and local law enforcement agencies who has jurisdiction for the facility of the alleged sexual abuse when criminal behavior has been alleged.

(c, d) ICE policy 11062.2 states that the investigator specialized training shall cover, at a minimum, interviewing sexual abuse and assault victims sexual abuse and assault evidence collection in confinement settings, the criteria and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The Auditor reviewed the investigator specialized training curriculum and all topics outlined in section c are covered. EPHR reported no allegations of sexual abuse within the audit period.

(e) ICE policy 11062.2 states the FOD shall ensure facility staff cooperate with outside investigators and endeavor to remain informed about the progress of outside investigations. EPHR reported no allegations of sexual abuse in the audit period. The designee on coordinating with outside investigators interview indicated the facility would cooperate with outside law enforcement agencies and remain informed about the progress of the investigation.

§115.172 – Evidentiary standard for administrative investigations.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

ICE policy 11062.2 states that when an administrative investigation is undertaken, that no standard higher than a preponderance of the evidence is imposed in determining whether allegations of sexual abuse are substantiated. EPHR has had no allegations or administrative investigation in this audit period for the Auditor to review.

§115.176 – Disciplinary sanctions for staff.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a, c, d) ICE policy 11062.2 states that staff suspected of perpetrating detainee sexual abuse are removed of duties from detainee contact pending the outcome of the investigation. This policy also states upon receiving information from a FOD or Special Agent in Charge (SAC) of the removal or resignation in lieu of removal of staff for violating agency or facility sexual abuse and assault policies OPR shall report that information to appropriate law enforcement agencies, unless the activity was clearly not criminal and make reasonable efforts to report that information to any relevant licensing bodies, to the extent known. EPHR has had no allegations or investigations regarding staff to detainee sexual abuse during the audit period.

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

Notes:

(a, b) ICE policy 11062.2 states the FOD shall ensure that an ICE employee, facility employee, contractor or volunteer suspected of perpetrating sexual abuse or assault is removed from all duties requiring detainee contact pending the outcome of an investigation. The FOD also notifies the appropriate law enforcement agency, ERO's Assistant Director for Field Operations, and notifies JIC. This policy also states the OPR is responsible for making reasonable efforts to report information to any relevant licensing bodies, to the extent known. EPHR does not have or employ any volunteers or contractors as reported by SDDO (b) (7)(C), (b) (6)

§115.182 – Access to emergency medical services.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Notes:

(a, b) ICE policy 11062.2 states detainee victims of sexual abuse shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including contraception and sexual transmitted infections prophylaxsis, in accordance with professionally accepted standards of care and shall be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. EPHR reported no allegations of sexual abuse in the audit period. . The designee onaccess to emergency medical services for detainee victims of sexual abuse interview indicated if a detainee were to report being sexually abused the policy protocols would be followed.

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

Notes:

(a) ICE policy 11087.1 states the FOD shall conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault occurring at a holding facility, and unless the allegation was determined to be unfounded, prepare a written report recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse and assault. Such review, shall ordinarily occur within 30 days of ERO's receipt of the investigation results from the investigating authority. The FOD shall implement the recommendations for improvement, or shall document its reasons for not doing so, in a written justification. Both the report and justification shall be forwarded to the ICE PSA Coordinator. ICE has established a

departmental form to help ensure capturing all the required components of this standard. EPHR reported no allegations of sexual abuse in the last 12 months. The EPHR PAQ indicates this standard would be completed in the case a sexual abuse allegation was made.

§115.187 – Data collection.
Outcome: Not Applicable (provide explanation in notes)
Notes:

This standard is N/A as there are no records of sexual abuse at the facility, records are maintained by Headquarters. SDDO (b) (6), (b) (7)(C) stated that Headquaters maintains case records related to sexual abuse allegations.

§115.193 – Audits of standards.
Outcome: Not low risk
Notes:

EPHR is not low risk. The Auditor found five standards that the facility does not meet. The facility characteristics allow for constant and direct supervision of the detainees in each of the three hold rooms. Video monitoring is used in assisting detainee supervision. The facility has had no substantiated allegations during the review period. Due to the facility's non-compliance on four standards which are 115.115, 115.116, 115.117 and 115.141 the Auditor finds it to be not low risk.

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

The Auditor had access to and the opportunity to observe all areas of the facility, review relevant documentation to complete a thorough audit of the facility, and conduct private interviews with staff and detainees. The Auditor was able to receive confidential information or correspondence from detainees and staff during the audit process.

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.

Joseph Martin September 10, 2018
Auditor's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Joseph Martin	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	270 625-(b) (6), (b)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	El Paso Field Office
ICE Field Office Director:	William P. Joyce
PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	11541 Montana Ave, El Paso, TX 79936
Mailing address: *(if different from above)*	

INFORMATION ABOUT FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	ICE El Paso Hold Room		
Physical address:	11541 Montana Ave. El Paso, TX 79936		
Mailing address: *(if different from above)*			
Telephone number:	(915) 856-5504		
Facility type:	ICE Holding Facility		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Field Office Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(915) 269-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(D)	**Title:**	Supervisory Detention and Deportation Officer
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	(915) 298-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Auditor conducted the PREA audit of the El Paso Hold Room (EPHR) on June 12th and 13th, 2018. The audit indicated the facility was non-compliant on the following standards; 115.115 section f, 115.116 sections a and b, 115.117 section c, 115.121 section e, and 115.141 section c.

115.115 (f): On October 26, 2018, the Auditor received documentation that the facility has been brought into compliance on the above mentioned standards. EPHR held training for all staff in reference to cross-gender, transgender and intersex searches. The Auditor reviewed the curriculum used and staff acknowledgment forms which indicated all have received this training. This training and Auditor review brought standard 115.115 section f into "Meets" compliance.

115.116 (a,b): EPHR's Assistant Field Office Director provided guidance to the facility's' staff by referencing policy 11087.1 Operations of ERO Holding Facilities. This guidance explained that detainees who are disabled including blindness, low-vision or limited in his or her ability to read or understand English or Spanish shall be read the agency's zero-tolerance policy and reporting mechanisms in a format they can understand and such documented. This action brings standard 115.116 sections a and b into "Meets" compliance.

115.117 (c): Due to unforeseen circumstances, the original Auditor was unable to complete the review of the CAP documentation for standard 115.117 (c). For this reason, (b) (6), (b) (7)(C) a second certified PREA Auditor with Creative Corrections, LLC reviewed the CAP documentation submitted for this standard. Documentation provided in the CAP confirms that a plan was implemented that will assist the agency and facility to accomplish substantial compliance. An additional selection of staff by this Auditor was requested, and reviewed that confirmed each had received an updated background re-investigation within the past 5 yrs. After a review of the plan and the additional selection of staff and each of their respective updated background re-investigations, this standard is found to be compliant.

115.121 (e): On October 1, 2018 EPHR leadership engaged in discussion with the Fort Bliss Police Department and the facility has requested their assistance in sexual abuse and/or assault allegations and has asked that they follow the guidelines set forth in section a through d of this standard. This action brings standard 115.121 e into "Meets" compliance.

115.141 (c): ICE leadership provided guidance to EPHR of Directive 11087.1 which addresses the requirements of standard 115.141. Guidance was provided to all EPHR staff of the policy and procedures to ensure detainees are assessed for his or her risk of sexual victimization or abusiveness and when assessed for the either, he or she is not housed with another detainee who is assessed for the other. Therefore, this standard is now "Meets" compliance.

The facility has now met 29 of the 31 standards and 2 are non-applicable.

The tally in the final report was miscalculated; there were 24 standards met, 5 not met, and 2 non-applicable. Standards 115.193 and 115.201 were not initially calculated into the final report tally.

PROVISIONS

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

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

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

Notes:

(b) ICE policy 11087.1 states that cross-gender strip searches or cross-gender visual body cavity searches are not conducted except in exigent circumstances, including consideration of officer safety or by Medical Practitioners. The Designee on Viewing and Searching Detainees by Staff of the Opposite Gender interview indicated there are no cross-gender strip searches or visual body cavity searches done at the facility. EPHR does not house juvenile detainees.

(c) ICE policy 11087.1 states that all strip searches and visual body cavity searches shall be documented. EPHR does not perform these searches and there were zero occurrences within the audit period as indicated on the PAQ and as indicated by the Designee on Viewing and Searching Detainees by Staff of the Opposite Gender interview.

(d) ICE policy 11087.1 states that the Field Officer Director (FOD) shall ensure that detainees are permitted to shower, perform bodily functions and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine hold room checks, or is otherwise appropriate in connection with a medical exam or monitored bowel movement under medical supervision. The Auditor observed the holding rooms and the toilet area in each. Partial privacy walls provide sufficient coverage to allow detainees to perform bodily functions without being viewed by any staff. The Auditor also observed the camera angles and visually ensured they do not view the toilet areas. Detainees housed at EPHR do not shower or change clothing in the facility. EPHR reports no allegations of staff voyeurism within the audit period. Random staff interviews indicated that staff announce their presence when entering into any of the hold rooms.

(e) ICE policy 11087.1 states the detainees shall not be searched or physically examined for the sole purpose of determing the detainee's gender. The policy further states that conversations with the detainee, reviewing medical records or a broader medical exam by a medical practitioner may be used. The designee on viewing and searching detainees by staff of the opposite gender and random sample of staff interviews indicated knowledge of this policy and what options were allowable. EPHR has no medical staff employed but random sample staff interviews indicated that medical staff from the ICE detention facility nearby could be called if needed.

(f) The designee on viewing and searching detainees by staff of the opposite gender and random sample of staff interviews indicated staff had been trained on how to search detainees using the technique of male or female. However, through these interviews the Auditor determined that staff had not received training on how to search transgender and intersex detainees. Therefore, this section of the standard is non-compliant. The corrective action is to train staff to ensure they understand the differences in searching transgender and intersex detainees and document such training. EPHR has completed corrective action on this standard as of October 26, 2018. All staff were training and acknowledgment forms of such training were maintained of all facility staff. The Auditor reviewed the training curriculum used which covered cross-gender, transgender and intersex searches. In addition, the Auditor reviewed the training acknowledgment forms for all facility staff. This section is now compliant after corrective action was completed.

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

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

Notes:

(a) ICE policy 11081.1 states that detainees with disabilities including deaf or hard of hearing, blind or low vision, or those who have intellectual, psychiatric or speech disabilities have the opportunity to participate in or benefit from the agency's effort to prevent, detect and respond to sexual abuse. EPHR has PREA information posted in the processing area and in each of the holding rooms that includes information about the agency's zero tolerance for sexual abuse and assault, how to report sexual abuse by using a toll-free hotline, understanding victim reactions and crisis intervention services that are available. This information is posted in English and Spanish, and the reporting information is in several languages. The random staff interviews indicated that this information is not discussed when detainees are brought into the facility unless a detainee asks. The staff interviews also indicated that low vision detainees have been brought into the facility and have stated they were not in possession of their eye glasses and couldn't see to read without them. The Auditor asked if the PREA information was read to him or her and the common answer was no. For all detainees to benefit from this agency information, those who can't see to read, the information should be supplied in a different format so they also get the information that is posted. Therefore, this section of the standard is non-compliant. The corrective action could be that when staff gain knowledge that a detainee has low-vision or is blind that prevents them from reading the information posted in English or Spanish that the information should be read to them and documented so each and every detainee understands. This could be accomplished by staff reading the information to them and if the detainee does not understand English or Spanish that staff could use the interpretive services that the facility already has in place. The EPHR Assistant Field Office Director provided all facility staff with guidance and referenced ICE Directive 11087.1 which states disabled detainees shall be provided with in-person or telephonic interpretation services to ensure that PREA information that includes the agency's zero-tolerance policy and reporting mechanisms are read to detainees who are blind or have low vision. On October 26, 2018 the Auditor reviewed documentation from the AFOD memorandum to all EPHR staff which brings this section of the standard into "Meets" compliance.

(b) ICE policy 11087.1 states that each facility shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect and respond to sexual abuse to detainees who are LEP. The Auditor found that the random staff interviews indicated that detainees who do not understand English or Spanish do not benefit from the posted PREA information as staff do not use the interpretive service to read the information to them. Therefore, this section of the standard is non-compliant. A corrective action could be to train staff to understand that when detainees come in who do not understand English or Spanish that the PREA information is read to them through the interpretive service that the facility already uses to communicate with them about their processing information. The designee on accomodating detainees with disabilities or who are LEP and random staff interviews

indicated there have been no occurrences within the audit period. But if it was to occur, the interpreter translator service would be used when applicable and that other detainees may be used but detainees who were minors, alleged abusers, detainees who witnessed the abuse or detainees who have a significant relationship with the alleged abuser would not. The random staff and designee on accommodating detainees with disabilities interviews indicated each would help a detainee with disabilities that include those who are blind, deaf or illiterate in reporting allegations of sexual abuse. The Auditor received no indication that assistance devices such as TTY machine or Braile materials were available. The interview responses from the staff indicated for detainees that had disabilities such as deaf, hard of hearing, intellectual or psychiatric disabilities the PREA information would be relayed to them in a method they could understand by using any available means necessary. As stated above in section a, staff interviews indicated that detainees who were low vision were not read the PREA information upon intake to the facility. As noted above a corrective action could be for staff to read the PREA information to detainees who are low-vision or blind upon intake and document such was completed. The EPHR Assistant Field Office Director provided all facility staff with guidance and referenced ICE Directive 11087.1 which states disabled detainees shall be provided with in-person or telephonic interpretation services to ensure that PREA information that includes the agency's zero-tolerance policy and reporting mechanisms are read to detainees who are unable to read and understand English and Spanish. On October 26, 2018 the Auditor reviewed documentation from the AFOD memorandum to all EPHR staff which brings this section of the standard into "Meets" compliance.

(c) The designee on accomodating detainees with disabilities or who are LEP and random staff interviews indicated there have been no occurrences within the audit period. But if it was to occur, the interpreter translator service would be used when applicable and that other detainees may be used but detainees who were minors, alleged abusers, detainees who witnessed the abuse or detainees who have a significant relationship with the alleged abuser would not. The random staff and designee on accommodating detainees with disabilities interviews indicated each would help a detainee with disabilities that include those who are blind, deaf or illiterate in reporting allegations of sexual abuse

§115. 117 - Hiring and promotion decisions

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

Notes:

(a, b) ICE policy 6-7.0 ICE Personnel Security and Suitability Program directs the requirements of this standard to include asking required questions to applicants for new-hires or promotions. Any new-hire for the agency to include contractors and volunteers who may have contact with detainees are investigated to ensure they have not engaged in any acts that are prohibited in this standard. EPHR has had no promotions in the last 12 months. The Auditor used e-mail communication with (b) (6), (b) (7)(C) who is Unit Chief of the Personnel Security Unit of the OPR to corroborate the practice of asking the required questions to new-hires and promotions and background investigations being performed on new-hires, contractors and volunteers.

(c) ICE policy 6-7.0 states all new employees shall receive the required background investigation and shall be updated every five years. Two random staff were chosen to show initial background investigations and to show compliance with an updated investigation being conducted within the five year timeframe. The Auditor used e-mail communication with (b) (6), (b) (7)(C) who is the Unit Chief of the Personnel Security Unit (PSU) of the OPR . (b) (6), (b) (7)(C) provided documentation of two EPHR staff with dates of their initial background investigation and with dates of their updated five year. One of the staff members showed the initial and updated background investigation with a timeframe of five years and two months and the other showed the staff member being submitted for processing on his five year aniiversary but the updated investigation was not completed. Upon further communication with (b) (6), (b) (6), (b) (7)(C) he explained the staff member was submitted for the updated 5 year to be completed which is a process that takes up to 195 days. Therefore, with this Auditor's understanding of the requirement of this standard to include the required five year timeframe and it being "conducted" this section of the standard is non-compliant. The process that takes up to 195 days is less than a reasonable timeframe to show compliance with the standard as it goes well beyond the five-years. A proposed Corrective Action Plan (CAP) that was approved for implementation included the following step to assist the facility in achieving substantial compliance with this section of the standard. The ERO will request PSU for a roster of the reinvestigation due dates to provide to the AFOD to monitor and send notification to PSU to determine if the reinvestigation is on schedule. The facility will communicate with PSU six months prior to the expiration of the initial or previous investigation to initiate the reinvestigation of the employee(s). Email correspondence will be maintained in the employees record and will be provided as evidentiary documentation. On February 6, 2019 an additional random selection of eleven facility staff were submitted by (b) (6), (b) (7)(C) a certified PREA Auditor with Creative Corrections, LLC. The submission included a request for documentation reflecting dates of initial background investigations as well as the most recent background re-investigations. On February 10, 2019 the requested information was received and reviewed by Auditor (b) (6), (b) (7)(C) The review of the documentation reflected that the agency had conducted a background re-investigation of each of the staff selected within the past 5 yrs and since the DHS PREA Standards became effective March 7, 2014, this standard is found to be compliant.

(d) ICE policy 6-8.0 ICE Suitability Screening Requirments for Contractor Personnel states that background investigations are conducted on contracted staff before they have contact with detainees. EPHR does not employ any contracted staff. Due to the policy 6-8.0 giving required procedures for contracted staff and the fact the facility does not employ any contracted staff this section is found to be compliant.

(e) The ICE background investigation process includes written information to the applicant that material ommissions or providing false information shall be grounds for termination or withdrawal of an offer of employment. Due to this agency process this section is found to be compliant.

(f) The Auditor contacted (b) (6), (b) (7)(C) Unit Chief of the Personnel Security Unit of the OPR, who stated that if a federal agency request background investigation material involving a former employee then it is provided. The Auditor contacted (b) (6), (b) (7)(C) ICE OPR Prevention of Sexual Assault Coordinator and she stated there is a protocol in place to provide such information to facilities that are non-federal agencies. A institutional employer would need to send a request and the information on substantiated allegations of sexual abuse would be provided.

§115. 121 - Evidence protocols and forensic medical examinations

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

Notes:

(a, b) ICE policy 11062.2 Sexual Abuse and Assault Prevention and Intervention directs that sexual abuse allegations are coordinated by facility staff with the FOD, OPR , OIG and local law enforcement. Allegations that appear to be criminal are referred to the local police department. There were no investigations for the Auditor to reference for investigation practices. The Auditor determined that there is a process in place to ensure that sexual abuse allegations that occur at EPHR are handled within the guidelines of these sections of the standard.

(c, d) The designee on provision for forensic medical examinations interview indicated that detainee victims of sexual abuse would be taken to a local hospital for a forensic medical examination at no cost to the detainee when evidentarily or medically appropriate and that SAFE's or SANE's are employed at the local hospital which provides crisis intervention services. There was no evidence presented that indicated the facility has established a MOU with any local hospital or has had any contact to establish one. There have been no sexual abuse allegations within the audit period. It is recommended by the Auditor for the facility to establish contact with the hospital and to possibly reach an understanding detainees would be taken there in the need of a forensic exam.

(e) EPHR provided no documentation that it has requested the local law enforcement agency who peforms criminal investigations at the facility to adhere to the requirements of this standard specifically sections a through d. Therefore, this section of the standard is non-compliant. A corrective action would be for the facility to contact the agency and form written communication that requests them to follow the guidelines of this section. The Auditor reviewed a memorandum that stated on October 1, 2018 EPHR leadership communicated with the Fort Bliss Police Department and requested their assistance in investigating allegations of sexual abuse and/or assault and requested they follow the guidelines of this standard, specifically, sections a through d. The Auditor now finds this section of the standard as "Meets" compliance.

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

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

Notes:

(a) ICE policy 11087.1 states the requirements of agency staff to consider if a detainee may be high risk of being sexually abused and when necessariy taking steps to mitigate such danger. The designee on detainee risk assessment and random sample of staff interviews indicated staff conduct risk assessments by using personal observations, asking direct questions, using a standardized form for assessing detainees risk levels and by records check.

(b) EPHR does not house detainees overnight however in most cases the facility uses a standardized form for assessing detainees risk of sexual victimization and uses the information to hold separate from detainees who are violent or has a history of abusive acts.

(c) EPHR provided one example of documentation during the pre on-site visit phase. EPHR uses a standardized form that covers all the components of this section (1-9). However Random Staff interviews indicated that the standardized form for the Risk Assessment Classification (RCA) is only used for detainees that are being transferred to other ICE facilities for detention. Staff consistently said that if the detainee was going to be taken back to Mexico then the standardized form would not be used. In this case criminal records history and other documentation they would have, would cover most of the components except for section (7) which allows for the detainee to self-identify as being gay, lesbian, bisexual, transgender, intersex, or gender noncomforming. Therefore this section is non-compliant. All detainees should be able to self-identify upon admission to the facility and that information should be used in assessing detainees for risk of sexual victimization. Corrective action could be to train all staff to use the standardized form for all detainees or to ask this question in addition to other information available to gather all pertinent information in assessing for sexual victimization. On October 26, 2018 the Auditor received a memorandum that guidance was provided to EPHR users of ICE Directive 11087.1 which addresses the requirements of this standard to include allowing the detainee to self identify as being gay, lesbian, bisexual, transgender, intersex, or gender non-conforming. The Auditor finds this section to now be "Meets" compliance.

(d) ICE policy 11087.1 states the requirement of this section. The designee on detainee risk assessment and random staff interviews i indicated staff use a heightened protection once a detainee is considered to be high-risk for sexual victimization. Staff stated they would more than likely sit the detainee outside of the holding rooms on a bench to keep him or her separate from other detainees or place him or her in a holding room alone. ICE policy 11087.1 states the requirements of the dissemination of sensitive information provided by the detainees. Random staff interviews indicated each knew his or her responsibility in keeping sensitive information private.

§115. Choose an item.

Outcome: Choose an item.

Notes:

§115.193

Outcome: Low Risk

Notes:

EPHR is now at Low Risk. The Auditor found five standards during the audit that the facility did not meet compliance. The facility corrected all non-compliant standards during a corrective action period. The facility characteristics allow for constant and direct supervision of the detainees in each of the three hold rooms. Video monitoring is used in assisting detainee supervision. The facility has had no substantiated allegations during the review period. Due to the facility correcting standards previously found to be non-compliant and the favorable physical characteristics the facility is now at low risk for detainee sexual abuse.

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.

Joseph Martin(b) (6), (b) (7)(C)_____ February 15, 2019
Auditor's Signature & Date