Office of Professional Responsibility

CAP Final Determination Report and PREA Compliance Audit Report

El Paso Service Processing Center

July 16 - 18, 2024

U.S. Immigration and Customs Enforcement

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

Homeland Security

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INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	El Paso Service Processing Center		
Physical address:	8915 Montana Ave. El Paso, Texas 79925		
Telephone number:			
Facility type:	Service Processing Center		
PREA Incorporation Date:	9/22/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Assistant Field Office Director (AFOD)
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FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS

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

During the audit, the Auditor found El Paso Service Processing Center met 24 standards, had 1 standards that exceeded, had 1 standard that was non-applicable, and had 15 non-compliant standards. As a result of the facility being out of compliance with 15 standards, the facility entered into a 180-day corrective action period which began on September 13, 2024, and ended on March 12, 2025. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

Number of Standards Initially Not Met: 15

- §115.13 - Detainee supervision and monitoring.
- §115.15 - Limits to cross-gender viewing and searches.
- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.
- §115.17 - Hiring and promotion decisions.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.51 - Detainee reporting.
- §115.53 - Detainee access to outside confidential support services.
- §115.61 - Staff reporting duties.
- §115.64 - Responder duties.
- §115.65 - Coordinated response.
- §115.81 - Medical and mental health assessments; history of sexual abuse.
- §115.86 - Sexual abuse incident reviews.

Number of Standards Exceeded: 0

Number of Standards Met: 9

- §115.13 - Detainee supervision and monitoring.
- §115.15 - Limits to cross-gender viewing and searches.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.51 - Detainee reporting.
- §115.53 - Detainee access to outside confidential support services.
- §115.61 - Staff reporting duties.
- §115.64 - Responder duties.
- §115.65 - Coordinated response.
- §115.86 - Sexual abuse incident reviews.

Number of Standards Not Met: 6

- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.
- §115.17 - Hiring and promotion decisions.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.

- §115.42 - Use of assessment information.
- §115.81 - Medical and mental health assessments; history of sexual abuse.

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; compiles in all material ways with the standard for the relevant review period)

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "The EPC ensures that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse assault, other forms of violence or harassment, and to prevent significant self-harm and suicide. In determining adequate levels of detainee supervision and determining the need for video monitoring, the AFOD shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the compositions of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant factors." An interview with the AFOD, the facility PM, and PSA Compliance Manager indicated an assessment of the facility's staffing levels is conducted annually. In an interview with the PM, it was indicated the facility's staffing plan provides the minimum requirements for all security positions and the posts which are required to be filled. In an interview with the PM, it was further indicated the facility has been consistently staffed with more staff required by minimum requirements. However, in interviews with the PM and PSA Compliance Manager it was confirmed neither staff member could articulate the review considers all elements required by the facility policy and subsection (c) of this standard. During the on-site audit, the Auditor reviewed the facility comprehensive security guidelines and confirmed they had last been reviewed or updated on September 1, 2023. During the on-site audit, the Auditor observed no blind spots and the facility maintained adequate staff and video monitoring to protect detainees from sexual abuse.

(d): EPSPC policy 2.11 states, "Frequent unannounced security inspections shall be conducted on all shifts to control the introduction of contraband, identify, and deter sexual abuse of detainees; ensure safety, security, and good order, prevent escapes, maintain sanitary standards, and eliminate fire and safety hazards. This will include frequent security inspections of all personnel entering or exiting the secured perimeter of the EPC and shall prohibit staff from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operation functions of the facility." An interview with the PSA Compliance Manager indicated all security supervisors are required to conduct unannounced security inspections every day and on every shift. An interview with the PSA Compliance Manager further indicated each supervisor will document the unannounced security inspections in the housing unit logbooks in red ink. Interviews with two supervisors confirmed they conduct unannounced security rounds to review paperwork, such as the logbooks, check to ensure the officer has signed the comprehensive guideline review, and to make sure there is only one person in each bunk; however, interviews with two supervisors could not confirm unannounced security inspections are conducted to identify and deter sexual abuse. Interviews with two supervisors further indicated unannounced security inspections are also conducted in all areas of the facility, to include areas which may be closed at night. In addition, interviews with two supervisors confirmed staff are prohibited from notifying other staff the unannounced security inspections are occurring. During the on-site audit, the Auditor observed a supervisor conducting an unannounced security inspection, and confirmed he answered the phone ringing in the housing unit officer cage, and based on hearing the one-sided conversation, the officer in the first housing unit was calling to inform the second housing unit officer the supervisor was coming in through the bathroom gate. In addition,

following the phone call, the Auditor observed the supervisor counseling the officer over the phone and warning the officer they would be reprimanded should the officer notify other staff, unannounced security inspections were being conducted in the future.

Recommendation (d): The Auditor recommends the facility train all security staff on the requirements of subsection (d) of the standard which prohibits staff from notifying other staff, unannounced security inspections are being conducted.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. An interview with the AFOD, the facility PM, and PSA Compliance Manager indicated that an assessment of the facility's staffing levels is conducted annually; however, in interviews with the PM and PSA Compliance Manager it was confirmed neither staff member could articulate the review considers all elements required by the facility policy and subsection (c) of this standard. To become compliant, the facility must implement a process to assess staffing levels, and the need for video monitoring, to include consideration of generally accepted detention and correctional practices, 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, and any other relevant factors, including but not limited to the length of time detainees spend in the agency custody. Once implemented, the facility must submit documentation to confirm the assessment took into consideration all requirements of subsection (c) of the standard.

The facility is not in compliance with subsection (d) of the standard. Interviews with two supervisors confirmed they conduct unannounced security inspections to review paperwork, such as the logbooks, check to ensure the officer has signed the comprehensive guideline review, and to make sure there is only one person in each bunk; however, interviews with two supervisors could not confirm unannounced security inspections are conducted to identify and deter sexual abuse. To become compliant, the facility must submit documentation which confirms all security supervisors have received training on the requirements of subsection (d) of the standard to include unannounced security inspections are to be conducted to identify and deter sexual abuse.

Corrective Action Taken:

The facility submitted documentation to confirm the facility conducted an annual staffing meeting and completed an annual staffing plan, which included the facility's need for video monitoring, to include consideration of generally accepted detention and correctional practices, 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, and any other relevant factors, including but not limited to the length of time detainees spend in the agency custody. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

The facility submitted a training curriculum and training rosters which confirm all security supervisors have received training on the requirements of subsection (d) of the standard to include unannounced security inspections are to be conducted to identify and deter sexual abuse. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (d) of the standard.

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

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

Notes:

(b)(c)(d)(e)(f): EPSPC policy 2.11 states, "Pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down

search is required or in exigent circumstances. Pat-down searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All pat-down searches by staff of the opposite gender shall be documented. Strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches will be documented." The Auditor reviewed a memorandum to the file which states, "Concerning 115.15 (f)-Exhibit 6, Limits to Cross-Gender Viewing and Searches, there has been zero (0) cross-gender searches conducted within the last 12 months at the El Paso Processing Center (EPC). Supporting documentation stating zero strip searches will be provided." An interview with the PSA Compliance Manager indicated the facility does not conduct cross-gender pat-down searches, cross-gender strip searches, or visual body cavity searches, unless there are exigent circumstances. An interview with the PSA Compliance Manager further indicated if a cross-gender pat-down search, strip search, or visual cavity search was to occur at the facility it would be documented in the facility Detainee Strip Search and Cross-gender Logbook. During the on-site audit, the Auditor reviewed the Detainee Strip Search and Cross-gender Logbook and confirmed there were no cross-gender pat-down searches, strip searches, or visual cavity searches which occurred during the audit period. Interviews with six random DOs confirmed they were aware cross-gender pat-down searches, strip searches, cross-gender strip searches, and visual body cavity searches are strictly prohibited at EPSPC; however, if exigent circumstances, require a search to occur, it would be documented in the facility Detainee Strip Search and Cross-gender Logbook. In interviews with 27 detainees, it was indicated they are routinely pat-down searched when they leave the housing unit; however, the pat-down search is always conducted by staff of the same gender. In interviews with 27 detainees, it was further indicated none had been strip-searched while housed at EPSPC.

(g): EPSPC policy 2.11 states, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing. The officers and/or staff may proceed once the area is clear to enter." In an interview with the PSA Compliance Manager, it was indicated cross-gender supervisors do not conduct unannounced rounds in the housing units of the opposite gender detainees. In an interview with the PSA Compliance Manager, it was further indicated the facility procedures for entering the housing units require prior to cross-gender staff entering a housing unit, the staff member must notify the housing unit officer, 15 minutes before entering the housing unit, to allow all detainees to exit the shower and toilet areas which was observed by the Auditor during the on-site audit. An interview with the PSA Compliance Manager indicated facility procedures require staff of the opposite gender to call the housing unit 15 minutes prior to entering the housing unit and the officers assigned to the housing unit will instruct all detainees to exit the showers and the toilet areas, as opposite gender staff will be entering. An interview with the PSA Compliance Manager further indicated only male staff work in the male housing units and only female staff work in the female housing units and female staff can relieve a male officer, if necessary; however, the same procedure would be followed prior to the female officer entering the unit. During the on-site audit, the Auditor observed the 15-minute procedure and confirmed the detainees are given a 15-minute warning of opposite gender staff entering the housing units. Interviews with 27 random detainees indicated they are provided privacy while showering, using the toilet, or changing their clothes. Interviews with 27 random detainees further indicated they are always aware of opposite gender staff entering the housing area. During the on-site audit, the Auditor reviewed the facility control centers view of all housing units and toilet areas and confirmed a strategically placed black box prohibits cross gender viewing of detainees while using the toilet, changing, or showering. During the on-site audit, the Auditor further observed the processing (intake) area and confirmed the area is divided into a male side and a female side; however, on both sides, the holding cells have large windows, which enable staff of the opposite gender to visually monitor the detainees. In addition, during the on-site audit the Auditor observed in the holding cells on the male side, a moveable metal privacy barrier was

placed near the toilets; however, the moveable metal privacy barrier did not adequately shield the toilets from being viewing by cross-gender staff in the area. During the on-site audit the Auditor observed the female side had a permanent wall barrier around the toilet area; however, it did not adequately shield the toilets from being viewed by cross-gender staff assigned to the area.

(h): EPSPC is not designated as Family Residential Centers; and therefore, subsection (h) is not applicable.

(i)(j): EPSPC policy 2.11 states, "All pat-down searches shall be performed in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. Security staff shall be trained in proper procedures for conducting pat searches, including cross-gender pat searches and searches of transgender and intersex detainees." The Auditor reviewed the PPS Detainee Search curriculum and confirmed it states, "Detainee searches should be frequent, unannounced and conducted in a professional, dignified manner." The Auditor reviewed the Agency Cross-Gender, Transgender, and Intersex Searches curriculum and confirmed the curriculum includes the proper procedures for conducting pat-down searches including cross-gender pat-down searches and searches of transgender and intersex detainees. The Auditor 13 security staff files (10 DOs and 3 ICE staff) and confirmed all confirmed all staff had completed the facility Detainee Search training and the Agency Cross-Gender, Transgender, and Intersex Searches curriculum. Interviews with six random DOs confirmed they had received training in conducting pat-searches and pat-searches of transgender or intersex detainees. Interviews with six random DOs further confirmed each DO could articulate searches are conducted in a professional and respectful manner. In addition, interviews with six random DOs confirmed each DO could articulate a search of a transgender detainee could not be performed for the sole purpose of determining the detainee's genital status. During the on-site audit, the Auditor observed a pat-search of a detainee and confirmed staff of the same gender conducted the pat-search professionally and respectfully communicating with detainee as he conducted the search.

Corrective Action:

The facility is not in compliance with subsection (g) of the standard. During the on-site audit, the Auditor observed the processing (intake) area and confirmed the area is divided into a male side and a female side; however, on both sides, the holding cells have large windows, which enable staff of the opposite gender to visually monitor the detainees. During the on-site audit the Auditor further observed in the holding cells on the male side, a moveable metal privacy barrier was placed near the toilets; however, the moveable metal privacy barrier did not adequately shield the toilets from being viewing by cross-gender staff in the area. In addition, during the on-site audit the Auditor observed the female side had a permanent wall barrier around the toilet area; however, it did not adequately shield the toilets from being viewed by cross-gender staff assigned to the area. To become compliant, the facility must submit documentation to confirm the facility has implemented a process to ensure detainees are able to utilize the toilets in the holding cells without being viewed by staff of the opposite gender.

Corrective Action Taken:

The facility submitted five photographs which confirm frosted paint has been added to the lower part of the windows of the male and female sides of the processing hold room. In addition, the facility submitted two photographs of signs posted outside both holding rooms which states, "All personnel of the opposite gender must announce their presence and be granted access before entering an area where detainees are likely to be in a state of undress." Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (g) of the standard.

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

Outcome: Does not Meet Standard

Notes:

(a)(b): EPSPC policy 2.11 states, "The EPC shall take appropriate steps to ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and assault. Such steps will include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, by: (a) Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. (b) Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication. EPSPC will take 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 limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary." EPSPC policy 2.11 further states, "Where practicable, provisions for written translation of materials related to sexual abuse or assault shall be made for any significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." Interviews with the PSA Compliance Manager, two Processing Officers, and six random DOs indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse, to include but not limited to, the use of a teletypewriter (TTY), a Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for those detainees who are deaf or hard of hearing. Interviews with the PSA Compliance Manager, two Processing Officers, and six random DOs further indicated for detainees who have limited reading skills or are LEP, staff will utilize the facility language line to interpret the information or a staff interpreter, who is proficient in the detainee's preferred language. In addition, interviews with the PSA Compliance Manager, two Processing Officers, and six random DOs indicated if a detainee is blind, the staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. During the on-site audit, the Auditor observed the ICE National Detainee Handbook, and the DHS-prescribed Sexual Assault Awareness (SAA) Information pamphlet were readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese. In addition, the Auditor observed the facility Detainee Handbook, was readily available in four languages, to include English, Spanish, French, and Russian. In interviews with 19 LEP detainees it was indicated, during intake staff utilized either a staff member or the language line to interpret; however, information regarding sexual abuse was not read to them. In interviews with 18 LEP detainees, 8 detainees whose preferred language is Spanish confirmed all written material had been provided to them in Spanish; however, 3 detainees whose preferred language is Spanish, 1 detainee whose preferred language was Chinese, 1 detainee whose preferred language was Russian, 2 detainees whose preferred language was Arabic, 1 detainee whose preferred language was Iranian and 1detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with one detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. During the on-site audit, the Auditor observed a video of a detainee intake and confirmed the detainee had been given both handbooks and the DHS-prescribed SAA Information pamphlet; however, the Auditor could not confirm the material was given to the determine in the manner the detainee could understand. A review of 32 detainee files confirmed LEP detainees are not consistently provided written materials related to sexual abuse in a format or through methods resulting in effective communication.

(c): EPSPC policy 2.11 states, "In matters relating to allegations of sexual abuse, the facility will employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities

in accordance with professionally accepted standards of care. EPSPC will provide detainees with disabilities and detainees with limited English proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services will be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE/ERO determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse or assault, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse or assault." Interviews with six random DOs indicated if a detainee victim expressed a preference for another detainee to interpret, and it is approved by the Agency, they would accommodate the detainee victim and it would be documented in an incident report. Interviews with six random DOs further indicated all DOs interviewed was aware they could not utilize the alleged abuser, a detainee who witnessed the alleged abuse, or a detainee who has a significant relationship with the alleged abuser to interpret for the detainee victim. A review of 11 sexual abuse allegation investigations confirmed there were no instances where another detainee was utilized for interpretation during an allegation of sexual abuse investigation.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) if the standard. In interviews with 18 LEP detainees, eight detainees whose preferred language is Spanish confirmed all written material had been provided to them in Spanish; however, three detainees whose preferred language is Spanish, one detainee whose preferred language was Chinese, one detainee whose preferred language was Russian, two detainees whose preferred language was Arabic, one detainee whose preferred language was Iranian and one detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with one detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. A review of 32 detainee files confirmed LEP detainees are not consistently provided written materials related to sexual abuse in a format or through methods resulting in effective communication. To become compliant, the facility must implement a procedure to ensure all detainees with disabilities, to include limited English proficient, are provided meaningful access and an equal opportunity to participate in or benefit from all aspects of the Agency and the facility's efforts to prevent, detect, and respond to sexual abuse, in a manner they can understand. Once implemented the facility must submit documentation which confirms all applicable staff have been trained on the procedure. In addition, the facility must submit 10 detainee files, if applicable, specifically, detainee files which do not include detainees whose preferred language is English, Spanish, French, or Russian.

Corrective Action Taken:

The Auditor reviewed the updated checklist and confirmed the checklist documents the detainee has received the ICE National Detainee Handbook, the Local Detainee Handbook, Video Orientation, and the DHS prescribed SAA Information pamphlet. A review of the updated checklist, available on-site in English, Punjabi, Romanian, Russian, Turkish, Spanish, Arabic, Bengali, Chinese, French, Haitian-Creole, Hindi, Portuguese further confirmed the checklist includes the EPC zero-tolerance policy, prevention and self-protection, the investigative process, and definitions of sexual abuse. The facility submitted a transcript of the orientation video in English, Punjabi, Romanian, Russian, Turkish, Vietnamese, Spanish, Arabic, Bengali, Chinese, French, Haitian-Creole, Hindi, Portuguese. The facility submitted an Accessing Sign Language Services flyer. The facility submitted a training curriculum and staff sign in sheets which confirm staff have been trained in the new procedure. The facility submitted 10 detainee files. The Auditor reviewed the submitted files and confirmed the files included detainees whose preferred languages are Tigrinya (1), Turkish (2), Persian (3), Arabic (1), (Vietnamese) (1), Thai (1) and Uzbek (1). The Auditor reviewed the file of the detainee whose preferred language was Tigrinya and could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet; however, could confirm the detainee did not receive the local handbook or the information included in the facility PREA video in the detainee's preferred language. The Auditor reviewed the files of two

detainees whose preferred language was Turkish and could not confirm one of the detainees received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet in a language the detainees could understand and in the other file the Auditor could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet; however, could confirm the detainee did not receive the local detainee handbook in a language the detainee could understand. The Auditor reviewed the file of three detainees whose preferred language was Persian and could not confirm the detainees received either the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet in the detainees' preferred language; however, could confirm under the section which included the local handbook the facility indicated N/A and none. The Auditor reviewed the file of one detainee whose preferred language was Arabic and could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet in the detainee's preferred language. The Auditor reviewed the file of one detainee whose preferred language was Vietnamese and could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet in the detainee's preferred language; however, could confirm under the section which included the local handbook the facility indicated none. The Auditor reviewed the file of one detainee whose preferred language was Thai and could not confirm the detainee received either the ICE National Detainee Handbook, DHS prescribed SAA Information pamphlet, or the local handbook in the detainee's preferred language. The Auditor reviewed the file of one detainee whose preferred language was Uzbek and could not confirm the detainee received either the ICE National Detainee Handbook, DHS prescribed SAA Information, or the local handbook in the detainee's preferred language. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsections (a) and (b) of the standard.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. EPSPC policy 2.11 states, "The EPC shall not hire or promote anyone who may have interactions with detainees, and shall not enlist the services of any contractor or volunteer who may have interaction with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution; who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. When the EPC is considering hiring or promoting staff, it shall ask all applicants who may have contact with detainees directly about previous misconduct described in paragraph (a) of this section, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The EPC shall also enforce upon employees a continuing affirmative duty to disclose any such misbehavior. Before hiring new employees, who may have contact with detainees, the EPC shall require a background investigation to regulate whether the candidate for hire

is suitable for employment with the agency. The agency shall conduct an updated background investigation for agency employees every five years. The EPC shall also perform a background investigation before soliciting the services of any contractor who may interact with detainees. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate. Unless prohibited by law, the EPC shall provide information on substantiated allegations of sexual abuse involving a former employee upon receiving a request from an intuitional employer for whom such employee has applied to work." An interview with the HRM indicated all potential employees and contractors are required to complete an application on-line, and an interview, and if accepted they are given a conditional offer of employment pending proof of eligibility to work in the United States, completion of a satisfactory background investigation, and reference checks. An interview with the HRM further indicated background investigations are completed by the Personnel Security Unit (PSU), to determine suitability for employment with both the Agency and the facility and the PSU will conduct a background investigation every five years on all Agency staff and facility staff. In addition, in an interview with the HRM it was indicated all potential employees, contractors, and volunteers are required to complete a DHS 6 Code of Federal Regulations Part 115 form during the hiring process and each employee is required to complete the form during their annual in-service training and during a promotion process. In an interview with the HRM it was further indicated if she receives a request from an institutional employer regarding a former employee, if there was a substantiated allegation of sexual abuse, in the prospective employee's file, she would share the information. During the on-site audit, the Auditor reviewed the on-line application and confirmed the applicant is required to sign the following statement, "I understand that I may be found "unfit for duty" for the following "Falsification or unlawful concealment, removal, mutilation or destruction of any official documents or records, or concealment of material facts by willful omissions from official documents or records including, but not limited to, logbooks, statements related to investigations, and other utterance, whether written or verbal of an untruthful nature." During the on-site audit, the Auditor further reviewed the DHS 6 Code of Federal Regulations Part 115 form and confirmed the form asks, "Have you ever been found to have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution, or convicted of engaging or attempting to engage in sexual activity with any person by force, threat of force or coercion or if the victim did not or could not consent? Have you been civilly or administratively adjudicated to have engaged in the activity described above? Have you been found to have engaged in sexual harassment at work?" A review of the DHS 6 Code of Federal Regulations Part 115 form further confirmed the participant is required to acknowledge by signature the following statement, "I understand that a knowing and willful false response may result in a negative finding regarding my fitness as a contract employee supporting ICE. Furthermore, should my answers change at any time I understand I am responsible for immediately reporting the information to my Program Manager." An interview with the AFOD indicated there have been four Agency promotions within the past year, to include himself and he did not believe he, or the other staff, were required to complete the DHS 6 Code of Federal Regulations Part 115, as part of the promotion process. The Auditor reviewed 16 files, which included 10 DOs, 3 contractor staff (2 ACEPEX Management Corporation, 1 Magavi Enterprises), and 3 volunteers and confirmed a DHS 6 Code form had been completed annually during the in-service training. In addition, a review of the files confirmed three of the facility staff had received a promotion during the audit period and had completed a DHS 6 Code form prior to the promotion. The Auditor submitted 20 names which included 10 facility staff, 7 contract staff (4 STG medical, 2 ACEPEX Management Corporation, 1 Magavi Enterprises), and 3 ICE staff utilizing the PSU Background Investigation for Employees and Contractors to PSU to confirm completion of initial background investigations, use of the DHS 6 Code of Federal Regulations Part 115 form, and background investigations being completed every five years. Documentation confirming completion had been received for all names except for the four contracted STG medical staff as PSU could not locate the records; and therefore, the Auditor could not confirm completion of initial background investigations or use of the DHS 6 Code of Federal Regulations Part 115 form prior to hiring contracted STG medical staff.

Corrective Action:

The facility is not in compliance with subsections (b) and (d) of the standard. An interview with the AFOD indicated there have been four agency promotions within the past year, to include himself. He indicated he did not believe he or the other staff were required to complete the DHS 6 Code of Federal Regulations Part 115, as part of the promotion process. The Auditor submitted the names of four STG contracted medical staff, utilizing the PSU Background Investigation for Employees and Contractors to PSU to confirm completion of initial background investigations and the DHS 6 Code of Federal Regulations Part 115 form; however, could not confirm completion of initial background investigations or use of the DHS 6 Code of Federal Regulations Part 115 form prior to hiring the STG contracted medical staff. To become compliant, the Agency shall implement a process to ensure that prior to promotions, staff are asked about previous misconduct described in subsection (a) of the standard. The facility must implement a practice which requires all STG contract staff complete both a background check and the DHS 6 Code of Federal Regulations Part 115 form prior to hiring. In addition, the facility must submit documentation that all STG contract staff employed at the facility have completed both a background check and the DHS 6 Code of Federal Regulations Part 115 form.

Corrective Action Taken:

The Agency submitted an email form the PSU Unit Chief which states, "For the federal staff promotions, OHC notifies us that the individual has selected the tentative job offer and PSD then collects the "PREA Questionnaire" as part of our vetting process. The process is typically confirmed by PSD during the auditor's email to PSD for the background info." Based on the information provided regarding receiving the "PREA Questionnaire" as part of the Agency's vetting process the Auditor accepts the submitted documentation and finds the Agency in substantial compliance with subsection (b) of the standard. The facility submitted a hiring roster; however, the outcome of documentation submitted to PSD by the Auditor would be received following the date of final submission for corrective action: March 12, 2025; and therefore, cannot be accepted for compliance. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (d) of the standard.

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

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

Notes:

(a)(b)(c)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." EPSPC policy 2.11 further states, "The AFOD shall promptly report the incident to the ICE FOD and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the AFOD shall also notify the local government entity or contractor that operates the EPC." EPSPC policy 2.11 further states, "Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." A review of the facility investigative protocol confirms the policy includes a description of the responsibilities of the Agency, the facility, and law enforcement and requires all PREA allegation reports and referrals be documented and maintained for at least five years. A review of the facility investigative protocol further confirms the protocol requires the SDDO on duty, or the PSA Compliance Manager, to notify the AFOD. An interview with the AFOD indicated all allegations of sexual

abuse, whether the abuser is a detainee, employee, contractor, or volunteer, are reported through the chain of command by the officer or staff member receiving the allegation notifying the PSA Compliance Manager who will notify the SDDO, who notifies within two hours, the AFOD, JIC, and ICE OPR/DHS OIG. An interview with the AFOD further indicated the AFOD notifies the DFOD and the DFOD notifies the FOD and the AFOD or the PSA Compliance Manager will notify the FBI, if the allegation appears to be criminal. An interview with the PSA Compliance Manager/Investigator indicated he will begin an administrative investigation once OPR/JIC indicate the allegation has been determined to be a PREA allegation. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed notifications had been made to ICE OPR, DHS OIG, and the Joint Intake Center (JIC). In addition, the Auditor reviewed the Agency website (https://www.ice.gov/prea) and confirmed Agency Policy 11062.2 is posted and available to the public. However, a review of the facility website (https://www.ice.gov/detain/detention-facilities/el-paso-service-processing-center) and confirmed the facility website links with the Agency website; however, a review of the facility website could not confirm EPSPC policy 2.11 had been posted on the website. In addition, during the on-site audit, through Auditor observations, the Auditor confirmed EPSPC policy 2.11 is not available to the public.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. A review of the facility website could not confirm EPSPC policy 2.11 had been posted on the website. In addition, during the on-site audit, through Auditor observations, the Auditor confirmed EPSPC policy 2.11 is not available to the public. To become compliant, the facility must submit documentation which confirms EPSPC policy 2.11 is available to the public.

Corrective Action Taken:

The facility submitted a photograph of the investigation protocols posted in visitation area of the facility. The Auditor reviewed the photo and confirmed the posted protocol includes all required elements of standard 115.22. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (c) of the standard.

§115.33 - Detainee education.

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(f): EPSPC policy 2.11 states, "Upon admission to the EPC all detainees shall be notified of the EPC's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee handbook and provided with information about the EPC's SAAPI Program. Such information shall include, at a minimum: the EPC's zero-tolerance for all forms of sexual abuse and assault, the name of the EPC PSA Compliance Manager, and information about how to contact him/her, prevention and intervention strategies, definition and examples of detainee-on-detainee sexual abuse and assault, staff on-detainee sexual abuse and assault and coercive sexual activity, explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS/OIG and the ICE/OPR investigation processes, information about self-protection and indicators of sexual abuse and assault, prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings, the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The EPC shall provide the detainee notification, orientation, or instructions in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The EPC shall maintain documentation of detainee participation in the instruction session." Interviews with the PSA Compliance Manager, and two Processing Officers indicated during the intake process, detainees are provided the ICE National Detainee Handbook, DHS-prescribed SAA Information pamphlet, a facility Detainee Handbook, and are shown a PREA video. Receipt of these items are documented by detainee signature on the detainee Admission Checklist Form. Interviews with the PSA Compliance Manager, two Processing Officers and six random DOs further indicated reasonable accommodations are made to ensure a detainee receives orientation on the Agency's and facility's sexual abuse

prevention and response, to include but not limited to, the use of a teletypewriter (TTY), or Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for those detainees who are deaf or hard of hearing. In addition, interviews with the PSA Compliance Manager, two Processing Officers and six random DOs indicated detainees who have limited reading skills, or who are LEP, staff will utilize the facility language line to interpret the information or a staff interpreter, who is proficient in the detainee's preferred language and if a detainee is blind, staff would read the information to the detainee. Interviews with the PSA Compliance Manager, two Processing Officers and six random DOs further indicated if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. During the on-site audit, the Auditor observed the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet and confirmed the handbook is available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese. During the on-site audit, the Auditor further reviewed the ICE National Detainee Handbook and confirmed the handbook includes information on the Agency's zero tolerance policy, prevention and intervention strategies, definitions and examples of detainee-on-detainee sexual abuse, explanation of methods for reporting sexual abuse, information about self-protection, reporting sexual abuse will not negatively impact your immigration proceeding and the right to receive treatment and counseling if subjected to sexual abuse. In addition, during the on-site audit the Auditor reviewed the facility Detainee Handbook and confirmed the handbook is available in English, Spanish, Arabic, French and Russian and includes information on the facility's zero tolerance policy, definitions, and examples of detainee-on-detainee sexual abuse, avoiding sexual assault, how to report sexual abuse and assault, and contact information CASFV. In interviews with 19 LEP detainees it was indicated, during intake staff utilized either a staff member or the language line to interpret; however, information regarding sexual abuse was not read to them. In interviews with 18 LEP detainees, 8 detainees whose preferred language was Spanish, it was confirmed all written material had been provided to them in Spanish; however, 3 other detainees whose preferred language is Spanish, 1 detainee whose preferred language was Chinese, 1 detainee whose preferred language was Russian, 2 detainees whose preferred language was Arabic, 1 detainee whose preferred language was Iranian and 1detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with one detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. During the on-site audit, the Auditor observed a video of a detainee intake and confirmed the detainee had been given both handbooks and the DHS-prescribed SAA Information pamphlet; however, the Auditor could not determine, from the video, if the orientation received was in the detainee's preferred language. A review of 32 detainee files confirmed, detainees sign an acknowledgement confirming they received the ICE National Detainee Handbook, facility handbook, and the DHS-prescribed SAA Information pamphlet in Spanish; however, the Auditor could not confirm detainees have received the information in the PREA video. In addition, a review of several files confirmed the detainee's preferred language was something other than the orientation they received; and therefore, the Auditor confirmed detainees are not consistently provided orientation in a manner they can understand.

(d)(e): EPSPC policy 2.11 states, "The EPC shall post on all housing unit bulletin boards the following notices: the DHS-prescribed sexual abuse and assault awareness notice, the name of the PSA Compliance Manager (PREA Coordinator), information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (incl. toll-free hotline numbers where available). If no such local organization exist, the EPC shall make available the same information about national organizations. The EPC shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, which contained the name of the facility PSA Compliance Manager, and the CASFV flyer in English, Haitian Creole, Punjabi, and Spanish posted in all housing units of the facility. In an interview with the PSA Compliance Manager, it was indicated, if needed, the facility would translate the information available in the flyer in a language the detainee can understand prior to given the detainee access to the services

CASFV provides. Interviews with the PSA Compliance Manager and two Processing Officers indicated each detainee is provided the DHS-prescribed SAA Information pamphlet during the intake process; however, A review of 32 detainee files confirmed; detainees are not consistently provided the DHS-prescribed SAA Information in a manner they can understand.

Corrective Action:

The facility is not in compliance with subsection (a) and (b) of the standard. In interviews with 19 LEP detainees it was indicated, during intake staff utilized either a staff member or the language line to interpret; however, information regarding sexual abuse was not read to them. In interviews with 18 LEP detainees, to include 8 detainees whose preferred language is Spanish confirmed all written material had been provided to them in Spanish; however, 3 detainees whose preferred language is Spanish, 1 detainee whose preferred language was Chinese, 1 detainee whose preferred language was Russian, 2 detainees whose preferred language was Arabic, 1 detainee whose preferred language was Iranian and 1detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with one detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. A review of 32 detainee files confirmed, detainees sign an acknowledgement confirming they received the ICE National Detainee Handbook, facility handbook, and the DHS-prescribed SAA Information pamphlet in Spanish; however, the Auditor could not confirm detainees have received the information in the PREA video. In addition, a review of several files confirmed the detainee's preferred language was something other than the orientation they received; and therefore, the Auditor confirmed detainees are not consistently provided orientation in a manner they can understand. To become compliant, the facility must implement a procedure to ensure during intake all detainees are provided orientation in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all applicable staff have been trained on the implemented procedure. In addition, the facility must submit 10 detainee files, specifically, if applicable, detainee files which do not include detainees whose preferred language is English, Spanish, Arabic, French, or Russian to confirm the facility orientation program is being delivered in a manner all detainees can understand.

Corrective Action Taken:

The Auditor reviewed the updated checklist and confirmed the checklist documents the detainee has received the ICE National Detainee Handbook, the Local Detainee Handbook, Video Orientation, and the DHS prescribed SAA Information pamphlet. A review of the updated checklist, available on-site in English, Punjabi, Romanian, Russian, Turkish, Spanish, Arabic, Bengali, Chinese, French, Haitian-Creole, Hindi, Portuguese further confirmed the checklist includes the EPC zero-tolerance policy, prevention and self-protection, the investigative process, and definitions of sexual abuse. The facility submitted a transcript of the orientation video in English, Punjabi, Romanian, Russian, Turkish, Vietnamese, Spanish, Arabic, Bengali, Chinese, French, Haitian-Creole, Hindi, Portuguese. The facility submitted an Accessing Sign Language Services flyer. The facility submitted a training curriculum and staff sign in sheets which confirm staff have been trained in the new procedure. The facility submitted 10 detainee files. The Auditor reviewed the submitted files and confirmed the files included detainees whose preferred languages are Tigrinya (1), Turkish (2), Persian (3), Arabic (1), (Vietnamese) (1), Thai (1) and Uzbek (1). The Auditor reviewed the file of the detainee whose preferred language was Tigrinya and could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet; however, could confirm the detainee did not receive the local handbook or the information included in the facility PREA video in the detainee's preferred language. The Auditor reviewed the files of two detainees whose preferred language was Turkish and could not confirm one of the detainees received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet in a language the detainees could understand and in the other file the Auditor could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet; however, could confirm the detainee did not receive the local detainee handbook in a language the detainee could understand. The Auditor reviewed the file of three detainees whose preferred language was Persian and could not confirm the detainees received either the ICE

National Detainee Handbook and DHS prescribed SAA Information pamphlet in the detainees' preferred language; however, could confirm under the section which included the local handbook the facility indicated N/A and none. The Auditor reviewed the file of one detainee whose preferred language was Arabic and could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet in the detainee's preferred language. The Auditor reviewed the file of one detainee whose preferred language was Vietnamese and could not confirm the detainee received the ICE National Detainee Handbook and DHS prescribed SAA Information pamphlet in the detainee's preferred language; however, could confirm under the section which included the local handbook the facility indicated none. The Auditor reviewed the file of one detainee whose preferred language was Thai and could not confirm the detainee received either the ICE National Detainee Handbook, DHS prescribed SAA Information pamphlet, or the local handbook in the detainee's preferred language. The Auditor reviewed the file of one detainee whose preferred language was Uzbek and could not confirm the detainee received either the ICE National Detainee Handbook, DHS prescribed SAA Information, or the local handbook in the detainee's preferred language. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsections (a) and (b) of the standard.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(d)(f)(g): EPSPC policy 2.11 states, "All detainees shall be screened upon arrival at the EPC for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment will be completed within twelve hours of admission to the EPC. The facility will consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: 1) whether the detainee has a mental, physical, or developmental disability; 2) the age of the detainee; 3) the physical build and appearance of the detainee; 4) whether the detainee has previously been incarcerated or detained; 5) the nature of the detainee's criminal history; 6) whether the detainee has any convictions for sex offenses against an adult or child; 7) whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; 8) whether the detainee has self-identified as having previously experienced sexual victimization; and 9) the detainee's own concerns about his or her physical safety. Detainees will not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to items (1), (7), (8), or (9) above. The initial screening will consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive. The EPC will implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates." The Auditor reviewed the facility Detainee Risk Classification Assessment and confirmed the assessment considers whether the detainee has previously been incarcerated or detained; whether the detainee has any developmental, mental or physical disabilities; if the detainee identifies as lesbian, gay, bisexual, transgender, intersex or gender nonconforming; whether the detainee has ever been a victim of sexual assault; if the detainee is young or elderly; physical build of the detainee; whether the detainee has ever been approached for sex, threatened with sexual assault; has a history of sexual victimization; whether the detainee has any fear of placement in the general population; any history of violent crimes (excluding sex offenses, domestic violence); any history as a sex offender with adult or child victims; any history of prior acts of sexual abuse; incident reports for violent acts or offenses while detained; and incident reports of sexual misconduct while detained or incarcerated. A review of the facility Detainee Risk Classification Assessment further confirms the assessment includes initial classification, medical clearance, and housing unit assignment will be completed within 12 hours of admission, includes the detainee's preferred language, and a space for identification of communications devices utilized to complete the assessment, such as the Language Line, TTY, or any other communication

impairment. In addition, a review of the facility Detainee Risk Classification Assessment confirms the assessment states, "Detainees shall not be disciplined for refusing to answer any of the questions." An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June of 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the assessment is completed during the detainee's intake into the facility. Interviews with two Processing Officers further indicated during the intake process, staff will review the detainee's rap sheet and their DHS 213 form to determine the detainee's classification level, once the classification level is determined, intake staff will notify the Detention Management Unit (DMU), and the DMU will provide the processing staff the detainee's housing assignment. In addition, interviews with two Processing Officers, indicated a detainee's classification level and initial housing assignment is completed prior to conducting the risk assessment; and therefore, neither Processing Officer could articulate what steps are to be taken if the risk assessment indicates the detainee is likely to be a sexual aggressor or a sexual abuse victim with the exception of notifying the PSA Compliance Manager and medical staff, if a detainee had identified as likely to be a sexual abuse victim. In an interview with two Processing Officers, it was further indicated detainees are provided privacy when answering the questions on the assessment and they are not disciplined for refusing to answer any of the questions. In addition, interviews with two Processing Officers indicated the risk assessment is kept in the detainee's file and the files are maintained in a locked file room which the Auditor observed during the on-site audit. During the on-site audit, the Auditor requested a roster of detainees who reported prior victimization and a roster of those who identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed confirmed the detainee had not been assessed upon arrival at the facility. A review of 32 detainee files further confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee, indicated she had not been asked the questions during the intake process, and disclosed she had been sexually abused many times prior to leaving her country and requested to see mental health; and therefore, the Auditor, had the facility immediately escort the detainee to see mental health staff. Interviews with the AHSA and an LPN indicated medical staff also conducts an assessment regarding sexual abuse, during the medical intake assessment; however, a review of the ISHC medical assessment indicated the assessment does not include all elements required by subsection (c) of this standard.

(e): EPSPC policy 2.11 states, "EPC shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." In an interview with a Classification Officer, it was indicated he maintains a reclassification "due list" to ensure all detainees are reclassified 60 days from the detainee's initial assessment. In an interview with a Classification Officer if was further indicated in June 2024, the facility implemented a Detainee Risk Classification Assessment to be completed during intake and again 60 days after the initial assessment. In addition, in an interview with a Classification Officer it was indicated processing and classification staff will note on the assessment, if it was an initial, a 60–90-day reclassification, or a 90–120-day reclassification and if the reclassification is conducted prior to a detainee being released from administrative segregation or protective custody, if the initial assessment had been done incorrectly, or if the detainee was a victim of sexual abuse Classification staff will note "special classification" on the assessment form. However, in an interview with the Classification Officer, it was confirmed the Classification Officer had difficulty in explaining if a reclassification of the detainee is completed or if staff complete a reassessment. The Auditor reviewed 32 detainee files and confirmed 17 detainees had arrived at the facility prior to the implementation of the Detainee Risk Classification Assessment and none of the

17 detainees had received an initial assessment upon arrival to ELPSC. A review of 17 files confirmed the detainee had been re-classified within 60-90 days; however, there was no documentation to confirm the facility re-assessed the detainee for risk of abusiveness or victimization. A review of the remaining 15 files indicated an initial assessment had been completed utilizing the Detainee Risk Classification Assessment; however, 13 of the files confirmed the detainees had not been housed at the facility for longer than 60 days; and therefore, did not require the completion of a re-assessment. A review of the remaining 15 files further confirmed there were 2 detainee files which confirmed a re-assessment was required between 60-90 days and the detainees had been reclassified at 60 days; however, there was no documentation to confirm the detainee had been re-assessed to determine their risk for victimization or abusiveness. In addition, the Auditor reviewed 11 sexual abuse allegation investigation files and confirmed the detainee victim had been reassessed after reporting an allegation of sexual abuse utilizing the Detainee Risk Classification Assessment.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June of 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the classification level and the housing assignment is completed prior to conducting the risk assessment and neither Processing Officer could articulate what steps to take if the risk assessment indicates the detainee is likely to be a sexual abuse aggressor or a sexual abuse victim with the exception of notifying the PSA Compliance Manager and medical staff, if a detainee had identified as likely to be a sexual abuse victim. In an interview with the AHSA and an LPN it was indicated medical staff also conducts an assessment regarding sexual abuse, during the medical intake assessment; however, a review of the ISHC medical assessment indicated the assessment does not include all elements required by subsection (c) of this standard. While on-site, the Auditor requested a roster of detainees who reported prior victimization and a roster of those that been identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed confirmed the detainee had not been assessed upon arrival at the facility. A review of 32 detainee files further confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee, indicated she had not been asked the questions during the intake process. To become compliant, the facility must develop and implement a process to ensure detainees are assessed on intake to identify those detainees who are identified to be likely aggressors or sexual abuse victims and are housed to prevent sexual abuse taking necessary steps to mitigate any such danger. Once implemented the facility must submit documentation to confirm all applicable staff have been trained on the implemented process. The facility must provide the Auditor with 15 detainee files who, based on the initial risk assessment, were identified to likely be sexual aggressors or sexual abuse victims to confirm the facility utilized the information gained from the initial risk assessment to house detainees to prevent sexual abuse and any additional steps taken by the facility to mitigate any such dangers.

The facility is not in compliance with subsection (e) of the standard. In an interview with a Classification Officer if was indicated in June 2024, the facility implemented a Detainee Risk Classification Assessment to be completed during intake and again 60 days after the initial assessment. In an interview with the Classification Officer, it was further confirmed the Classification Officer had difficulty in explaining if a reclassification of the detainee is completed or if staff is required to complete a re-assessment. The Auditor reviewed 32 detainee files and confirmed 17 detainees had arrived at the facility prior to the implementation of the Detainee Risk Classification Assessment and none of the 17 detainees had received an initial assessment upon arrival to

ELPSC. A review of 17 files confirmed the detainee had been re-classified within 60-90 days; however, there was no documentation to confirm the facility re-assessed the detainee for risk of abusiveness or victimization. A review of the remaining 15 files indicated an initial assessment had been completed utilizing the Detainee Risk Classification Assessment; however, 13 of the files confirmed the detainees had not been housed at the facility for longer than 60 days; and therefore, did not require the completion of a re-assessment. A review of the remaining 15 files further confirmed there were 2 detainee files which confirmed a re-assessment was required between 60-90 days and the detainees had been reclassified at 60 days; however, there was no documentation to confirm the detainee had been re-assessed to determine their risk for victimization or abusiveness. To become compliant, the facility must submit documentation to confirm the facility re-assesses all detainees between 60-90-days from the initial assessment. The facility must submit documentation that all applicable staff, to include Classification staff, to have been trained on the procedure. If applicable, the facility must submit 15 detainee files to confirm the detainees had been reassessed between 60-90 days utilizing the Detainee Risk Classification Assessment.

Corrective Action Taken:

The facility submitted the Detainee Risk Classification Assessment Training curriculum and sign in sheets confirming 46 staff members have completed the training. The Auditor reviewed the curriculum and confirmed the curriculum states, "Detainee RCA will be submitted to the Detention Management Unit (DMU). DMU will determine detainee housing assignment utilizing the Detainee Risk Classification Assessment separating the victims from the perpetrators within the housing units. DMU will then update the Vulnerable-Aggressor Roster utilizing the Detainee RCA." A review of the training curriculum also outlines sides of the dorms to house those identified as victims and those identified as perpetrators. The facility submitted 10 Detainee Risk Classification Assessments, the corresponding ICE Classification Worksheet, and a Vulnerable-Aggressor Roster to include detainees who arrived after 3/2/2025. However, the Auditor required the facility provide the Auditor with 10 detainee initial risk assessments, Detention Worksheets, and the Vulnerable-Aggressor Roster to include detainees who arrive at the facility after 3/2/2025 to confirm detainees received their initial housing assignments based on information gained from the Detainee Risk Classification Assessment; and therefore, the Auditor could not confirm the facility utilizes the information gained from the initial risk assessment to assess all detainees on intake to identify those likely to be sexual aggressors or sexual victims and houses detainees to prevent sexual abuse taking necessary steps to mitigate any such danger. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (a) of the standard.
The facility submitted 10 detainee re-assessments, which occurred after 1/22/25 and the corresponding initial assessments, to confirm detainees are reassessed between 60 and 90 days as required by subsection (e) of the standard. The facility submitted the Detainee Risk Classification Assessment Training curriculum. The Auditor reviewed the curriculum and confirmed the curriculum states, "Detainee RCA will be submitted to the Detention Management Unit (DMU). DMU will determine detainee housing assignment utilizing the Detainee Risk Classification Assessment separating the victims from the perpetrators within the housing units. DMU will then update the Vulnerable-Aggressor Roster utilizing the Detainee RCA." A review of the training curriculum further confirms the training included the timeframes to complete the required detainee reassessment; however, the training does not include the procedure how to utilize information gained from a detainee's reassessment to determine the detainee's risk of sexual abuse. The facility submitted staff rosters which confirmed 46 staff have completed the training. The facility did not submit additional documentation to confirm compliance. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (e) of the standard.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard

Notes:

(a)(b)(c): EPSPC policy 2.2 Classification states, "EPC will ensure that detainees are housed according to their classification levels. Participation in work assignments and available activities shall be consistent with safety and

security considerations. Under no circumstances will issues of facility management, or other factors external to the detainee classification system, influence a detainee's classification level." EPSPC policy 2.11 states, "When making assessment and housing decisions for a transgender or intersex detainee, the facility will consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility will consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs will always be taken into consideration as well. The facility's placement of a transgender or intersex detainee will be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee will be reassessed at least twice each year to review any threats to safety experienced by the detainee. When operationally feasible, transgender and intersex detainees will be given the opportunity to shower separately from other detainees." An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June of 2024, approximately one month prior to the facility on-site audit. Interviews with the PSA Compliance Manager and Classification Officer confirmed they were not aware of the identity of the detainees who reported previous sexual victimization or those detainees who are likely to sexual aggressors and they were not aware of their current housing assignments, recreation schedule, voluntary work assignment, or any other activity they be participating in. Interviews with the PSA Compliance Manager and the Classification Officer further confirmed the facility did not make individualized determinations about how to ensure the safety of each detainee. An interview with a Processing Officer indicated if a transgender detainee was received at the facility, she will ask the transgender detainee if they have any fear of being placed into general population and will advise medical staff, who will decide the housing placement. An interview with another Processing Officer indicated a transgender detainee will automatically be placed in protective custody until medical and ICE can agree on their placement. An interview with an LPN indicated a transgender detainee would be housed in protective custody until medical and mental health providers can see them and once they have seen them, the facility will conduct a Transgender Care Committee (TCC), to be conducted within 72 hours, to determine housing for the detainee. In an interview with a Classification Officer, it was indicated transgender detainees are reassessed every 60-90 days. During the on-site audit, the Auditor reviewed a transgender detainee file and confirmed the transgender detainee was placed into protective custody upon entering the facility. A review of the transgender detainee's file further confirmed a TCC was conducted the following day, and an Individualized Detention Plan (IDP) was completed and indicated the transgender detainee was asked about his gender and self-assessment of his safety needs and he indicated he wanted to be housed with females, as he is biologically female, and the facility considered his gender self-identification and housed him on the female housing unit. While on-site the Auditor requested to interview the transgender detainee; however, he refused the interview. During the on-site audit, the Auditor requested a roster of detainees who reported prior victimization and a roster of those who identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed confirmed the detainee had not been assessed upon arrival at the facility. A review of 32 detainee files further confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee, indicated she had not been asked the questions during the intake process. The Auditor reviewed two transgender detainee files and confirmed the detainees had been reassessed within 60-90 days of intake. An interview with a transgender detainee indicated she had been asked about her safety during the TCC and was allowed to shower daily in intake processing.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June of 2024, approximately one month prior to the facility on-site audit. Interviews with the PSA Compliance Manager and Classification Officer confirmed they were not aware of the identity of the detainees who reported previous sexual victimization or those detainees who are likely to sexual aggressors and they were not aware of their current housing assignments, recreation schedule, voluntary work assignment, or any other activity they be participating in. Interviews with the PSA Compliance Manager and the Classification Officer further confirmed the facility did not make individualized determinations about how to ensure the safety of each detainee. During the on-site audit, the Auditor requested a roster of detainees who reported prior victimization and a roster of those who identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed confirmed the detainee had not been assessed upon arrival at the facility. A review of 32 detainee files further confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee, indicated she had not been asked the questions during the intake process. To become compliant, the facility must develop and implement a process to ensure information from the initial risk assessment is used to inform assignment of the detainee to housing, recreation, voluntary work, and any other activities and the facility shall make individualized determinations about how to ensure their safety. Once implemented, the facility must submit documentation to confirm all applicable staff have been trained on the implemented process. The facility must submit the files of 15 detainees who based on the initial risk assessment were identified to likely be sexual aggressors or sexual abuse victims to confirm the facility utilized information gained from the initial risk assessment to inform assignment of the detainee to housing, recreation, voluntary work, and any other activities to ensure the detainee's safety.

Corrective Action Taken:

The facility submitted a memo from PCM (b) (6), (b) (7)(C) which states, "All staff are to remember that while conducting recreation, religious services, or other activities provided at El Paso Processing Center they are to always remain vigilante. All roving posts are to be moving around, and Day Room officers are to continue roving their assigned housing units" and "when feasible, continuing the separation of perpetrators from victims outside of their housing units, possible victims are to be placed in front while the perpetrators are placed in the back of the room." The facility submitted briefing memos for all shifts confirming the memorandum from PCM (b) (6), (b) (7)(C) (b) (6) was read to all shifts. The facility submitted nine detainee files. The Auditor reviewed the submitted files and confirmed six of the files included detainees who were screened for voluntary work prior to the facility implementing a practice 12/31/2024 requiring staff to verify with the Detention Management Unit (DMU) prior to hiring new detainee workers; and therefore although not compliant with the standard the Auditor accepts the submitted files included documentation prior to the implemented practice; and therefore, are not being considered to determine compliance. The Auditor reviewed the remaining three files and confirmed the three files included detainees who identified as experiencing prior sexual abuse and their applications for employment were reviewed by the DMU prior to placing the detainees into an initial assignment; however, a review of the three submitted files confirmed two of the detainees were reassigned to a new work assignment without review by the DMU. In addition, the Auditor reviewed the initial risk assessments and the corresponding Detention Worksheets and could not confirm housing was determined based on a review of the initial risk assessment. The facility submitted a copy of the Vulnerable-Aggressor Roster. The Auditor reviewed the submitted Vulnerable-Aggressor Roster and confirmed the facility added the work location onto the document; however, the work locations were incorrect, noting the Law Library Worker was documented as working FEE-4 and the FEE-4 worker was documented as a

Law Library Worker. Upon review of all submitted documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (a) of the standard.

§115.51 - Detainee reporting.

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

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "Detainees shall have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting. Staff shall take seriously all statements from detainees claiming to be victims of sexual abuse or assault and shall respond supportively and non-judgmentally. Any detainee may report acts of sexual abuse or assault to ant employee, contractor, or volunteer. If a detainee is not comfortable making the report to a staff person with whom he/she is comfortable in speaking about the allegations. The EPC shall provide instructions on how detainees may contact their consular officials or the DHS Office of the Inspector General, to confidentially and if desired, anonymously, report these incidents." EPSPC policy 2.11 further states, "Staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." During the on-site audit, the Auditor observed information in all housing units and common areas of the facility, in English and Spanish, advising the detainees how to contact their consular official, the DHS OIG, and the DRIL, to confidentially and if desired anonymously report an incident of sexual abuse. In addition, the Auditor observed, in English and Spanish an Agency provided a PREA Hotline to report allegations of sexual abuse. Interviews with the facility PSA Compliance Manager and six Random DOs indicated detainees are provided multiple ways to report sexual abuse, retaliation, and any staff neglect of their responsibilities which may have contributed to an incident of sexual abuse. Interviews with six random DOs further indicated all reports received verbally, in writing, anonymously, and from third parties must be immediately reported and documented. Interviews with 21 random detainees, confirmed they were aware of several ways to report an incident of sexual abuse as they are posted in the housing units. During the on-site audit, utilizing a detainee pin, the Auditor tested all numbers provided and confirmed the DHS OIG and the DRIL numbers were in good working order; however, the Auditor tested the Agency PREA Hotline and left a message advising the call was a test of the PREA Hotline and instructed the receiver to immediately notify the PSA Compliance Manager or the audit team upon receipt; however, the Auditor did not receive a response.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. During the on-site audit, utilizing a detainee pin, the Auditor tested the provided Agency PREA Hotline and left a message advising the call was a test of the PREA Hotline and instructed the receiver to immediately notify the PSA Compliance Manager or the audit team upon receipt; however, the Auditor did not receive a response. To become compliant, the Agency must submit documentation to confirm the Agency PREA Hotline, provided to the detainees, is in good working order.

Corrective Action Taken:

The facility submitted an email from Talton services which confirms the facility requested a review of the facility phone's ability to allow anonymous calls. The facility submitted a PREA logbook which confirms a test call was completed. In addition, the facility submitted documentation which confirms a PREA call was received. The facility submitted a test PREA call email notification from the facility Captain. The email confirmed notification had been made to the facility PCM and the ICE SDDO. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d): EPSPC policy 2.11 states, EPSPC policy 2.11 states, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and prosecution of sexual abuse and assault perpetrators to address victims' needs most appropriately. The EPC shall attempt to enter into memoranda of understanding or other agreements with community service providers or, if local providers are not available, national organizations that provide legal advocacy and confidential emotional support services from immigrant victims of crime. The AFOD shall establish procedures to make available to detainee's information about local organizations that can assist detainees who have victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If no such local organizations exist, the EPC shall make available the same information about national organizations. Following an allegation of sexual abuse, the AFOD shall establish procedures to make available, to the full extent possible, additional outside victim services. The EPC shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available, the EPC shall work with ICE to provide these services from a qualified staff member from a community-based organization, or qualified ICE staff member. The victim advocate shall be able to provide emotional support, crisis intervention, information and referrals. The EPC shall enable reasonable communication between detainees and these organizations or agencies, in as confidential manner as possible. Staff shall inform detainees, prior to giving them access to outside resources, of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." EPSPC policy 2.11 further states, "A local agreement between the EPC and Center Against Sexual and Family Violence (CASFV) states that the CASFV will provide support in crisis intervention, counseling to address victim needs and other support services." The Auditor reviewed an Agreement of Understanding, between EPSPC and CASFV, dated November 29, 2017, without an ending date and confirmed the Agreement indicated CASFV would provide legal advocacy and confidential support services for the immigrant victims of crime housed at the facility. During the on-site audit, the Auditor utilized a detainee telephone in a housing unit and spoke with an advocate from CASFV who confirmed CASFV provides telephonic emotional support services, crisis intervention, and counseling for all detainee victims who call the center. An interview with the advocate from CASFV further confirmed a detainee victim of sexual abuse would be taken to UMC for a SANE Examination and would be accompanied by a CASFV victim advocate during the SANE exam and any investigatory interviews, to provide emotional support, crisis intervention, information, and any necessary referrals. During the on-site audit, the Auditor observed the CASFV Flyer posted in English, Haitian Creole, Punjabi, and Spanish on all housing units and confirmed the flyer provides the detainees with a mailing address and telephone numbers to access the service. An interview with the PSA Compliance Manager indicated the facility can translate the flyer in other languages, if needed. During the on-site audit, the Auditor reviewed the facility Detainee Handbook and confirmed detainees are notified all phone calls are subject to being monitored; however, the Auditor could not confirm, prior to giving them access to CASFV, the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. During the on-site audit, the Auditor observed the CASFV Flyer posted in English, Haitian Creole, Punjabi, and Spanish on all housing units and confirmed the flyer provides the detainees with a mailing address and telephone numbers to access the service; however, the flyer does not notify detainees all phone calls are subject to being monitored or the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor reviewed the facility Detainee Handbook and confirmed detainees are notified all phone calls are subject to being monitored; however, the Auditor could not confirm, prior to giving them access to CASFV, the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. To become compliant, the facility must submit documentation that the facility advises all detainees the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws prior to giving them access to outside resources available to report an allegation of sexual abuse.

Corrective Action Taken:

The facility submitted 10 detainee files. The Auditor reviewed the files and confirmed detainees, during the intake process, are advised the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws prior to giving them access to outside resources available to report an allegation of sexual abuse. Upon review of all submitted documentation the facility is now in compliance with subsection (d) of the standard.

§115.61 - Staff reporting duties.

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

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." EPSPC policy 2.11 states, "If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the facility shall report that information to the FOD so that ICE can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. Information concerning the identity of the detainee victim reporting itself, shall be limited to those who have a need-to-know in order to make decisions concerning the victim's welfare, and for law enforcement/investigative purposes. Apart from such reporting, staff shall not reveal any information related to a sexual abuse and assault report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the EPC, or to make medical treatment, investigation, law enforcement, or other security and management decisions." EPSPC policy 2.11 further states, "All staff must immediately report: (a) any knowledge, suspicion, or information regarding an incident or allegation of sexual abuse occurring at the EPC. (b) Any retaliation against detainees or staff who reported or participated in an investigation about sexual abuse or assault; and (c) Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff must be able to report the above outside of the chain of command." A review of EPSPC policy 2.11 confirms the policy does not include a method for staff to report an allegation of sexual abuse outside the chain of command. Interviews with six random DOs confirmed they were very knowledgeable and could articulate their responsibilities to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Interviews with six random DOs further confirmed they were aware sharing of information regarding an allegation of sexual abuse is limited to protect the detainee or staff from in the facility or to make medical treatment, investigation, law enforcement, or facility management decisions. Interviews with six random DOs confirmed they could anonymously report an allegation of sexual abuse; however, they could not articulate who or how they could report the allegation to without going through their chain of command. Interviews with the AFOD and the PSA Compliance Manager indicated if an allegation of sexual abuse involved a vulnerable adult, the Texas mandatory reporting laws require a report to be made to the Adult Protective Services. In an interview with the AFOD it was confirmed the AFOD was knowledgeable regarding his reporting duties under Agency policy 1106.2. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed none of the allegations included a vulnerable adult. In an interview with the AFOD it was confirmed EPSPC policy 2.11 had been submitted and approved by the Agency. EPSPC does not house juvenile detainees.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. A review of EPSPC policy 2.11 confirms the policy does not include a method for staff to report an allegation of sexual abuse outside the chain of command. Interviews with six random DOs confirmed they could anonymously report an allegation of sexual abuse; however, they could not articulate who or how they could report the allegation to without going through their chain of command. To become compliant, the facility must revise EPSPC policy 2.11 to include a method to which staff can report an allegation of sexual abuse outside the chain of command. Once EPSPC policy 2.11 has been revised, the facility must submit documentation to confirm all staff have been trained on the revised policy.

Corrective Action Taken:

The facility submitted addendum to EPSPC policy 2.11. The Auditor reviewed the addendum and confirmed the addendum includes, "Third party reporting of sexual abuse can be made via DRIL Line, OIG, email, phone call to a supervisor, or an ICE Deportation Officer. A review of the submitted addendum to EPSPC further confirms the addendum includes "the EPC addresses each case by reporting through the chain of command up to the FOD; however, a rewording of the updated policy which includes although this is the preferred method staff have the option of reporting an allegation outside the chain of command; and therefore, the addendum is clearer to staff. The facility submitted an email notification to all supervisors to brief updated EPSPC policy to line-staff. The facility submitted Staff Training Notifications for Addendum 2.11 which included staff signature to confirm all OAFM, Medical, and Food Service staff have received the training. Upon review of all available documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

§115.64 - Responder duties.

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

Notes:

(a)(b): EPSPC policy 2.11 states, "Staff shall take immediate action to separate any detainee who alleges that he/she has been sexually abused or assaulted from the alleged assailant and shall refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms. Staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation. The first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder shall: Request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Ensure the alleged abuser does not take any action that could destroy evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first responder is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." However, EPSPC policy further states, "The following protocol is not all inclusive. Circumstances may arise in a detention setting that cannot be addressed in a single protocol; however, this list should serve to standardize procedures. a. Separate the Alleged Victim and Abuser as quickly as possible. b. Preserve and protect any crime scene until proper steps can be taken to collect any evidence. c. Immediately notify the SDDO and Contract Security Supervisor on duty. d. Do not let the alleged victim or abuser take any action that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first responder is not a Security Staff member, the responder shall be required to request the alleged victim not take any actions that could destroy physical evidence; remain with the alleged victim and notify security staff immediately. Refer the victim to the healthcare unit for evaluation and any necessary medical or mental health treatment." During the on-site audit the Auditor reviewed the facility training curriculum and confirmed it states, "If a detainee informs you that he/she has been sexually assaulted by another detainee, you must isolate the detainee and notify the

Team PPS Supervisor immediately. Do not allow the detainee to return to his living area. Do not allow him/her to shower." Therefore, EPSPC policy 2.11 provides 1st responder staff with conflicting direction. Doing so could destroy vital evidence needed for investigation/prosecution. During the on-site audit the Auditor further reviewed the facility Sexual Abuse First Responder cards carried by staff on their person to remind them of the steps they must take in response to an allegation of sexual abuse and confirmed the card states, "Do not let the alleged victim or abuser take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating." Interviews with six random DOs confirmed if a detainee reported an allegation of sexual abuse, they would separate the detainee, call for backup, secure the scene, and would not allow the detainee victim or the abuser to take any action which could destroy physical evidence. Interviews with two non-security first responders indicated they would immediately call for officers, instruct the detainees to separate, and would immediately notify their supervisor. Interviews with two non-security first responders further indicated the non-security first responders would not allow the detainee victim, or the abuser, take any action which could destroy evidence. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed all files included an incident report which confirmed the victim, and the abuser, were immediately separated, and taken to medical, for medical and mental health evaluations and observation.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. A review of EPSPC policy 2.11, which serves as the facility coordinated response plan, confirms the policy provides 1st responder staff with conflicting direction. During the on-site audit the Auditor reviewed the facility training curriculum and confirmed it states, "If a detainee informs you that he/she has been sexually assaulted by another detainee, you must isolate the detainee and notify the Team PPS Supervisor immediately. Do not allow the detainee to return to his living area. Do not allow him/her to shower." Therefore, EPSPC policy 2.11 provides 1st responder staff with conflicting direction. Doing so could destroy vital evidence needed for investigation/prosecution." During the on-site audit the Auditor further reviewed the facility Sexual Abuse First Responder cards carried by staff on their person to remind them of the steps they must take in response to an allegation of sexual abuse and confirmed the card states, "Do not let the alleged victim or abuser take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating." Interviews with six random DOs confirmed if a detainee reported an allegation of sexual abuse, they would separate the detainee, call for backup, secure the scene and would not allow the detainee victim or the abuser to take any action that could destroy physical evidence. Interviews with two non-security first responders confirmed the non-security first responders would not allow the detainee victim, or the abuser take any action that could destroy evidence. To become compliant, the facility must revise EPSPC policy 2.11, the facility PREA training curriculum, and the facility Sexual Abuse First Responder cards to include first responders shall request the alleged victim and ensure the abuser does not take any action that could destroy physical evidence, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Once revised, the facility must submit documentation which confirms all staff, to include non-security staff, have received training on updated EPSPC policy 2.11.

Corrective Action Taken:

The facility submitted updated first responder cards which confirm the new cards request victims do not take any action that could destroy evidence. The facility submitted a staffing roster which confirms the facility is in the process of distributing the updated first responder cards. The facility submitted a training curriculum which confirms the training curriculum has been updated to include first responders are to request that victims do not take any action that could destroy evidence. The facility submitted a memorandum to all staff which includes an addendum to EPSPC policy 2.11 which states, "d. Request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating,

defecating, smoking, drinking, or eating." The facility submitted a Briefing/Training Addendum to SAAPI policy email which instructs Captains, Food Service Managers, Medical and OAFM to include the contents in all staff daily briefing for a period of 2 weeks. The facility submitted Staff Training Notifications for Addendum 2.11 which included staff signature to confirm all OAFM, Medical and Food Service staff have received the training. The facility submitted a sample Detention Operations Report to confirm the training material has been included for one day shift, swing shift and graveyard shift briefings. Upon review of all submitted documentation the facility is now in compliance with subsections (a) and (b) of the standard.

§115.65 - Coordinated response.

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

Notes:

(a)(b): EPSPC policy 2.11 states, "The EPC must use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a security staff member, and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise." The Auditor reviewed the facility coordinated response plan and confirmed the plan takes a multidisciplinary team approach to responding to sexual abuse. The plan coordinates the actions taken by facility responders to include first responders, medical and mental health staff, investigators, and the facility leadership in response to an incident of sexual abuse; however, the plan is not in compliance with standard §115.64 and the actions to be taken by 1st responders and non-security responders. Interviews with six random DOs confirmed if detainee reported an allegation of sexual abuse to them, they would separate the detainee, call for backup, secure the scene, and ensure the detainee victim and abuser does not take any action that could destroy physical evidence. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed the facility utilized a coordinated, multidisciplinary response, in responding to each allegation.

(c)(d): EPSPC policy 2.11 states, "If a victim is transferred between detention facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility). If the receiving facility is unknown to the sending facility, the sending facility shall notify the FOD, so that he or she can notify the receiving facility." In an interview with the PSA Compliance Manager, AHSA, and an LPN it was confirmed they were knowledgeable in the requirements of subsections (c) and (d) of the standard by indicated if a detainee victim of sexual abuse is transferred to a facility covered by DHS PREA, they would provide the receiving facility of the incident and the detainee's need for medical or social services and if the facility is not covered by DHS PREA they would provide the information unless the detainee requests otherwise; and therefore, in review of the EPSPC policy 2.11, and staff interviews, the Auditor finds the facility in substantial compliance with subsections (c) and (d) of the standard.

Recommendations (c)(d): The Auditor recommends the facility update the coordinated response plan to include the verbiage, "If a victim of sexual abuse is transferred between facilities covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services" and "if a victim is transferred from a DHS immigration detention facility to a facility, not covered by paragraph (c) of this section, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise;" to coincide with the facility's practice.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. Although the Auditor confirmed the coordinated response plan coordinates the actions taken by facility responders to include first responders, medical and mental health staff, investigators, and the facility leadership in response to an incident of sexual abuse a

review of the plan confirms the plan is not in compliance with standard §115.64 regarding the actions to be taken by 1st responders. To become compliant, the facility must revise policy EPSPC policy 2.11, which serves as the facility coordinated response plan, to include first responders shall request the alleged victim and ensure the abuser does not take any action that could destroy physical evidence, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Once revised, the facility must submit documentation to confirm all security first responders have received training on the updated policy EPSPC 2.11. If applicable, the facility must submit all sexual abuse allegation investigations which occur during the CAP period.

Corrective Action Taken:

The facility submitted updated first responder cards which confirm the new cards request victims do not take any action that could destroy evidence. The facility submitted a staffing roster which confirms the facility is in the process of distributing the updated first responder cards. The facility submitted a training curriculum which confirms the training curriculum has been updated to include first responders are to request that victims do not take any action that could destroy evidence. The facility submitted a memorandum to all staff which includes an addendum to EPSPC policy 2.11 which states, "d. Request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating." The facility submitted a Briefing/Training Addendum to SAAPI policy email which instructs Captains, Food Service Managers, Medical and OAFM to include the contents in all staff daily briefing for a period of 2 weeks. The facility submitted Staff Training Notifications for Addendum 2.11 which included staff signature to confirm all OAFM, Medical and Food Service staff have received the training. The facility submitted a sample Detention Operations Report to confirm the training material has been included for one day shift, swing shift and graveyard shift briefings. Upon review of all submitted documentation the facility is now in compliance with subsection (a) of the standard.

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

Outcome: Does not Meet Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff will, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June of 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the Detainee Risk Classification Assessment is completed during the detainee's intake into the facility; however, neither Processing Officer could articulate what steps to take should the risk assessment identifies the detainee as likely to be a sexual aggressor or sexual abuse victim except for notifying the PSA Compliance Manager and medical staff if a detainee was identified as a sexual abuse victim. Interviews with the AHSA and an LPN indicated medical staff conducts an assessment regarding sexual abuse, during the detainee's intake into the facility; however, a review of the ISHC medical assessment indicated the assessment does not include all elements required by subsection (c) of standard 115.41. A review of the medical assessment further indicates if a detainee reports prior victimization and it is within six months, "refer for mental health assessment" and "if the medical assessment indicates the detainee has previously sexually assaulted anyone "refer for a mental health assessment." An interview with an LPN, indicated he would refer all detainees who report prior victimization or previously sexually assaulted someone for a mental health and medical assessment and the detainee would be seen by medical staff for an evaluation within

two working days. An interview with an LPN further indicated mental health staff are notified via telephone when a detainee needs a mental health assessment, and the notification would be entered into the medical computer system. An interview with a LCSW indicated she immediately gets notification of all mental health telephone encounters and will conduct a mental health assessment of the detainee within 24 hours. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. The Auditor reviewed 32 detainee files which included 3 detainee files, and corresponding mental health files, in which the detainee was identified as having experienced prior victimization upon completion of the Detainee Risk Classification Assessment and confirmed the detainee's mental health files indicated the detainee had been seen by mental health staff within 24 hours. In addition, the Auditor reviewed two detainee mental health files where the detainee had been identified on the Detainee Risk Classification Assessment as likely to be a sexual aggressor and confirmed the detainee had not received a mental health assessment within 72 hours. The Auditor reviewed the corresponding medical risk assessment and confirmed the medical risk assessment indicated the detainee had not answered in the positive, when asked by the medical staff; and therefore, although the Detainee Risk Classification Assessment identified the detainee as a being a perpetrator of sexual abuse, medical staff did not refer the detainee to mental health as required.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated that the facility implemented the Detainee Risk Classification Assessment in June 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the assessment is completed during the detainee's intake into the facility; however, neither Processing Officer could articulate what steps are to be taken if the risk assessment indicates the detainee is likely to be an aggressor or a sexual abuse victim; however, they indicated they would notify the PSA Compliance Manager and medical staff, if a detainee was identified as a sexual abuse victim. Interviews with the AHSA and an LPN indicated medical staff conducts an assessment regarding sexual abuse, during the detainee's intake into the facility; however, a review of the ISHC medical assessment indicated the assessment does not include all elements required by subsection (c) of standard 115.41. A review of the medical assessment further indicates if a detainee reports prior victimization and it is within six months, "refer for mental health assessment" and "if the medical assessment indicates the detainee has previously sexually assaulted anyone "refer for a mental health assessment." The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. The Auditor reviewed 32 detainee files which included 3 detainee files, and corresponding mental health files, in which the detainee was identified as having experienced prior victimization upon completion of the Detainee Risk Classification Assessment and confirmed the detainee's mental health files indicated the detainee had been seen by mental health staff within 24 hours. In addition, the Auditor reviewed two detainee mental health files where the detainee had been identified on the Detainee Risk Classification Assessment as likely to be a sexual aggressor and confirmed the detainee had not received a mental health assessment within 72 hours. The Auditor reviewed the corresponding medical risk assessment and confirmed the medical risk assessment indicated the detainee had not answered in the positive, when asked by the medical staff; and therefore, although the Detainee Risk Classification Assessment identified the detainee as a being a perpetrator of sexual abuse, medical staff did not refer the detainee to mental health as required. To become compliant, the facility must implement a process to ensure if the Detainee Risk Classification Assessment identifies a detainee has experienced prior sexual victimization or perpetrated sexual abuse, the detainee is immediately referred to a medical and/or mental health practitioner for follow-up. Once implemented, the facility must submit documentation which confirms all applicable staff, to include Intake, Medical, and Mental Health have received training on the implemented process. If applicable, the facility must submit 10 detainee files, and the corresponding medical and/or mental health records, who based on the Detainee Risk Classification Assessment, were identified to have experienced prior sexual victimization or perpetrated sexual abuse.

Corrective Action Taken:

The facility submitted an updated Detainee Risk Classification Assessment which includes the addition, "If a detainee answers yes to questions 2-10, 13, 15, or 16 the detainee must be immediately referred to medical/mental health for a follow-up exam". The facility submitted PREA Compliance Manager submitted an email to IHSC which states, "Good afternoon, as we discussed earlier today, currently PREA auditors are requested the following: Intake process, processing is to interview the detainee determining if detainee is a possible victim or perpetrator using the Detainee Risk Classification Assessment (Attached). The Detainee RCA is then forwarded to medical for evaluation and determination if detainee is to be forwarded to mental health. It is being ask by the PREA Auditors that once medical receives a Detainee Risk Classification Assessment (RCA) it is to be noted in the screening form that detainee is being evaluated due to saying yes to either being a victim or perpetrator. It is to also be noted why detainee was not forwarded to mental health for evaluation after stating yes to one of the questions. Mental health is then to document why detainee was not evaluated as well. Please let me know if this would be possible." The facility submitted an email response from IHSC to the above request which states, "IHSC El Paso current intake process has being vetted by IHSC HQ, saying this, IHSC El Paso will not deviate from the current intake process. Current process follows PBNDS guidance and IHSC policies;" and therefore, the Auditor cannot confirm through practice the facility has implemented a process to ensure if the Detainee Risk Classification Assessment identifies a detainee has experienced prior sexual victimization or perpetrated sexual abuse, the detainee is immediately referred to a medical and/or mental health practitioner for follow-up. The facility submitted 11 detainee files. The Auditor reviewed the files and confirmed none of the files included the updated Detainee Risk Classification Assessment and two of the files included Detainee Risk Classification Assessment which did not include referring detainees who identified as perpetrating sexual abuse by answering yes to sections 13, 15, or 16. A review of the 11 detainee files, and corresponding medical and mental health files, confirmed 3 of the files reviewed did not include detainees who identified as experiencing prior sexual abuse or perpetrating sexual abuse. In addition, a review of the remaining eight detainee files, and corresponding medical and mental health files, could not confirm any of the detainees were referred for medical or mental health follow-up based upon information gained from the Detainee Risk Classification Assessment and three detainees who identified as experiencing prior sexual abuse based on their responses to the Detainee Risk Classification Assessment did not advise medical of their prior history of sexual abuse; and therefore, were not referred to mental health for an evaluation. The facility submitted two documents entitled Provision 115.17 and Re: Time Sensitive; however, the Auditor could not open the document. Upon review of all documentation, or lack thereof, the Auditor continues to find the facility does not meet subsection (a) of the standard.

§115.86 - Sexual abuse incident reviews.

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

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "The facility shall conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For any substantiated or unsubstantiated allegations, the facility shall prepare a written report within 30 days of the conclusion of the investigations 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. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and the response shall be forwarded to the FOD, or his or her designee, for transmission to the ICE PSA Coordinator. The facility shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual

review shall be provided to the AFOF and the FOD, or his or her designee, for transmission to the ICE PSA Coordinator." An interview with the PSA Compliance Manager/Incident Review Team, indicated the facility has established a review team that consists of upper-level management and allows for input from the custody staff, investigators, medical and mental health practitioners and utilizes a Sexual Abuse or Assault Incident Review form to document the review. An interview with the PSA Compliance Manager/Incident Review Team further indicated a review is completed within 30 days after the Agency closes the investigation and the review includes a recommendation for improvement and will document the reasons if the recommendations are not followed. The Auditor reviewed the Sexual Abuse or Assault Incident Review form and confirmed the review team considers whether the incident or allegation was motivated by race; ethnicity; gender identity: lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, the review includes recommendations for improvement. The Auditor reviewed 11 investigative files and confirmed 5 of the sexual abuse incident reviews were completed within 30 days of the Agency closure of the investigative file, 3 of the reviews were completed after 30 days (2 of the 3 were completed 6 months after the closure by the Agency), and 3 sexual abuse allegation investigation files did not include documentation to confirm a sexual abuse incident review had been completed even though the Agency sexual abuse allegation investigation files had been closed for more than 60 days. A review of 11 sexual abuse allegation investigation files further confirmed for the 5 files which included a sexual abuse incident review, the review had been forwarded to the AFOD and the Agency PSA Coordinator. An interview with the PSA Compliance Manager confirmed the facility's 2023 PREA Data Review, dated March 27, 2024, had not been forwarded to the Agency PSA Coordinator; however, during the on-site audit, the facility forwarded the annual review to the Agency PSA Coordinator and provided the Auditor with the email documentation, confirming compliance.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed 11 investigative files and confirmed 5 of the sexual abuse incident reviews were completed within 30 days of the Agency closure of the investigative file, 3 of the reviews were completed after 30 days (2 of the 3 were completed 6 months after the closure by the Agency), and 3 sexual abuse allegation investigation files did not include documentation to confirm a sexual abuse incident review had been completed even though the Agency sexual abuse allegation investigation files had been closed for more than 60 days. To become compliant, the facility must develop and implement a process to ensure a sexual abuse incident review is completed within 30 days of the conclusion of each sexual abuse allegation investigation. Once implemented, the facility must submit documentation which confirms, all applicable staff, have received training on the implemented process. If applicable, the facility must submit any closed sexual abuse allegation investigation files, and the corresponding incident review, which occur during the corrective action plan (CAP) period.

Corrective Action Taken:

The facility submitted El Paso Processing Center Sexual Abuse and Assault Prevention and Intervention Program Policy 2024 which confirms the policy requires a sexual abuse incident review is completed within 30 days of the conclusion of each sexual abuse allegation investigation. The facility submitted a memorandum with the subject 115.86-Sexual Abuse Incident Reviews addressed to the El Paso Processing Center PREA Investigators which states, "Each facility shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change of policy or practice could better prevent, detect, or respond to sexual abuse. The facility shall implement the recommendations for improvement or shall document its reason for not doing so in a written response. Both the report and response shall be forwarded to the agency PSA Coordinator. The review team shall consider whether the incident or allegations was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise cause by other group dynamics at the facility." The memorandum is signed by 4 staff members. The

facility submitted documentation to confirm 8 sexual abuse incident reviews were conducted on 10/9/2024 within the required time frame. The facility submitted documentation to confirm 6 sexual abuse incident reviews were conducted on 11/14/2024 within the required time frame. The facility submitted documentation to confirm six sexual abuse incident reviews were conducted on 1/6/2025 within the required time frame. As the facility has submitted 12 closed sexual abuse allegation incident reviews which have occurred during the CAP period the Auditor no longer requires the facility submit all closed sexual abuse allegation investigation files and the corresponding incident review which occur during the corrective action plan (CAP) period. Upon review of all submitted documentation the Auditor now finds the facility in compliance with subsection (a) of the standard.

AUDITOR CERTIFICATION:

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

Robin Bruck 3/02/2025

Auditor's Signature & Date

(b) (6), (b) (7)(C) 4/09/2025

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 5/05/2025

Assistant Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	7/16/2024	**To:**	7/18/2024
AUDITOR INFORMATION			
Name of auditor:	Robin Bruck	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866-(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 Director:	Mary DeAnda-Ybarra		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	11541 Montana Ave., Suite E, El Paso, TX 79936		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	El Paso Service Processing Center		
Physical address:	8915 Montana Ave., El Paso, Texas 79925		
Telephone number:	915-225-1900		
Facility type:	Service Processing Center		
PREA Incorporation Date:	9/22/2015		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Assistant Field Office Director (AFOD)
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	915-726-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	915-487-(b) (6), (b)

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the El Paso Service Processing Center (EPSPC) was conducted July 16 – July 18, 2024, by U.S. Department of Justice (DOJ) and DHS Certified PREA Auditors Robin M. Bruck and (b) (6), (b) (7)(C), employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the U.S. Immigration and Customs Enforcement (ICE) PREA Program Manager (PM) (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) and Assistant Program Manager (APM) (b) (6), (b) (7)(C), both DOJ and DHS Certified PREA Auditors. The PM's role is to provide oversight for the ICE PREA audit process and liaison with ICE Office of Professional Responsibilities (OPR), External Reviews and Analysis Unit (ERAU) during the audit review process. The purpose of the audit was to assess the facility's compliance with the DHS PREA Standards. The EPSPC is owned by U.S. Immigration and Customs Enforcement and operated by Paragon Professional Services (PPS), and is in El Paso, Texas. The audit is the third DHS PREA audit for EPSPC and includes a review period between July 18, 2023, and July 18, 2024.

The facility has a design capacity of 840. On the first day of the on-site audit, the detainee population was 813 detainees (577 males and 233 females). The top three nationalities of the facility population are Guatemala, Mexico, and Venezuela. The average length of stay is approximately 51 days. The facility does not house juveniles or family units.

Approximately six weeks prior to the onsite audit, the ERAU Inspections and Compliance Specialist (ICS) Team Lead (TL), (b) (6), (b) (7)(C), provided the Auditor with the Agency policies, facility's policies, and other pertinent documents through the ICE Audit Management and Review System (AMRS). The Pre-Audit Questionnaire (PAQ), policies, and supporting documentation had been organized utilizing the PREA Pre-Audit: Policy and Document Request DHS Immigration Detention Facilities form and placed into exhibit folders within AMRS for ease of auditing. Prior to the on-site audit, the Auditor reviewed all documentation provided, the Agency website, (https://www.ice.gov) and confirmed the facility website (https://www.ice.gov/detain/detention-facilities/el-paso-service-processing-center) links to the Agency website. The main policy which governs EPSPC's sexual abuse prevention, intervention and response efforts is ESEPC policy 2.11 Sexual Abuse Assault Prevention and Intervention Program Policy 2023.

An entrance briefing was held in the EPSPC's conference room on Tuesday, July 16, 2024, at 8:15 a.m. For the on-site portion only of the audit, the ICE ERAU ICS (b) (6), (b) (7)(C), opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C), ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), Detention and Deportation Officer (DDO), ICE/ERO
(b) (6), (b) (7)(C), DDO, ICE/ERO
(b) (6), (b) (7)(C), DDO, ICE/ERO
(b) (6), (b) (7)(C), Assistant Field Office Director (AFOD), ICE/ERO
(b) (6), (b) (7)(C), PSA Compliance Manager, PPS
(b) (6), (b) (7)(C), American Correctional Association (ACA) Supervisor, PPS
(b) (6), (b) (7)(C), Mail Clerk, PPS
(b) (6), (b) (7)(C), Contract Detention Operations Supervisor (CDOS), PPS
(b) (6), (b) (7)(C), Mail Clerk, PPS
(b) (6), (b) (7)(C), Chaplin, Jesuit Rescue Service
(b) (6), (b) (7)(C), ACA Supervisor, PPS

(b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (SDDO), ICE/ERO
(b) (6), (b) (7)(C), DDO, ICE/ERO
(b) (6), (b) (7)(C), Food Service Assistant Manager (FSAM), PPS
(b) (6), (b) (7)(C), CDOS, PPS
(b) (6), (b) (7)(C), Recreation Specialist (RS), PPS
(b) (6), (b) (7)(C), RS, PPS
(b) (6), (b) (7)(C), Assistant Health Services Administrator (AHSA), PPS
(b) (6), (b) (7)(C), Deputy Program Manager (DPM), PPS
(b) (6), (b) (7)(C), Captain, Asset
(b) (6), (b) (7)(C), SDDO, ICE/ERO
(b) (6), (b) (7)(C), SDDO, ICE/ERO
Robin M. Bruck, DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC
(b) (6), (b) (7)(C), DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC

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

A site review of the facility was conducted by the Auditors, and accompanied by key staff from EPSPC and ICE. All areas of the facility where detainees are afforded the opportunity to go were observed to include housing units, programming, booking/intake, recreation, visitation, laundry, food service, library, and medical areas. In addition, the Auditor observed the control center, sally port, and administrative offices. During the on-site audit, the Auditor made visual observations of bathrooms and shower areas, camera locations, and the number of staff assigned in all areas of the facility. During the on-site audit, the Auditor further observed PREA information, in English and Spanish, in all common areas of the facility and within the housing units near the detainee telephones, which included the DHS-prescribed sexual assault notice, the Detention and Reporting Information Line (DRIL) poster, the DHS Office of Inspector General (OIG) poster, the Center Against Sexual and Family Violence (CASFV) poster, and information for contacting consular officials. In addition, during the on-site audit, the Auditor tested the telephone numbers provided for the DRIL, the DHS OIG, and CASFV and confirmed they were in good working order; however, not all phones available to the detainees allowed for anonymous calling when following the instructions provided by the facility.

According to the PAQ, EPSPC (b) (7)(E) to assist with the monitoring of detainees. During the on-site audit the Auditor observed (b) (7)(E)
(b) (7)(E)

The EPSPC PAQ indicates the facility employs 729 employees who may have reoccurring contact with detainees, consisting of 552 PPS and Asset security staff (363 males 189 females), 43 medical and mental health staff (19 ICE Health Services Corps (IHSC) and 24 STG International), and 117 ICE staff. Additional staff included 27 food service staff, 14 maintenance staff, and contract employes to include 15 ACEPEX Management Corporation staff who provide heating, ventilation, and air conditioning (HVAC) and plumbing services and 10 MAVAGI Enterprises staff who provide custodial services. In addition, the facility utilizes 35

volunteers employed by Jesuit Rescue Services to provide religious services. According to the PAQ correctional staff work in five shifts (b) (7)(E) [redacted]. The facility provided the Auditor with staff rosters for random selection of interviews and file reviews. During the on-site audit, the Auditors interviewed 20 staff members which included the AFOD, a Program Manager (PM), the PSA Compliance Manager/PREA Investigator/Retaliation Monitor/Disciplinary Officer/Incident Review Team Member, a Human Resource Manager (HRM), the AHSA, a Licensed Practical Nurse (LPN), a Licensed Clinical Social Worker (LCSW), a Segregation Supervisor, 2 Staff who Conduct Unannounced Rounds, the Grievance Officer (GO), 2 Processing Officers, a Classification Officer, and 6 Random Detention Officers (DO)s. In addition, the Auditor interviewed a contractor and a volunteer. All interviews were conducted in a private setting allowing for confidentiality for those participating in the interview process.

The Auditor conducted 27 detainee interviews to include 2 random English-speaking detainees and 19 limited English proficient (LEP) detainees, 1 transgender detainee, 1 detainee who identified as gay, 2 disabled detainees, 1 detainee who reported sexual abuse at the facility, and 1 detainee who reported a history of sexual abuse. LEP interviews were conducted with the use of a language line through Language Services Associates (LSA) provided by Creative Corrections, LLC. All interviews were conducted in a private setting allowing for confidentiality for those participating in the interview process.

The facility PREA Allegation Spreadsheet indicated the facility had 28 sexual abuse allegations closed during the reporting period. The Auditor reviewed 11 of the closed sexual abuse allegation investigations, which included 5 detainee-on-detainee allegations and 6 staff-on-detainee allegations and confirmed 10 of the sexual abuse allegation investigations were determined to be unsubstantiated and 1 was determined to be unfounded.

An exit briefing was conducted on Thursday, July 18, 2024, at 2:30 p.m. The ICE ERAU TL opened the briefing and turned it over to the Auditor. In attendance were:

(b) (6), (b) (7)(C), ICS/ICE/OPR/ERAU
(b) (6), (b) (7)(C), DO, ICE/ERO
(b) (6), (b) (7)(C), AFOD, ICE/ERO
(b) (6), (b) (7)(C), PSA Compliance Manager, PPS
(b) (6), (b) (7)(C), ACA Supervisor, PPS
(b) (6), (b) (7)(C), CDOS, PPS
(b) (6), (b) (7)(C), DO, ICE/ERO
(b) (6), (b) (7)(C), Deputy Chief Compliance Manager (DCCM), PPS
(b) (6), (b) (7)(C), CDOS, PPS
(b) (6), (b) (7)(C), AHSA, PPS
(b) (6), (b) (7)(C), DPM, Asset
(b) (6), (b) (7)(C), SDDO, ICE/ERO
(b) (6), (b) (7)(C), SDDO, ICE/ERO
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(b) (6), (b) (7)(C), DOJ/DHS Certified PREA Auditor, Creative Corrections, LLC

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

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 1

- §115.31 - Staff training.

Number of Standards Met: 24

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator.
- §115.18 - Upgrades to facilities and technologies.
- §115.21 - Evidence protocols and forensic medical examinations.
- §115.32 - Other training.
- §115.34 - Specialized training: Investigations.
- §115.35 - Specialized training: Medical and mental health care.
- §115.43 - Protective custody.
- §115.52 - Grievances.
- §115.54 - Third-party reporting.
- §115.62 - Protection duties.
- §115.63 - Reporting to other confinement facilities.
- §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.
- §115.82 - 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: 15

- §115.13 - Detainee supervision and monitoring.
- §115.15 - Limits to cross-gender viewing and searches.
- §115.16 - Accommodating detainees with disabilities and detainees who are limited English proficient.
- §115.17 - Hiring and promotion decisions.
- §115.22 - Policies to ensure investigation of allegations and appropriate agency oversight.
- §115.33 - Detainee education.
- §115.41 - Assessment for risk of victimization and abusiveness.
- §115.42 - Use of assessment information.
- §115.51 - Detainee reporting.
- §115.53 - Detainee access to outside confidential support services.
- §115.61 - Staff reporting duties.
- §115.64 - Responder duties.
- §115.65 - Coordinated response.

- §115.81 - Medical and mental health assessments; history of sexual abuse.
- §115.86 - Sexual abuse incident reviews.

Number of Standards Not Applicable: 1

- §115.14 - Juvenile and family detainees.

PROVISIONS

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

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

Outcome: Meets Standard

Notes:

(c): EPSPC policy 2.11 states, "The EPC maintains a zero-tolerance policy for all forms of sexual abuse or assault. It is the policy of the EPC to provide a safe and secure environment for all detainees, employees, contractors, and volunteers, free from the threat of sexual abuse or assault, by maintaining a Sexual Abuse and Assault Prevention and Intervention (SAAPI) Program that ensures effective procedures for preventing, reporting, responding to, investigating, and tracking incidents or allegations of sexual abuse or assault." A review of the facility policy confirmed the policy outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment through, but not limited to, hiring practices, training, unannounced security inspections, mandatory reporting protocols, investigations, and support from outside victim advocates. During the on-site audit, the Auditor observed the DHS-prescribed sexual abuse and assault awareness notice posted in all housing units and common areas of the facility. In interviews with 20 staff members, it was confirmed all staff interviewed were knowledgeable regarding both the Agency and facility zero tolerance policies. Interviews with the AFOD, the facility Program Manager, and the PSA Compliance Manager confirmed EPSPC policy 2.11 was referred and approved by the Agency.

(d): EPSPC policy 2.11 states, "The facility shall designate a Prevention of Sexual Assault (PSA) Compliance Manager who shall serve as the EPC point of contact for the local field office and ICE PSA Coordinator. The PSA Compliance Manager must have sufficient time and authority to oversee facility efforts to comply with EPC sexual abuse and assault prevention and intervention policies and procedures." The Auditor reviewed the facility Organizational Chart and confirmed the PSA Compliance Manager reports directly to the DCCM. An interview with the facility PSA Compliance Manager confirmed he is the point of contact for the Agency PSA Coordinator and has the time and authority to effectively oversee the facility's efforts to comply with the facility's sexual abuse, prevention, and intervention policies and procedures.

Corrective Action:

No corrective action needed.

§115.13 - Detainee supervision and monitoring.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "The EPC ensures that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse assault, other forms of violence or harassment, and to prevent significant self-harm and suicide. In determining adequate levels of detainee supervision and determining the need for video monitoring, the AFOD shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the compositions of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse as well as other incidents reflecting on facility security and detainee safety, the length of time detainees spend in agency custody, and any other relevant

factors." An interview with the AFOD, the facility PM, and PSA Compliance Manager indicated an assessment of the facility's staffing levels is conducted annually. In an interview with the PM, it was indicated the facility's staffing plan provides the minimum requirements for all security positions and the posts which are required to be filled; however, the facility did not provide a copy of a written assessment. In an interview with the PM, it was further indicated the facility has been consistently staffed with more staff required by minimum requirements. However, in interviews with the PM and PSA Compliance Manager it was confirmed neither staff member could articulate the review considers all elements required by the facility policy and subsection (c) of this standard. During the on-site audit, the Auditor reviewed the facility comprehensive security guidelines and confirmed they had last been reviewed or updated on September 1, 2023. During the on-site audit, the Auditor observed no blind spots and the facility maintained adequate staff and video monitoring to protect detainees from sexual abuse.

(d): EPSPC policy 2.11 states, "Frequent unannounced security inspections shall be conducted on all shifts to control the introduction of contraband, identify, and deter sexual abuse of detainees; ensure safety, security, and good order, prevent escapes, maintain sanitary standards, and eliminate fire and safety hazards. This will include frequent security inspections of all personnel entering or exiting the secured perimeter of the EPC and shall prohibit staff from alerting others that these security inspections are occurring unless such announcement is related to the legitimate operation functions of the facility." An interview with the PSA Compliance Manager indicated all security supervisors are required to conduct unannounced security inspections every day and on every shift. An interview with the PSA Compliance Manager further indicated each supervisor will document the unannounced security inspections in the housing unit logbooks in red ink. Interviews with two supervisors confirmed they conduct unannounced security rounds to review paperwork, such as the logbooks, check to ensure the officer has signed the comprehensive guideline review, and to make sure there is only one person in each bunk; however, interviews with two supervisors could not confirm unannounced security inspections are conducted to identify and deter sexual abuse. Interviews with two supervisors further indicated unannounced security inspections are also conducted in all areas of the facility, to include areas which may be closed at night. In addition, interviews with two supervisors confirmed staff are prohibited from notifying other staff the unannounced security inspections are occurring. During the on-site audit, the Auditor observed a supervisor conducting an unannounced security inspection, and confirmed he answered the phone ringing in the housing unit officer cage, and based on hearing the one-sided conversation, the officer in the first housing unit was calling to inform the second housing unit officer the supervisor was coming in through the bathroom gate. In addition, following the phone call, the Auditor observed the supervisor counseling the officer over the phone and warning the officer they would be reprimanded should the officer notify other staff, unannounced security inspections were being conducted in the future.

Recommendation (d): The Auditor recommends the facility train all security staff on the requirements of subsection (d) of the standard which prohibits staff from notifying other staff, unannounced security inspections are being conducted.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. An interview with the AFOD, the facility PM, and PSA Compliance Manager indicated that an assessment of the facility's staffing levels is conducted annually; however, in interviews with the PM and PSA Compliance Manager it was confirmed neither staff member could articulate the review considers all elements required by the facility policy and subsection (c) of this standard. To become compliant, the facility must implement a process to assess staffing levels, and the need for video monitoring, to include consideration of generally accepted detention and correctional practices, 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, and any other relevant factors, including but not limited to the length of time

detainees spend in the agency custody. Once implemented, the facility must submit documentation to confirm the assessment took into consideration all requirements of subsection (c) of the standard.

The facility is not in compliance with subsection (d) of the standard. Interviews with two supervisors confirmed they conduct unannounced security inspections to review paperwork, such as the logbooks, check to ensure the officer has signed the comprehensive guideline review, and to make sure there is only one person in each bunk; however, interviews with two supervisors could not confirm unannounced security inspections are conducted to identify and deter sexual abuse. To become compliant, the facility must submit documentation which confirms all security supervisors have received training on the requirements of subsection (d) of the standard to include unannounced security inspections are to be conducted to identify and deter sexual abuse.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable

Notes:

The Auditor reviewed a memorandum to the file which states, "Concerning 115.14, Exhibit 5, Juvenile and Family detainees, the El Paso Processing Center (EPC) does not house juveniles or families and has not done so in the last year." Through Auditor observations and interviews with facility staff it was confirmed the facility does not house juvenile detainees or family units; and therefore, standard 115.14 is not applicable.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(b)(c)(d)(e)(f): EPSPC policy 2.11 states, "Pat-down searches of male detainees by female staff shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances. Pat-down searches of female detainees by male staff shall not be conducted unless in exigent circumstances. All pat-down searches by staff of the opposite gender shall be documented. Strip searches or visual body cavity searches by staff of the opposite gender shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner. All strip searches and visual body cavity searches will be documented." The Auditor reviewed a memorandum to the file which states, "Concerning 115.15 (f)-Exhibit 6, Limits to Cross-Gender Viewing and Searches, there has been zero (0) cross-gender searches conducted within the last 12 months at the El Paso Processing Center (EPC). Supporting documentation stating zero strip searches will be provided." An interview with the PSA Compliance Manager indicated the facility does not conduct cross-gender pat-down searches, cross-gender strip searches, or visual body cavity searches, unless there are exigent circumstances. An interview with the PSA Compliance Manager further indicated if a cross-gender pat-down search, strip search, or visual cavity search was to occur at the facility it would be documented in the facility Detainee Strip Search and Cross-gender Logbook. During the on-site audit, the Auditor reviewed the Detainee Strip Search and Cross-gender Logbook and confirmed there were no cross-gender pat-down searches, strip searches, or visual cavity searches which occurred during the audit period. Interviews with six random DOs confirmed they were aware cross-gender pat-down searches, strip searches, cross-gender strip searches, and visual body cavity searches are strictly prohibited at EPSPC; however, if exigent circumstances require a search to occur, it would be documented in the facility Detainee Strip Search and Cross-gender Logbook. In interviews with 27 detainees, it was indicated they are routinely pat-down searched when they leave the housing unit; however, the pat-down search is always conducted by staff of the same gender. In interviews with 27 detainees, it was further indicated none had been strip-searched while housed at EPSPC.

(g): EPSPC policy 2.11 states, "Detainees shall be able to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Staff of the opposite gender shall announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing. The officers and/or staff may proceed once the area is clear to enter." In an interview with the PSA Compliance Manager, it was indicated cross-gender supervisors do not conduct unannounced rounds in the housing units of the opposite gender detainees. In an interview with the PSA Compliance Manager, it was further indicated the facility procedures for entering the housing units require prior to cross-gender staff entering a housing unit, the staff member must notify the housing unit officer 15 minutes before entering the housing unit, to allow all detainees to exit the shower and toilet areas which was observed by the Auditor during the on-site audit. An interview with the PSA Compliance Manager indicated facility procedures require staff of the opposite gender to call the housing unit 15 minutes prior to entering the housing unit and the officers assigned to the housing unit will instruct all detainees to exit the showers and the toilet areas, as opposite gender staff will be entering. An interview with the PSA Compliance Manager further indicated only male staff work in the male housing units and only female staff work in the female housing units and female staff can relieve a male officer, if necessary; however, the same procedure would be followed prior to the female officer entering the unit. During the on-site audit, the Auditor observed the 15-minute procedure and confirmed the detainees are given a 15-minute warning of opposite gender staff entering the housing units. Interviews with 27 random detainees indicated they are provided privacy while showering, using the toilet, or changing their clothes. Interviews with 27 random detainees further indicated they are always aware of opposite gender staff entering the housing area. During the on-site audit, the Auditor reviewed the facility control center's view of all housing units and toilet areas and confirmed a strategically placed black box prohibits cross gender viewing of detainees while using the toilet, changing, or showering. During the on-site audit, the Auditor further observed the processing (intake) area and confirmed the area is divided into a male side and a female side; however, on both sides, the holding cells have large windows, which enable staff of the opposite gender to visually monitor the detainees. In addition, during the on-site audit the Auditor observed in the holding cells on the male side, a moveable metal privacy barrier was placed near the toilets; however, the moveable metal privacy barrier did not adequately shield the toilets from being viewing by cross-gender staff in the area. During the on-site audit the Auditor observed the female side had a permanent wall barrier around the toilet area; however, it did not adequately shield the toilets from being viewed by cross-gender staff assigned to the area.

(h): EPSPC is not designated as Family Residential Centers; and therefore, subsection (h) is not applicable.

(i)(j): EPSPC policy 2.11 states, "All pat-down searches shall be performed in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. Security staff shall be trained in proper procedures for conducting pat searches, including cross-gender pat searches and searches of transgender and intersex detainees." The Auditor reviewed the PPS Detainee Search curriculum and confirmed it states, "Detainee searches should be frequent, unannounced and conducted in a professional, dignified manner." The Auditor reviewed the Agency Cross-Gender, Transgender, and Intersex Searches curriculum and confirmed the curriculum includes the proper procedures for conducting pat-down searches including cross-gender pat-down searches and searches of transgender and intersex detainees. The Auditor reviewed 13 security staff files (10 DOs and 3 ICE staff) and confirmed all staff had completed the facility Detainee Search training and the Agency Cross-Gender, Transgender, and Intersex Searches curriculum. Interviews with six random DOs confirmed they had received training in conducting pat-searches and pat-searches of transgender or intersex detainees. Interviews with six random DOs further confirmed each DO could articulate searches are conducted in a professional and respectful manner. In addition, interviews with six random DOs confirmed each DO could articulate a search of a transgender detainee could not be performed for the sole purpose of determining the detainee's genital status. During the on-site audit, the

Auditor observed a pat-search of a detainee and confirmed staff of the same gender conducted the pat-search professionally and respectfully communicating with detainee as he conducted the search.

Corrective Action:

The facility is not in compliance with subsection (g) of the standard. During the on-site audit, the Auditor observed the processing (intake) area and confirmed the area is divided into a male side and a female side; however, on both sides, the holding cells have large windows which enable staff of the opposite gender to visually monitor the detainees. During the on-site audit the Auditor further observed in the holding cells on the male side, a moveable metal privacy barrier was placed near the toilets; however, the moveable metal privacy barrier did not adequately shield the toilets from being viewing by cross-gender staff in the area. In addition, during the on-site audit the Auditor observed the female side had a permanent wall barrier around the toilet area; however, it did not adequately shield the toilets from being viewed by cross-gender staff assigned to the area. To become compliant, the facility must submit documentation to confirm the facility has implemented a process to ensure detainees are able to utilize the toilets in the holding cells without being viewed by staff of the opposite gender.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b): EPSPC policy 2.11 states, "The EPC shall take appropriate steps to ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and assault. Such steps will include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, or detainees who have intellectual, psychiatric, or speech disabilities, limited reading skills, or who are blind or have low vision, by: (a) Providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. (b) Providing access to written materials related to sexual abuse in formats or through methods that ensure effective communication. EPSPC will take 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 limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary." EPSPC policy 2.11 further states, "Where practicable, provisions for written translation of materials related to sexual abuse or assault shall be made for any significant segments of the population with limited English proficiency. Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate." Interviews with the PSA Compliance Manager, two Processing Officers, and six random DOs indicated reasonable accommodations are made to ensure a detainee receives notification, orientation, and instruction on the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse, to include but not limited to, the use of a teletypewriter (TTY), a Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for those detainees who are deaf or hard of hearing. Interviews with the PSA Compliance Manager, two Processing Officers, and six random DOs further indicated for detainees who have limited reading skills or are LEP, staff will utilize the facility language line to interpret the information or a staff interpreter, who is proficient in the detainee's preferred language. In addition, interviews with the PSA Compliance Manager, two Processing Officers, and six random DOs indicated if a detainee is blind, the staff would read the information to the detainee and if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. During the on-site audit, the Auditor observed the ICE National Detainee Handbook, was readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese and the DHS-prescribed

Sexual Assault Awareness (SAA) Information pamphlet readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Ukrainian and Vietnamese. In addition, the Auditor observed the facility Detainee Handbook, was readily available in five languages, to include English, Spanish, French, Arabic and Russian. In interviews with 19 LEP detainees it was indicated, during intake staff utilized either a staff member or the language line to interpret; however, information regarding sexual abuse was not read to them. In interviews with 19 LEP detainees, 9 detainees whose preferred language is Spanish confirmed all written material had been provided to them in Spanish; however, 3 detainees whose preferred language is Spanish, 1 detainee whose preferred language was Chinese, 1 detainee whose preferred language was Russian, 2 detainees whose preferred language was Arabic, 1 detainee whose preferred language was Iranian and 1 detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with one detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. During the on-site audit, the Auditor observed a video of a detainee intake and confirmed the detainee had been given both handbooks and the DHS-prescribed SAA Information pamphlet; however, the Auditor could not confirm the material was given to the detainee in the manner the detainee could understand. A review of 32 detainee files confirmed LEP detainees are not consistently provided written materials related to sexual abuse in a format or through methods resulting in effective communication.

(c): EPSPC policy 2.11 states, "In matters relating to allegations of sexual abuse, the facility will employ effective expressive and receptive verbal communication techniques while communicating with detainees with disabilities in accordance with professionally accepted standards of care. EPSPC will provide detainees with disabilities and detainees with limited English proficiency with in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary. Interpretation services will be provided by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and ICE/ERO determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse or assault, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse or assault." Interviews with six random DOs indicated if a detainee victim expressed a preference for another detainee to interpret, and it is approved by the Agency, they would accommodate the detainee victim and it would be documented in an incident report. Interviews with six random DOs further indicated all DOs interviewed were aware they could not utilize the alleged abuser, a detainee who witnessed the alleged abuse, or a detainee who has a significant relationship with the alleged abuser to interpret for the detainee victim. A review of 11 sexual abuse allegation investigations confirmed there were no instances where another detainee was utilized for interpretation during an allegation of sexual abuse investigation.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. In interviews with 19 LEP detainees, eight detainees whose preferred language is Spanish confirmed all written material had been provided to them in Spanish; however, three detainees whose preferred language is Spanish, one detainee whose preferred language was Chinese, one detainee whose preferred language was Russian, two detainees whose preferred language was Arabic, one detainee whose preferred language was Iranian and one detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with one detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. A review of 32 detainee files confirmed LEP detainees are not consistently provided written materials related to sexual abuse in a format or through methods resulting in effective communication. To become compliant, the facility must implement a procedure to ensure all detainees with disabilities, to include limited English proficient, are provided meaningful access and an equal opportunity to participate in or benefit from all aspects of the Agency's and the

facility's efforts to prevent, detect, and respond to sexual abuse, in a manner they can understand. Once implemented the facility must submit documentation which confirms all applicable staff have been trained on the procedure. In addition, the facility must submit 10 detainee files, if applicable, specifically, detainee files which do not include detainees whose preferred language is English, Spanish, French, or Russian.

§115.17 - Hiring and promotion decisions.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks. ICE Directive 6-7.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity. EPSPC policy 2.11 states, "The EPC shall not hire or promote anyone who may have interactions with detainees, and shall not enlist the services of any contractor or volunteer who may have interaction with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution; who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity. When the EPC is considering hiring or promoting staff, it shall ask all applicants who may have contact with detainees directly about previous misconduct described in paragraph (a) of this section, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The EPC shall also enforce upon employees a continuing affirmative duty to disclose any such misbehavior. Before hiring new employees, who may have contact with detainees, the EPC shall require a background investigation to regulate whether the candidate for hire is suitable for employment with the agency. The agency shall conduct an updated background investigation for agency employees every five years. The EPC shall also perform a background investigation before soliciting the services of any contractor who may interact with detainees. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate. Unless prohibited by law, the EPC 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." An interview with the HRM indicated all potential employees and contractors are required to complete an application on-line, and an interview, and if accepted they are given a conditional offer of employment pending proof of eligibility to work in the United States, completion of a satisfactory background investigation, and reference checks. An interview with the HRM further indicated background investigations are completed by the Personnel Security Unit (PSU), to determine suitability for employment with both the Agency and the facility and the PSU will conduct a background investigation every five years on all Agency staff and facility staff. In addition, in an interview with the HRM it was indicated all potential employees, contractors, and volunteers are required to complete a DHS 6 Code of Federal Regulations Part 115 form during the hiring process and each employee is required to complete the form during their annual in-service training and during a promotion process. In an interview with the HRM it was further indicated if she receives a request from an institutional employer regarding a former employee, if there was a substantiated

allegation of sexual abuse in the prospective employee's file, she would share the information. During the on-site audit, the Auditor reviewed the on-line application and confirmed the applicant is required to sign the following statement, "I understand that I may be found "unfit for duty" for the following "Falsification or unlawful concealment, removal, mutilation or destruction of any official documents or records, or concealment of material facts by willful omissions from official documents or records including, but not limited to, logbooks, statements related to investigations, and other utterance, whether written or verbal of an untruthful nature." During the on-site audit, the Auditor further reviewed the DHS 6 Code of Federal Regulations Part 115 form and confirmed the form asks, "Have you ever been found to have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution, or convicted of engaging or attempting to engage in sexual activity with any person by force, threat of force or coercion or if the victim did not or could not consent? Have you been civilly or administratively adjudicated to have engaged in the activity described above? Have you been found to have engaged in sexual harassment at work?" A review of the DHS 6 Code of Federal Regulations Part 115 form further confirmed the participant is required to acknowledge by signature the following statement, "I understand that a knowing and willful false response may result in a negative finding regarding my fitness as a contract employee supporting ICE. Furthermore, should my answers change at any time I understand I am responsible for immediately reporting the information to my Program Manager." An interview with the AFOD indicated there have been four Agency promotions within the past year, to include himself and he did not believe he, or the other staff, were required to complete the DHS 6 Code of Federal Regulations Part 115, as part of the promotion process. The Auditor reviewed 16 files, which included 10 DOs, 3 contractor staff (2 ACEPEX Management Corporation, 1 Magavi Enterprises), and 3 volunteers and confirmed a DHS 6 Code form had been completed annually during the in-service training. In addition, a review of the files confirmed three of the facility staff had received a promotion during the audit period and had completed a DHS 6 Code form prior to the promotion. The Auditor submitted 20 names which included 10 facility staff, 7 contract staff (4 STG medical, 2 ACEPEX Management Corporation, 1 Magavi Enterprises), and 3 ICE staff utilizing the PSU Background Investigation for Employees and Contractors to PSU to confirm completion of initial background investigations, use of the DHS 6 Code of Federal Regulations Part 115 form, and background investigations being completed every five years. Documentation confirming completion had been received for all names except for the four contracted STG medical staff as PSU could not locate the records; and therefore, the Auditor could not confirm completion of initial background investigations or use of the DHS 6 Code of Federal Regulations Part 115 form prior to hiring contracted STG medical staff.

Corrective Action:

The facility is not in compliance with subsections (b) and (d) of the standard. An interview with the AFOD indicated there have been four agency promotions within the past year, to include himself. He indicated he did not believe he or the other staff were required to complete the DHS 6 Code of Federal Regulations Part 115, as part of the promotion process. In addition, although requested by the Auditor none of the staff could produce the t DHS 6 Code of Federal Regulations Part 115. The Auditor submitted the names of four STG contracted medical staff, utilizing the PSU Background Investigation for Employees and Contractors to PSU to confirm completion of initial background investigations and the DHS 6 Code of Federal Regulations Part 115 form; however, could not confirm completion of initial background investigations or use of the DHS 6 Code of Federal Regulations Part 115 form prior to hiring the STG contracted medical staff. To become compliant, the Agency shall implement a process to ensure that prior to promotions, staff are asked about previous misconduct described in subsection (a) of the standard. The facility must implement a practice which requires all STG contract staff complete both a background check and the DHS 6 Code of Federal Regulations Part 115 form prior to hiring. In addition, the facility must submit documentation that all STG contract staff employed at the facility have completed both a background check and the DHS 6 Code of Federal Regulations Part 115 form.

§115.18 - Upgrades to facilities and technologies.

Outcome: Meets Standard

Notes:

(a)(b): EPSPC policy 2.11 states, "When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the EPC shall consider the effect of the design, acquisition, expansion, or modification upon its ability to protect detainees from sexual abuse. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in a facility, the facility shall consider how such technology may enhance its ability to protect detainees from sexual abuse." The Auditor reviewed a memorandum to the file which states, "The designing of a new building was done in accordance with the ICE Facility Design Guide revised 2023 11." The Auditor reviewed another memorandum to the file which states, "The facility has not installed or updated video/electronic monitoring systems with the audit period." Interviews with the AFOD and the facility PSA Compliance Manager indicated a new building is currently under construction and has several more months to completion. Interviews with the AFOD and the facility PSA Compliance Manager further indicated the facility has had upgrades to the video monitoring equipment; the equipment was placed in the same location, as the prior equipment, as it provided the best view for monitoring detainee safety and protection from sexual abuse.

Corrective Action:

No corrective action needed.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e): The Agency's Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per Policy 11062.2, "when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." EPSPC policy 2.11 states, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and prosecution of sexual abuse and assault perpetrators to address victims' needs most appropriately. The EPC shall attempt to enter into memoranda of understanding or other agreements with community service providers or, if local providers are not available, national organizations that provide legal advocacy and confidential emotional support services from immigrant victims of crime. The AFOD shall establish procedures to make available to detainee's information about local organizations that can assist detainees who have victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If no such local organizations exist, the EPC shall make available the same information about national organizations. Following an allegation of sexual abuse, the AFOD shall establish procedures to make available, to the full extent possible, additional outside victim services. The EPC shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available, the EPC shall work with ICE to provide these services from a qualified staff member from a community-based organization, or qualified ICE staff member. The victim advocate shall be able to provide emotional support, crisis intervention, information and referrals. The EPC shall enable reasonable communication between detainees and these organizations or agencies, in as confidential manner as possible." EPSPC policy 2.11 further states, "Where evidentiarily or medically appropriate, at no cost to the detainee, and only with detainee's consent, the AFOD shall arrange for an alleged victim to undergo a forensic medical examination by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE), where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel. As requested by a victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam,

shall be allowed for support during a forensic exam and investigatory interviews." Interviews with the AFOD and the PSA Compliance Manager/Investigator indicated the facility is responsible for conducting administrative investigations and previously ICE ERO Administrative Investigation Unit (AIU) would conduct the investigation if the allegations appeared to be criminal; however, recently the facility has had discussions with the Federal Bureau of Investigations (FBI) who is now responsible for conducting criminal investigations within the facility. Interviews with the AFOD and the PSA Compliance Manager/Investigator further indicated the facility has not requested the FBI to follow the requirements of §115.21 (a)-(d); however, prior to the conclusion of the on-site audit, the AFOD sent the FBI an email to make the request and the FBI had replied, confirming all requirements contained in §115.21 (a)-(d) are currently part of the FBI protocol for investigating sexual abuse. In addition, interviews with the AFOD and the PSA Compliance Manager/Investigator indicated if a sexual abuse were to occur at the facility, the detainee victim would be transported to University Medical Center (UMC) for a SANE examination. During the on-site audit the Auditor interviewed the UMC Trauma Manager for Education, Injury Prevention, and SANE and confirmed a SANE nurse is available 24/7. An interview with the UMC Trauma Manager for Education, Injury Prevention, and SANE further confirmed a detainee victim would be transported to the UMC Emergency Room and once medically cleared, a SANE consult and examination would be completed at no cost with the consent of the detainee victim. In addition, an interview with the UMC Trauma Manager for Education, Injury Prevention, and SANE confirmed a victim advocate from CASFV, would be present to provide the detainee victim support during the examination and for investigatory interviews. The Auditor reviewed an Agreement of Understanding between EPSPC and CASFV, dated November 29, 2017, without an ending date and confirmed CASFV would provide legal advocacy and confidential support services for the immigrant victims of crime housed at the facility. During the on-site audit, the Auditor utilized a detainee telephone in a housing unit and spoke with an advocate from CASFV and confirmed a detainee victim of sexual abuse would be taken to UMC for a SANE examination and would be accompanied by a CASFV victim advocate during the exam and any investigatory interviews, to provide emotional support, crisis intervention, information, and any referrals should they be necessary. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed 3 criminal investigations had been conducted by ICE ERO AIU and 1 detainee victim was transported to UMC for a SANE examination; however, the detainee victim refused the exam. Interviews with the AFOD and the facility PSA Compliance Manager/Investigator indicated the facility protocol was developed in coordination with DHS. The facility does not house juveniles.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): The Agency provided Policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary; b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." EPSPC policy 2.11 further states, "The AFOD shall promptly report the incident to the ICE FOD and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. If an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the AFOD shall also notify the local government entity or contractor that

operates the EPC." EPSPC policy 2.11 further states, "Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years." A review of the facility investigative protocol confirms the policy includes a description of the responsibilities of the Agency, the facility, and law enforcement and requires all PREA allegation reports and referrals be documented and maintained for at least five years. A review of the facility investigative protocol further confirms the protocol requires the SDDO on duty, or the PSA Compliance Manager, to notify the AFOD. An interview with the AFOD indicated all allegations of sexual abuse, whether the abuser is a detainee, employee, contractor, or volunteer, are reported through the chain of command by the officer or staff member receiving the allegation notifying the PSA Compliance Manager who will notify the SDDO, who notifies within two hours, the AFOD, JIC, and ICE OPR/DHS OIG. An interview with the AFOD further indicated the AFOD notifies the DFOD and the DFOD notifies the FOD and the AFOD or the PSA Compliance Manager will notify the FBI, if the allegation appears to be criminal. An interview with the PSA Compliance Manager/Investigator indicated he will begin an administrative investigation once OPR/JIC indicate the allegation has been determined to be a PREA allegation. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed notifications had been made to ICE OPR, DHS OIG, and the Joint Intake Center (JIC). In addition, the Auditor reviewed the Agency website (https://www.ice.gov/prea) and confirmed Agency Policy 11062.2 is posted and available to the public. However, a review of the facility website (https://www.ice.gov/detain/detention-facilities/el-paso-service-processing-center) and confirmed the facility website links with the Agency website; however, a review of the facility website could not confirm EPSPC policy 2.11 had been posted on the website. In addition, during the on-site audit, through Auditor observations, the Auditor confirmed EPSPC policy 2.11 is not available to the public.

Corrective Action:

The facility is not in compliance with subsection (c) of the standard. A review of the facility website could not confirm EPSPC policy 2.11 had been posted on the website. In addition, during the on-site audit, through Auditor observations, the Auditor confirmed EPSPC policy 2.11 is not available to the public. To become compliant, the facility must submit documentation which confirms EPSPC policy 2.11 is available to the public.

§115.31 - Staff training.

Outcome: Exceeds Standard

Notes:

(a)(b)(c): The Agency's policy 11062.5.2 states, "The Agency shall document that all ICE personnel who may have contact with individuals in ICE custody have completed training." EPSPC policy 2.11 states, "Training on the EPC's SAAPI Program shall be included in initial and annual refresher training for all employees. Training shall include: The EPC's zero-tolerance policies for all forms of sexual abuse. Definitions and examples of prohibited and illegal sexual behavior. The right of detainees and staff to be free from sexual abuse, and from retaliation from reporting sexual abuse. Instructions that sexual abuse and/or sexual assault is never an acceptable consequence of detention. Recognition of situations where sexual abuse and/or sexual assault may occur. How to avoid inappropriate relationships with detainees. Working with vulnerable populations and addressing their potential vulnerability in the general population. Recognition of the physical, behavior, and emotional signs of sexual abuse and/or assault and ways to prevent and respond to such occurrences. The requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee victim's welfare, and for law enforcement/investigative purposes. The investigation process and how to ensure that evidence is not destroyed. Prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities. How to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees. Instructions on reporting knowledge or suspicion of sexual abuse and/or assault. Instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and/or assault." The Auditor reviewed the PPS Prison Rape Elimination Act (PREA) Sexual Abuse and Assault Prevention and Intervention (SAAPI) curriculum and confirmed the training includes the Agency and the facility's zero tolerance policies for all forms of sexual abuse; definitions and examples of prohibited behavior;

the right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotions signs of sexual abuse, and methods of preventing and responding to such occurrences; how to avoid inappropriate relationships with detainees; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees; procedures for reporting knowledge or suspicion of sexual abuse; and the requirement to limit reporting sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigation purposes. An interview with the PSA Compliance Manager indicated all staff, contractors, and volunteers are required to attend PREA training on an annual basis during facility In-Service training. Interviews with six random DOs confirmed their knowledge of PREA and how to fulfill their responsibilities. The Auditor reviewed 20 staff files, which included 10 DOs, 3 contractors, 4 medical contractors, and 3 volunteers and confirmed documentation of annual PREA training was included in each file. In addition, the Auditor reviewed three ICE staff training certificates and confirmed the three ICE staff had received PREA training for the years 2023 and 2024. Based on the facility conducting PREA training annually, the facility exceeds the requirement of the standard.

Corrective Action:

No corrective action needed.

§115.32 - Other training.

Outcome: Meets Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "All volunteers and other contractors who have contact with detainees shall be trained on their responsibilities under the EPC's sexual abuse prevention, detection, intervention and response policies and procedures. The level and type of training for volunteers and contractors will be based on the services they provide and their level of contact with detainees; however, all volunteers and contractors who have any contact with detainees must be notified of the ICE and EPC's zero-tolerance policy and informed how to report such incidents." An interview with the PSA Compliance Manager indicated the facility currently utilizes 35 volunteers for religious services. Each volunteer is required to complete annual ICE PREA Training for Contractors and Volunteers and the facility Sexual Abuse and Assault Prevention and Intervention training. The Auditor reviewed both training curriculums and confirmed the training includes the Agency and the facility zero tolerance policies and how to report an incident. An interview with a facility volunteer indicated volunteers must attend PREA training each year. During the on-site audit the Auditor reviewed three volunteer training files and confirmed they have received the required training. An interview with the PSA Compliance Manager confirmed "other" contractors were not required to receive PREA training as they spend a short time at the facility and are always escorted by a DO; however, during the on-site audit, the facility immediately developed and implemented a procedure to ensure all "other" contractors are trained on the Agency and the facility's zero tolerance policy and how to report an allegation of sexual abuse by mandating "other" contractors, and vendors, to sign in, upon entering the facility acknowledging the facility and Agency zero-tolerance policy and receipt of the facility "Guide to the Prevention and Reporting of Sexual Misconduct with Residents while at the El Paso Service Processing Center." The Auditor reviewed the implemented guide and confirmed the guide provides "other" contractors/vendors information on several ways of reporting sexual abuse, definitions of resident-on-resident sexual abuse, staff-on-detainee sexual abuse, ways to help prevent and detect sexual abuse, effective communication, red flags and the requirement to immediately report any knowledge, suspicion or information they may have regarding sexual abuse, staff neglect of responsibilities or an incident of retaliation, consequences for failing to report to include removal from providing continued services to the facility. During the on-site audit, the Auditor reviewed an email sent to all staff, with signed training certificates, informing them of the new process which was effective immediately. A review of the email to staff further confirmed the email included a sample of the Guide to the Prevention and Reporting of Sexual Misconduct with Residents while at the El Paso

Service Processing Center. In addition, the Auditor reviewed the sign-in sheet, and confirmed 10 "other" contractors/vendors had signed the sign-in sheet acknowledging the training and receiving a copy the guide.

Corrective Action:

No corrective action needed.

§115.33 - Detainee education.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(f): EPSPC policy 2.11 states, "Upon admission to the EPC all detainees shall be notified of the EPC's zero-tolerance policy for all forms of sexual abuse and assault through the orientation program and detainee handbook and provided with information about the EPC's SAAPI Program. Such information shall include, at a minimum: the EPC's zero-tolerance for all forms of sexual abuse and assault, the name of the EPC PSA Compliance Manager, and information about how to contact him/her, prevention and intervention strategies, definition and examples of detainee-on-detainee sexual abuse and assault, staff on-detainee sexual abuse and assault and coercive sexual activity, explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, the DHS/OIG and the ICE/OPR investigation processes, information about self-protection and indicators of sexual abuse and assault, prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings, the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The EPC shall provide the detainee notification, orientation, or instructions in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The EPC shall maintain documentation of detainee participation in the instruction session." Interviews with the PSA Compliance Manager, and two Processing Officers indicated during the intake process, detainees are provided the ICE National Detainee Handbook, DHS-prescribed SAA Information pamphlet, a facility Detainee Handbook, and are shown a PREA video. Receipt of these items are documented by detainee signature on the detainee Admission Checklist Form. Interviews with the PSA Compliance Manager, two Processing Officers and six random DOs further indicated reasonable accommodations are made to ensure a detainee receives orientation on the Agency's and facility's sexual abuse prevention and response, to include but not limited to, the use of a teletypewriter (TTY), or Telecommunication device for the deaf (TDD) phone, and an ICE Effective Communication card for those detainees who are deaf or hard of hearing. In addition, interviews with the PSA Compliance Manager, two Processing Officers and six random DOs indicated detainees who have limited reading skills, or who are LEP, staff will utilize the facility language line to interpret the information or a staff interpreter, who is proficient in the detainee's preferred language and if a detainee is blind, staff would read the information to the detainee. Interviews with the PSA Compliance Manager, two Processing Officers and six random DOs further indicated if a detainee has intellectual, psychiatric, or other disabilities, staff will seek the assistance of medical or mental health staff to ensure effective communication is established. During the on-site audit, the Auditor observed the ICE National Detainee Handbook and DHS-prescribed SAA Information pamphlet and confirmed the handbook is available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, K'iche' and Vietnamese and the DHS-prescribed SAA Information pamphlet readily available in 15 of the most prevalent languages encountered by ICE, specifically English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Portuguese, Romanian, Turkish, Bengali, Vietnamese, and Ukrainian. During the on-site audit, the Auditor further reviewed the ICE National Detainee Handbook and confirmed the handbook includes information on the Agency's zero tolerance policy, prevention and intervention strategies, definitions and examples of detainee-on-detainee sexual abuse, explanation of methods for reporting sexual abuse, information about self-protection, reporting sexual abuse will not negatively impact your immigration proceeding and the right to receive treatment and counseling if subjected to sexual abuse. In addition, during the on-site audit the Auditor reviewed the facility Detainee Handbook and confirmed the handbook is available in English,

Spanish, Arabic, French and Russian and includes information on the facility's zero tolerance policy, definitions, and examples of detainee-on-detainee sexual abuse, avoiding sexual assault, how to report sexual abuse and assault, and contact information for CASFV. Interviews with 19 LEP detainees indicated, during intake, staff utilized either a staff member or the language line to interpret; however, no information regarding sexual abuse was read to them. In interviews with 19 LEP detainees, 9 detainees whose preferred language was Spanish, it was confirmed all written material had been provided to them in Spanish; however, 3 other detainees whose preferred language is Spanish, 1 detainee whose preferred language was Chinese, 1 detainee whose preferred language was Russian, 2 detainees whose preferred language was Arabic, 1 detainee whose preferred language was Iranian and 1 detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with 1 detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. During the on-site audit, the Auditor observed a video of a detainee intake and confirmed the detainee had been given both handbooks and the DHS-prescribed SAA Information pamphlet; however, the Auditor could not determine, from the video, if the orientation received was in the detainee's preferred language. A review of 32 detainee files confirmed, detainees sign an acknowledgement confirming they received the ICE National Detainee Handbook, facility handbook, and the DHS-prescribed SAA Information pamphlet in Spanish; however, the Auditor could not confirm detainees have received the information in the PREA video. In addition, a review of several files confirmed the detainee's preferred language was something other than the orientation they received; and therefore, the Auditor confirmed detainees are not consistently provided orientation in a manner they can understand.

(d)(e): EPSPC policy 2.11 states, "The EPC shall post on all housing unit bulletin boards the following notices: the DHS-prescribed sexual abuse and assault awareness notice, the name of the PSA Compliance Manager (PREA Coordinator), information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers (incl. toll-free hotline numbers where available). If no such local organization exist, the EPC shall make available the same information about national organizations. The EPC shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet." During the on-site audit, the Auditor observed the DHS-prescribed sexual assault awareness notice, which contained the name of the facility PSA Compliance Manager, and the CASFV flyer in English, Haitian Creole, Punjabi, and Spanish posted in all housing units of the facility. In an interview with the PSA Compliance Manager, it was indicated, if needed, the facility would translate the information available in the flyer in a language the detainee can understand prior to giving the detainee access to the services CASFV provides. Interviews with the PSA Compliance Manager and two Processing Officers indicated each detainee is provided the DHS-prescribed SAA Information pamphlet during the intake process; however, a review of 32 detainee files confirmed detainees are not consistently provided the DHS-prescribed SAA Information in a manner they can understand.

Corrective Action:

The facility is not in compliance with subsection (a) and (b) of the standard. In interviews with 19 LEP detainees indicated, during intake, staff utilized either a staff member or the language line to interpret; however, no information regarding sexual abuse was read to them. In interviews with 19 LEP detainees, 9 detainees whose preferred language was Spanish, it was confirmed all written material had been provided to them in Spanish; however, 3 other detainees whose preferred language is Spanish, 1 detainee whose preferred language was Chinese, 1 detainee whose preferred language was Russian, 2 detainees whose preferred language was Arabic, 1 detainee whose preferred language was Iranian and 1 detainee whose preferred language was Turkish, it was further indicated they had received all written material in English only; and therefore, were unable to read it. In an interview with 1 detainee whose preferred language was Portuguese it was indicated he received the written material in Spanish; and therefore, was unable to read it. A review of 32 detainee files confirmed, detainees sign an acknowledgement confirming they received the ICE National Detainee Handbook, facility handbook, and the DHS-prescribed SAA Information pamphlet in Spanish; however, the Auditor could not confirm detainees have

received the information in the PREA video. In addition, a review of several files confirmed the detainee's preferred language was something other than the orientation they received; and therefore, the Auditor confirmed detainees are not consistently provided orientation in a manner they can understand. To become compliant, the facility must implement a procedure to ensure during intake all detainees are provided orientation in a manner all detainees can understand. Once implemented the facility must submit documentation which confirms all applicable staff have been trained on the implemented procedure. In addition, the facility must submit 10 detainee files, specifically, if applicable, detainee files which do not include detainees whose preferred language is English, Spanish, Arabic, French, or Russian to confirm the facility orientation program is being delivered in a manner all detainees can understand.

§115.34 - Specialized training: Investigations.

Outcome: Meets Standard

Notes:

(a)(b): EPSPC policy 2.11 states, "In addition to general training, all EPC staff responsible for conducting sexual abuse or assault investigations shall receive specialized training that covers, at a minimum, interviewing sexual abuse and assault victims, sexual abuse and assault evidence collection in confinement settings, the criterial and evidence required for administrative action or prosecutorial referral, and information about effective cross-agency coordination in the investigation process. The EPC must maintain written documentation verifying specialized training provided to investigators pursuant to this requirement." An interview with the PSA Compliance Manager/Investigator and review of the facility PAQ indicated the facility has four trained investigators that investigate all allegations of sexual abuse in the facility. Each investigator has completed specialized training on sexual abuse and cross agency coordination through the National Institute of Corrections (NIC) and the ICE Investigating Incidents of Sexual Abuse and Assault training curriculum. The Auditor reviewed both training curriculums and confirmed the curriculums contain all elements required by this standard. The Auditor reviewed all training certificates confirming all four investigators had completed both the required specialty training and the facility general PREA training as required by the standard. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed all administrative investigations had been conducted at the facility level by a trained investigator. A review of the 11sexual abuse allegation investigation files further confirmed three of the allegations were determined to be criminal; and therefore, investigated by ICE ERO AIU. In a review of the ICE SharePoint, it was confirmed the investigator from ERO AIU, who had completed the investigations, had received the required specialized training.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b)(c): Agency Policy 11062.2 states, "Specialized Training for IHSC Medical and Mental Health Staff. IHSC shall provide specialized training to all IHSC personnel and all full- and part-time medical and mental health staff who work in facilities where IHSC provides medical and mental health care. The training should cover how to detect and assess signs of sexual abuse and assault, how to preserve physical evidence of sexual abuse and assault, how to respond effectively and professionally to victims of sexual abuse and assault, and how and to whom to report allegations or suspicions of sexual abuse and assault." EPSPC policy 2.11 states, "EPC medical staff shall be trained in procedures for examining and treating victims of sexual abuse, in facilities where medical staff may be assigned these activities. Such specialized training shall include detecting and assessing signs of sexual abuse and assault, preserving physical evidence of sexual abuse, responding effectively to victims of sexual abuse and assault, and how and to whom to report allegations or suspicions of sexual abuse or assault. The EPC shall maintain documentation verifying employee, volunteer, and contractor training." The Auditor reviewed the IHSC Prison Rape Elimination Act (PREA) training curriculum and confirmed the training includes

how to detect signs and assess signs of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, how and to whom to report allegations or suspicions of sexual abuse and how to preserve physical evidence of abuse. The Auditor reviewed training sign-in sheets confirming IHSC staff and STG staff have completed the training. In addition, the Auditor reviewed four STG medical staff files and confirmed they had also received the facility general PREA training as required by §115.31. An interview with the AFOD confirmed EPSPC policy 2.11 has been submitted and approved by the Agency.

Corrective Action:

No corrective action needed.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(f)(g): EPSPC policy 2.11 states, "All detainees shall be screened upon arrival at the EPC for potential risk of sexual victimization or sexually abusive behavior and shall be housed to prevent sexual abuse or assault, taking necessary steps to mitigate any such danger. Each detainee shall be kept separate from the general population until he/she has been classified and may be housed accordingly. The initial classification process and initial housing assignment will be completed within twelve hours of admission to the EPC. The facility will consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: 1) whether the detainee has a mental, physical, or developmental disability; 2) the age of the detainee; 3) the physical build and appearance of the detainee; 4) whether the detainee has previously been incarcerated or detained; 5) the nature of the detainee's criminal history; 6) whether the detainee has any convictions for sex offenses against an adult or child; 7) whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; 8) whether the detainee has self-identified as having previously experienced sexual victimization; and 9) the detainee's own concerns about his or her physical safety. Detainees will not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to items (1), (7), (8), or (9) above. The initial screening will consider prior acts of sexual abuse or assault, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse or assault, as known to the facility, in assessing detainees for risk of being sexually abusive. The EPC will implement appropriate protections on responses to questions asked pursuant to this screening, limiting dissemination, and ensuring that sensitive information is not exploited to the detainee's detriment by staff or other detainees or inmates." The Auditor reviewed the facility Detainee Risk Classification Assessment and confirmed the assessment considers whether the detainee has previously been incarcerated or detained; whether the detainee has any developmental, mental or physical disabilities; if the detainee identifies as lesbian, gay, bisexual, transgender, intersex or gender nonconforming; whether the detainee has ever been a victim of sexual assault; if the detainee is young or elderly; physical build of the detainee; whether the detainee has ever been approached for sex, threatened with sexual assault; has a history of sexual victimization; whether the detainee has any fear of placement in the general population; any history of violent crimes (excluding sex offenses, domestic violence); any history as a sex offender with adult or child victims; any history of prior acts of sexual abuse; incident reports for violent acts or offenses while detained; and incident reports of sexual misconduct while detained or incarcerated. A review of the facility Detainee Risk Classification Assessment further confirms the assessment includes initial classification, medical clearance, and housing unit assignment will be completed within 12 hours of admission, includes the detainee's preferred language, and a space for identification of communications devices utilized to complete the assessment, such as the Language Line, TTY, or any other communication impairment. In addition, a review of the facility Detainee Risk Classification Assessment confirms the assessment states, "Detainees shall not be disciplined for refusing to answer any of the questions." An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the assessment is completed during the detainee's intake into the facility. Interviews with two Processing Officers further indicated during the intake process, staff will review the

detainee's rap sheet and their DHS 213 form to determine the detainee's classification level, once the classification level is determined, intake staff will notify the Detention Management Unit (DMU), and the DMU will provide the processing staff the detainee's housing assignment. In addition, interviews with two Processing Officers, indicated a detainee's classification level and initial housing assignment is completed prior to conducting the risk assessment; and therefore, neither Processing Officer could articulate what steps are to be taken if the risk assessment indicates the detainee is likely to be a sexual aggressor or a sexual abuse victim with the exception of notifying the PSA Compliance Manager and medical staff, if a detainee had identified as likely to be a sexual abuse victim. In an interview with two Processing Officers, it was further indicated detainees are provided privacy when answering the questions on the assessment and they are not disciplined for refusing to answer any of the questions. In addition, interviews with two Processing Officers indicated the risk assessment is kept in the detainee's file and the files are maintained in a locked file room which the Auditor observed during the on-site audit. During the on-site audit, the Auditor requested a roster of detainees who reported prior victimization and a roster of those who identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed, confirmed the detainee's had arrived at the facility prior to the implementation of the Detainee Risk Classification Assessment and had not been assessed for risk of sexual victimization or abusiveness. A review of the 15 detainee files which contained a completed assessment, confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee, indicated she had not been asked the questions during the intake process, and disclosed she had been sexually abused many times prior to leaving her country and requested to see mental health; and therefore, the Auditor, had the facility immediately escort the detainee to see mental health staff. Interviews with the AHSA and an LPN indicated medical staff also conducts an assessment regarding sexual abuse, during the medical intake assessment; however, a review of the IHSC medical assessment indicated the assessment does not include all elements required by subsection (c) of this standard.

(e): EPSPC policy 2.11 states, "EPC shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of the initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization." In an interview with a Classification Officer, it was indicated he maintains a reclassification "due list" to ensure all detainees are reclassified 60 days from the detainee's initial assessment. In an interview with a Classification Officer, it was further indicated in June 2024; the facility implemented a Detainee Risk Classification Assessment to be completed during intake and again 60 days after the initial assessment. In addition, in an interview with a Classification Officer it was indicated processing and classification staff will note on the assessment, if it was an initial, a 60–90-day reclassification, or a 90–120-day reclassification and if the reclassification is conducted prior to a detainee being released from administrative segregation or protective custody, if the initial assessment had been done incorrectly, or if the detainee was a victim of sexual abuse Classification staff will note "special classification" on the assessment form. However, in an interview with the Classification Officer, it was confirmed the Classification Officer had difficulty in explaining if a reclassification of the detainee is completed or if staff complete a reassessment. The Auditor reviewed 32 detainee files and confirmed 17 detainees had arrived at the facility prior to the implementation of the Detainee Risk Classification Assessment and none of the 17 detainees had received an initial assessment upon arrival to EPSPC. A review of 17 files confirmed the detainee had been re-classified within 60-90 days; however, there was no documentation to confirm the facility re-assessed the detainee for risk of abusiveness or victimization. A review of the remaining 15 files indicated an initial assessment had been completed utilizing the Detainee Risk Classification Assessment; however, 13 of the files confirmed the detainees had not been housed at the facility for longer than 60 days; and therefore, did not

require the completion of a re-assessment. A review of the remaining 15 files further confirmed there were 2 detainee files which confirmed a re-assessment was required between 60-90 days and the detainees had been reclassified at 60 days; however, there was no documentation to confirm the detainee had been re-assessed to determine their risk for victimization or abusiveness. In addition, the Auditor reviewed 11 sexual abuse allegation investigation files and confirmed the detainee victim had been reassessed after reporting an allegation of sexual abuse utilizing the Detainee Risk Classification Assessment.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the classification level and the housing assignment is completed prior to conducting the risk assessment and neither Processing Officer could articulate what steps to take if the risk assessment indicates the detainee is likely to be a sexual abuse aggressor or a sexual abuse victim with the exception of notifying the PSA Compliance Manager and medical staff, if a detainee had identified as likely to be a sexual abuse victim. In an interview with the AHSA and an LPN it was indicated medical staff also conducts an assessment regarding sexual abuse, during the medical intake assessment; however, a review of the IHSC medical assessment indicated the assessment does not include all elements required by subsection (c) of this standard. While on-site, the Auditor requested a roster of detainees who reported prior victimization and a roster of those that been identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed, confirmed the detainees had arrived at the facility prior to the implementation of the Detainee Risk Classification Assessment and had not been assessed for risk of sexual victimization or abusiveness. A review of the 15 detainee files that did contain a completed assessment, confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee, indicated she had not been asked the questions during the intake process. To become compliant, the facility must develop and implement a process to ensure detainees are assessed on intake to identify those detainees who are identified to be likely aggressors or sexual abuse victims and are housed to prevent sexual abuse taking necessary steps to mitigate any such danger. Once implemented the facility must submit documentation to confirm all applicable staff have been trained on the implemented process. The facility must provide the Auditor with 15 detainee files who, based on the initial risk assessment, were identified to likely be sexual aggressors or sexual abuse victims to confirm the facility utilized the information gained from the initial risk assessment to house detainees to prevent sexual abuse and any additional steps taken by the facility to mitigate any such dangers.

The facility is not in compliance with subsection (e) of the standard. In an interview with a Classification Officer it was indicated in June 2024, the facility implemented a Detainee Risk Classification Assessment to be completed during intake and again 60 days after the initial assessment. In an interview with the Classification Officer, it was further confirmed the Classification Officer had difficulty in explaining if a reclassification of the detainee is completed or if staff is required to complete a re-assessment. The Auditor reviewed 32 detainee files and confirmed 17 detainees had arrived at the facility prior to the implementation of the Detainee Risk Classification Assessment and none of the 17 detainees had received an initial assessment upon arrival to EPSPC. A review of 17 files confirmed the detainee had been re-classified within 60-90 days; however, there was no documentation to confirm the facility re-assessed the detainee for risk of abusiveness or victimization. A review of the remaining 15 files indicated an initial assessment had been completed utilizing the Detainee Risk Classification Assessment; however, 13 of the files confirmed the detainees had not been housed at the facility for

longer than 60 days; and therefore, did not require the completion of a re-assessment. A review of the remaining 15 files further confirmed there were 2 detainee files which confirmed a re-assessment was required between 60-90 days and the detainees had been reclassified at 60 days; however, there was no documentation to confirm the detainee had been re-assessed to determine their risk for victimization or abusiveness. To become compliant, the facility must submit documentation to confirm the facility re-assesses all detainees between 60-90-days from the initial assessment. The facility must submit documentation that all applicable staff, to include Classification staff, have been trained on the procedure. If applicable, the facility must submit 15 detainee files to confirm the detainees had been reassessed between 60-90 days utilizing the Detainee Risk Classification Assessment.

§115.42 - Use of assessment information.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): EPSPC policy 2.2 Classification states, "EPC will ensure that detainees are housed according to their classification levels. Participation in work assignments and available activities shall be consistent with safety and security considerations. Under no circumstances will issues of facility management, or other factors external to the detainee classification system, influence a detainee's classification level." EPSPC policy 2.11 states, "When making assessment and housing decisions for a transgender or intersex detainee, the facility will consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility will consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs will always be taken into consideration as well. The facility's placement of a transgender or intersex detainee will be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee will be reassessed at least twice each year to review any threats to safety experienced by the detainee. When operationally feasible, transgender and intersex detainees will be given the opportunity to shower separately from other detainees." An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June 2024, approximately one month prior to the facility on-site audit. Interviews with the PSA Compliance Manager and Classification Officer confirmed they were not aware of the identity of the detainees who reported previous sexual victimization or those detainees who are likely to be sexual aggressors and they were not aware of their current housing assignments, recreation schedule, voluntary work assignment, or any other activity they may be participating in. Interviews with the PSA Compliance Manager and the Classification Officer further confirmed the facility did not make individualized determinations about how to ensure the safety of each detainee. An interview with a Processing Officer indicated if a transgender detainee was received at the facility, she will ask the transgender detainee if they have any fear of being placed into general population and will advise medical staff, who will decide the housing placement. An interview with another Processing Officer indicated a transgender detainee will automatically be placed in protective custody until medical and ICE can agree on their placement. An interview with an LPN indicated a transgender detainee would be housed in protective custody until medical and mental health providers can see them and once, they have seen them, the facility will conduct a Transgender Care Committee (TCC), to be conducted within 72 hours, to determine housing for the detainee. In an interview with a Classification Officer, it was indicated transgender detainees are reassessed every 60-90 days. During the on-site audit, the Auditor reviewed a transgender detainee file and confirmed the transgender detainee was placed into protective custody upon entering the facility. A review of the transgender detainee's file further confirmed a TCC was conducted the following day, and an Individualized Detention Plan (IDP) was completed and indicated the transgender detainee was asked about his gender and self-assessment of his safety needs and he indicated he wanted to be housed with females, as he is biologically female, and the facility considered his gender self-identification and housed him on the female housing unit. While on-site the Auditor requested to interview the transgender detainee; however, he refused the interview. During the on-site audit, the Auditor requested a roster of detainees who reported prior victimization and a roster of those who identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a

detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed confirmed the detainee had not been assessed upon arrival at the facility. A review of 32 detainee files further confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee indicated she had not been asked the questions during the intake process. The Auditor reviewed two transgender detainee files and confirmed the detainees had been reassessed within 60-90 days of intake. An interview with a transgender detainee indicated she had been asked about her safety during the TCC and was allowed to shower daily in intake processing.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June 2024, approximately one month prior to the facility on-site audit. Interviews with the PSA Compliance Manager and Classification Officer confirmed they were not aware of the identity of the detainees who reported previous sexual victimization or those detainees who are likely to be sexual aggressors and they were not aware of their current housing assignments, recreation schedule, voluntary work assignment, or any other activity they may be participating in. Interviews with the PSA Compliance Manager and the Classification Officer further confirmed the facility did not make individualized determinations about how to ensure the safety of each detainee. During the on-site audit, the Auditor requested a roster of detainees who reported prior victimization and a roster of those who identified as likely aggressors; however, the PSA Compliance Manager indicated the facility has not had a detainee who had reported prior sexual abuse or had prior acts of sexual abuse; and therefore, he could not provide the requested rosters. During the on-site audit, the Auditor reviewed 32 detainee files and confirmed 15 files indicated the assessment was completed utilizing the Detainee Risk Classification Assessment; however, all additional files reviewed confirmed the detainee had not been assessed upon arrival at the facility. A review of 32 detainee files further confirmed 3 detainees had experienced prior sexual abuse, 2 detainees were likely to be perpetrators of sexual abuse, and 3 detainees identified as being transgender. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. An interview with one detainee, indicated she had not been asked the questions during the intake process. To become compliant, the facility must develop and implement a process to ensure information from the initial risk assessment is used to inform assignment of the detainee to housing, recreation, voluntary work, and any other activities and the facility shall make individualized determinations about how to ensure their safety. Once implemented, the facility must submit documentation to confirm all applicable staff have been trained on the implemented process. The facility must submit the files of 15 detainees who based on the initial risk assessment were identified to likely be sexual aggressors or sexual abuse victims to confirm the facility utilized information gained from the initial risk assessment to inform assignment of the detainee to housing, recreation, voluntary work, and any other activities to ensure the detainee's safety.

§115.43 - Protective custody.

Outcome: Meets Standard

Notes:

(a)(b)(c): EPSPC policy 2.12 Special Management Unit states, "Administrative Segregation is a non-punitive form of separation from the general population. These procedures should be developed in consultation with the FOD having jurisdiction for the facility. Detainees are placed in Administrative Segregation when their presence in the general population poses a threat to self, staff, or other detainees, property, or the security or orderly

operations of the EPC." EPSPC policy 2.12 further states, "Administrative Segregation to protect vulnerable populations shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, when no other viable housing options exist." EPSPC policy 2.11 states, "Victims and vulnerable detainees shall be housed in a supportive environment that represents the least restrictive housing options possible (e.g., in a different housing unit, transfer to another facility, medical housing, or protective custody), and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault." Interviews with the AFOD, Program Manager, PSA Compliance Manager, and a Segregation Supervisor indicated protective custody would only be utilized if a detainee vulnerable to sexual abuse requests protective custody and administrative segregation would only be utilized if there are no other viable housing options and as a last resort. Interviews with the AFOD, Program Manager, PSA Compliance Manager, and a Segregation Supervisor further indicated if a detainee were to be assigned to administrative segregation and/or protective custody due to being vulnerable to sexual abuse, the assignment would be documented to include detailed reasons for the placement and would not exceed 30 days. An interview with a Processing Officer indicated if a transgender detainee was received at the facility, she will ask the transgender detainee if they have any fear of being placed into general population and will advise medical staff, who will decide the detainee's initial housing; however, an interview with a second Processing Officer indicated a transgender detainee will automatically be placed in protective custody until medical and ICE can agree on their placement. An interview with an LPN indicated a transgender detainee would be housed in protective custody until medical and mental health providers can see them, which is within twenty-four hours of arrival and once they have seen them, the facility will conduct a Transgender Care Committee (TCC), to be conducted within 72 hours of the detainee's arrival at the facility, to determine housing for the detainee. In addition, interviews with the AFOD, PM, PSA Compliance Manager, and a Segregation Supervisor indicated the vulnerable detainee would have access to programs, visitation, counsel, and any other services available to the general population. An interview with the Segregation Supervisor and Auditor observations confirmed there were no detainees vulnerable to sexual abuse housed in the administrative segregation unit during the on-site audit. The Auditor reviewed three detainee files which included detainees who had reported a history of sexual abuse and confirmed the detainees had not been placed in administrative segregation or protective custody. A review of a transgender detainee file indicated, at the detainee's request, the detainee had been placed into protective custody for a total of four days and during the 72-hour review it was determined he would be released from protective custody. A review of the corresponding segregation order confirmed the order included detailed reasons for the placement. Interviews with the AFOD and the PM confirmed EPSPC policy 2.12 was developed in consultation with the ICE Field Office Director having jurisdiction over the facility.

(d)(e): EPSPC policy 2.12 states, "The CDOS will conduct a review within 72 hours of the detainee's placement in Administrative Segregation to determine whether segregation is still warranted. The review will include an interview with the detainee. A written record will be made of the decision and the justification. The Administrative Segregation Review (Form I-885) will be used for the review. If the detainee has been segregated for his or her own protection, but not at the detainee's request, the signature of the AFOD is required on the Form I-885 to authorize the detainee's continued detention. The CDOS will conduct the same type of review after the detainee has spent seven days in Administrative Segregation, and every week thereafter, for the first 30 days and at least every 10 days thereafter." EPSPC policy 2.12 further states, "The facility administrator must notify the appropriate FOD in writing as soon as possible, but no later than 72 hours after the initial placement of an ICE detainee in segregation if: The detainee has been placed in Administrative Segregation on the basis of a disability, medical or mental illness, other special vulnerability, or because the detainee is an alleged victim of a sexual assault, is an identified suicide risk or is on a hunger strike." Interviews with the AFOD and the PSA Compliance Manager indicated any placement of a detainee vulnerable to sexual abuse into administrative segregation and/or protective custody would require immediate notification to the ICE FOD, and the notification would be documented. An interview with a Segregation Supervisor indicated supervisory staff are required to conduct a review within 72 of the detainee's placement in segregation and will conduct an identical review every seven days until the detainee is released to general population. A review of a transgender detainee file indicated,

at the detainee's request, the detainee had been placed into protective custody for a total of four days and during a 72-hour review, it was determined the detainee could be released from protective custody. A review of the corresponding segregation order confirmed the order included detailed reasons for the placement.

Corrective Action:

No corrective action needed.

§115.51 - Detainee reporting.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "Detainees shall have multiple ways to privately, and if desired, anonymously, report signs or incidents of sexual abuse and assault, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents and will not be punished for reporting. Staff shall take seriously all statements from detainees claiming to be victims of sexual abuse or assault and shall respond supportively and non-judgmentally. Any detainee may report acts of sexual abuse or assault to any employee, contractor, or volunteer. If a detainee is not comfortable making the report to immediate point-of-contact line staff, he/she shall be allowed to make the report to a staff person with whom he/she is comfortable in speaking about the allegations. The EPC shall provide instructions on how detainees may contact their consular officials or the DHS Office of the Inspector General, to confidentially and if desired, anonymously, report these incidents." EPSPC policy 2.11 further states, "Staff shall accept reports made verbally, in writing, anonymously, and from third parties, and promptly document any verbal reports." During the on-site audit, the Auditor observed information in all housing units and common areas of the facility, in English and Spanish, advising the detainees how to contact their consular official, the DHS OIG, and the DRIL, to confidentially and if desired anonymously report an incident of sexual abuse. In addition, the Auditor observed in English and Spanish an Agency provided PREA Hotline, on a handmade flyer, to report allegations of sexual abuse. Interviews with the facility PSA Compliance Manager and six Random DOs indicated detainees are provided multiple ways to report sexual abuse, retaliation, and any staff neglect of their responsibilities which may have contributed to an incident of sexual abuse. Interviews with six random DOs further indicated all reports received verbally, in writing, anonymously, and from third parties must be immediately reported and documented. Interviews with 21 random detainees confirmed they were aware of several ways to report an incident of sexual abuse as they are posted in the housing units. During the on-site audit, utilizing a detainee pin, the Auditor tested all numbers provided and confirmed the DHS OIG and the DRIL numbers were in good working order; however, the Auditor tested the Agency PREA Hotline and left a message advising the call was a test of the PREA Hotline and instructed the receiver to immediately notify the PSA Compliance Manager or the audit team upon receipt; however, the Auditor did not receive a response.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. During the on-site audit, utilizing a detainee pin, the Auditor tested the provided Agency PREA Hotline and left a message advising the call was a test of the PREA Hotline and instructed the receiver to immediately notify the PSA Compliance Manager or the audit team upon receipt; however, the Auditor did not receive a response. To become compliant, the Agency must submit documentation to confirm the Agency PREA Hotline, provided to the detainees, is in good working order.

§115.52 - Grievances.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): EPSPC policy 2.11 states, "Formal grievances related to sexual abuse and assault may be filed at any time during, after, or in lieu of lodging an informal grievance or complaint and with no time limit imposed on when a grievance may be submitted. Written procedures must be implemented for identifying and handling time-sensitive grievances that involve an immediate threat to detainee's health, safety, or welfare related to sexual

abuse or assault. Decisions on grievances shall be issued within five days of receipt and appeals shall be responded to within 30 days. Detainees may obtain assistance from another detainee, the housing unit officer or other EPC staff, family members, or legal representatives. Staff will take reasonable steps to expedite requests for assistance from these other parties. All grievances related to sexual abuse and the facility's decision on any such grievance must be forwarded to the FOD." EPSPC policy 2.11 further states, "Detainees can file a formal grievance related to sexual assault as stated in standard 6.2 Grievance System, staff will provide the Detainee Grievance Form EPC-PBNDS-0011 upon request. The Contract Security Supervisor or SDDO on duty will be notified immediately. Detainee(s) requesting an Emergency Grievance involving sexual assault will be immediately isolated; the SDDO and Contract Security Supervisor on duty will be notified immediately. The detainee will be escorted to medical for further investigation and treatment by the Medical Staff. The detainee(s) requesting an Emergency Grievance involving sexual assault will not be pat searched. The area where the incident occurred will be restricted pending evidence gathering and a detailed investigation." The EPSPC Detainee Handbook states, "Detainees may file a formal grievance regarding sexual abuse at any time, there is no imposed time limit for sexual abuse grievances. If it is an emergency contact any trusted staff member immediately." An interview with the facility GO indicated detainees can file a paper grievance alleging sexual abuse and deposit into the mailbox, located outside of the housing unit, or the detainee can file a grievance alleging sexual abuse utilizing the facility tablets and are not required to follow an informal grievance process. An interview with the facility GO further indicated if a detainee expressed the need for assistance in filing a grievance, he would facilitate the detainee request and ensure he/she received the assistance needed. In addition, in an interview with the GO it was indicated, grievances alleging sexual abuse are considered time-sensitive and an immediate threat to detainee health, safety, and welfare; and therefore, if he were to receive a grievance alleging sexual abuse, after ensuring the detainee was safe, he would inform security and medical staff to ensure immediate action is taken including a medical assessment. In an interview with the GO, it was indicated he had five days to respond to a grievance and the facility had 30 days to respond to an appeal. An interview with the PSA Compliance Manager indicated all investigative reports, the grievance, and the grievance decision is forwarded to the FOD, upon completion. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed one allegation had been reported through the grievance process. The Auditor reviewed the sexual abuse allegation investigation file and confirmed the grievance was immediately forwarded to the PSA Compliance Manager for investigation, was closed within five days, and a response was sent to the detainee victim indicating the grievance had been closed and forwarded to facility PREA Investigator for investigation. A review of the sexual abuse allegation investigation file further confirmed the detainee did not require immediate medical attention and the grievance and response was sent via email to the FOD.

Corrective Action:

No corrective action needed.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): EPSPC policy 2.11 states, EPSPC policy 2.11 states, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and prosecution of sexual abuse and assault perpetrators to address victims' needs most appropriately. The EPC shall attempt to enter into memoranda of understanding or other agreements with community service providers or, if local providers are not available, national organizations that provide legal advocacy and confidential emotional support services from immigrant victims of crime. The AFOD shall establish procedures to make available to detainee's information about local organizations that can assist detainees who have victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If no such local organizations exist, the EPC shall make available the same information about national organizations. Following an allegation of sexual abuse, the AFOD shall establish procedures to make available, to the full extent possible, additional outside victim services. The EPC

shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available, the EPC shall work with ICE to provide these services from a qualified staff member from a community-based organization, or qualified ICE staff member. The victim advocate shall be able to provide emotional support, crisis intervention, information and referrals. The EPC shall enable reasonable communication between detainees and these organizations or agencies, in as confidential manner as possible. Staff shall inform detainees, prior to giving them access to outside resources, of the extent to which communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws." EPSPC policy 2.11 further states, "A local agreement between the EPC and CASFV states that the CASFV will provide support in crisis intervention, counseling to address victim needs and other support services." The Auditor reviewed an Agreement of Understanding between EPSPC and CASFV, dated November 29, 2017, without an ending date and confirmed the Agreement indicated CASFV would provide legal advocacy and confidential support services for the immigrant victims of crime housed at the facility. During the on-site audit, the Auditor utilized a detainee telephone in a housing unit and spoke with an advocate from CASFV who confirmed CASFV provides telephonic emotional support services, crisis intervention, and counseling for all detainee victims who call the center. An interview with the advocate from CASFV further confirmed a detainee victim of sexual abuse would be taken to UMC for a SANE examination and would be accompanied by a CASFV victim advocate during the SANE exam and any investigatory interviews, to provide emotional support, crisis intervention, information, and any necessary referrals. During the on-site audit, the Auditor observed the CASFV flyer posted in English, Haitian Creole, Punjabi, and Spanish on all housing units and confirmed the flyer provides the detainees with a mailing address and telephone numbers to access the service. An interview with the PSA Compliance Manager indicated the facility can translate the flyer in other languages, if needed. During the on-site audit, the Auditor reviewed the facility Detainee Handbook and confirmed detainees are notified all phone calls are subject to being monitored; however, the Auditor could not confirm detainees are notified, prior to giving them access to CASFV, the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Corrective Action:

The facility is not in compliance with subsection (d) of the standard. During the on-site audit, the Auditor observed the CASFV flyer posted in English, Haitian Creole, Punjabi, and Spanish on all housing units and confirmed the flyer provides the detainees with a mailing address and telephone numbers to access the service; however, the flyer does not notify detainees all phone calls are subject to being monitored or the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. During the on-site audit, the Auditor reviewed the facility Detainee Handbook and confirmed detainees are notified all phone calls are subject to being monitored; however, the Auditor could not confirm detainees are notified, prior to giving them access to CASFV, the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. To become compliant, the facility must submit documentation that the facility advises all detainees the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws prior to giving them access to outside resources available to report an allegation of sexual abuse.

§115.54 - Third-party reporting.

Outcome: Meets Standard

Notes:

EPSPC policy 2.11 states, "Third party reporting sexual abuse can be made via DRIL Line, OIG, email, phone call to a supervisor or Deportation Officer. The ICE official website, www.ice.gov is main source for the public. They can also contact the facility directly; the website provides contact numbers." A review of the facility website (https://www.ice.gov/detain/detention-facilities/el-paso-service-processing-center) which links to the Agency website (www.ice.gov/prea) confirmed the facility and Agency provides the public with multiple ways to report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents, on behalf of a detainee by providing the addresses and telephone numbers for the DHS OIG, the DRIL, and ICE OPR. The Auditor tested the phone number for the DHS OIG and

confirmed it is in good working order. Information for DRIL includes a telephone number and/or an on-line reporting form. The Auditor tested the telephone number for the DRIL and confirmed it was in good working order; however, the Auditor completed the on-line reporting form, and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the form is in good working order and as of completing this report, the Auditor has not received a response. Information for ICE OPR includes a telephone number and an email address iceoprintake@ice.dhs.gov for third party reporting. The Auditor tested the telephone number and confirmed it was in good working order. In addition, the Auditor sent an email to the address provided and informed the reader, the Auditor is testing the system and requested an immediate reply to confirm the email address is in good working order. The Auditor immediately received a response confirming the email had been received.

Recommendation: The Auditor recommends the Agency review the DRIL on-line reporting form to guarantee it is in good working order.

Corrective Action:

No corrective action needed.

§115.61 - Staff reporting duties.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." EPSPC policy 2.11 states, "If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the facility shall report that information to the FOD so that ICE can report the allegation to the designated State or local services agency under applicable mandatory reporting laws. Information concerning the identity of the detainee victim reporting itself, shall be limited to those who have a need-to-know in order to make decisions concerning the victim's welfare, and for law enforcement/investigative purposes. Apart from such reporting, staff shall not reveal any information related to a sexual abuse and assault report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the EPC, or to make medical treatment, investigation, law enforcement, or other security and management decisions." EPSPC policy 2.11 further states, "All staff must immediately report: (a) any knowledge, suspicion, or information regarding an incident or allegation of sexual abuse occurring at the EPC. (b) Any retaliation against detainees or staff who reported or participated in an investigation about sexual abuse or assault; and (c) Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff must be able to report the above outside of the chain of command." A review of EPSPC policy 2.11 confirms although the policy states, "staff must be able to report the above outside of the chain of command" the policy does not include a method for staff to do so. Interviews with six random DOs confirmed they were very knowledgeable and could articulate their responsibilities to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, retaliation, or staff failure to perform their duties he/she becomes aware of to their immediate supervisor. Interviews with six random DOs further confirmed they were aware sharing of information regarding an allegation of sexual abuse is limited to protect the detainee or staff from in the facility or to make medical treatment, investigation, law enforcement, or facility management decisions. Interviews with six random DOs confirmed they could anonymously report an allegation of sexual

abuse; however, they could not articulate who or how they could report the allegation to without going through their chain of command. Interviews with the AFOD and the PSA Compliance Manager indicated if an allegation of sexual abuse involved a vulnerable adult, the Texas mandatory reporting laws require a report to be made to the Adult Protective Services. In an interview with the AFOD it was confirmed the AFOD was knowledgeable regarding his reporting duties under Agency policy 1106.2. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed none of the allegations were reported by staff or included a vulnerable adult. In an interview with the AFOD it was confirmed EPSPC policy 2.11 had been submitted and approved by the Agency. EPSPC does not house juvenile detainees.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. A review of EPSPC policy 2.11 confirms the policy does not include a method for staff to report an allegation of sexual abuse outside the chain of command. Interviews with six random DOs confirmed they could anonymously report an allegation of sexual abuse; however, they could not articulate who or how they could report the allegation to without going through their chain of command. To become compliant, the facility must revise EPSPC policy 2.11 to include a method to which staff can report an allegation of sexual abuse outside the chain of command. Once EPSPC policy 2.11 has been revised, the facility must submit documentation to confirm all staff have been trained on the revised policy.

§115.62 - Protection duties.

Outcome: Meets Standard

Notes:

EPSPC policy 2.11 states, "If an EPC staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee." Interviews with the AFOD, PSA Compliance Manager, and six random DOs confirmed if they become aware a detainee was in substantial risk of sexual abuse their first response would be to ensure the safety of the detainee. The Auditor reviewed 11 investigative files and confirmed each file included an incident report which notes staff took immediate action to protect the detainee by separating the detainee victim from the alleged abuser immediately following the allegation of sexual abuse.

Corrective Action:

No corrective action needed.

§115.63 - Reporting to other confinement facilities.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): EPSPC policy 2.11 states, "Upon receiving an allegation that a detainee was sexually abused or assaulted while confined at another facility, the AFOD will notify the FOD and the appropriate administrator of the facility where the alleged abuse occurred as soon as possible, but no later than seventy-two (72) hours after receiving the allegation. The AFOD will notify the detainee in advance of such reporting. The facility shall document that it has provided such notification. A facility receiving such notification shall ensure the allegation is referred for investigation and reported to the FOD." During an interview with the AFOD it was indicated he would notify the appropriate agency officials where the alleged abuse occurred initially by phone and would follow up with an email for documentation as soon as possible, but no later than 72 hours, after he becomes aware of the incident. During an interview with the AFOD it was further indicated if he were to receive notification from another facility a detainee alleged an incident of sexual abuse while housed at EPSPC he would notify the FOD and would ensure the allegation is investigated. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed none of the allegations reported at EPSPC occurred at another facility.

Corrective Action:

No corrective action needed.

§115.64 - Responder duties.

Outcome: Does Not Meet Standard

Notes:

(a)(b): EPSPC policy 2.11 states, "Staff shall take immediate action to separate any detainee who alleges that he/she has been sexually abused or assaulted from the alleged assailant and shall refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms. Staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation. The first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder shall: Request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Ensure the alleged abuser does not take any action that could destroy evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first responder is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." However, EPSPC policy further states, "The following protocol is not all inclusive. Circumstances may arise in a detention setting that cannot be addressed in a single protocol; however, this list should serve to standardize procedures. a. Separate the Alleged Victim and Abuser as quickly as possible. b. Preserve and protect any crime scene until proper steps can be taken to collect any evidence. c. Immediately notify the SDDO and Contract Security Supervisor on duty. d. Do not let the alleged victim or abuser take any action that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the first responder is not a Security Staff member, the responder shall be required to request the alleged victim not take any actions that could destroy physical evidence; remain with the alleged victim and notify security staff immediately. Refer the victim to the healthcare unit for evaluation and any necessary medical or mental health treatment." During the on-site audit the Auditor reviewed the facility training curriculum and confirmed it states, "If a detainee informs you that he/she has been sexually assaulted by another detainee, you must isolate the detainee and notify the Team PPS Supervisor immediately. Do not allow the detainee to return to his living area. Do not allow him/her to shower." Therefore, EPSPC policy 2.11 provides first responder staff with conflicting direction. During the on-site audit the Auditor further reviewed the facility Sexual Abuse First Responder cards carried by staff on their person to remind them of the steps they must take in response to an allegation of sexual abuse and confirmed the card states, "Do not let the alleged victim or abuser take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating." Interviews with six random DOs confirmed if a detainee reported an allegation of sexual abuse, they would separate the detainee, call for backup, secure the scene, and would not allow the detainee victim or the abuser to take any action which could destroy physical evidence. Interviews with two non-security first responders indicated they would immediately call for officers, instruct the detainees to separate, and would immediately notify their supervisor. Interviews with two non-security first responders further indicated the non-security first responders would not allow the detainee victim, or the abuser, take any action which could destroy evidence. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed all files included an incident report which confirmed the victim, and the abuser, were immediately separated, and taken to medical, for medical and mental health evaluations and observation.

Corrective Action:

The facility is not in compliance with subsections (a) and (b) of the standard. A review of EPSPC policy 2.11, which serves as the facility coordinated response plan, confirms the policy provides first responder staff with conflicting direction. During the on-site audit the Auditor reviewed the facility training curriculum and

confirmed it states, "If a detainee informs you that he/she has been sexually assaulted by another detainee, you must isolate the detainee and notify the Team PPS Supervisor immediately. Do not allow the detainee to return to his living area. Do not allow him/her to shower." Therefore, EPSPC policy 2.11 provides first responder staff with conflicting direction. During the on-site audit the Auditor further reviewed the facility Sexual Abuse First Responder cards carried by staff on their person to remind them of the steps they must take in response to an allegation of sexual abuse and confirmed the card states, "Do not let the alleged victim or abuser take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating." Interviews with six random DOs confirmed if a detainee reported an allegation of sexual abuse, they would separate the detainee, call for backup, secure the scene and would not allow the detainee victim or the abuser to take any action that could destroy physical evidence. Interviews with two non-security first responders confirmed the non-security first responders would not allow the detainee victim, or the abuser take any action that could destroy evidence. To become compliant, the facility must revise EPSPC policy 2.11, the facility PREA training curriculum, and the facility Sexual Abuse First Responder cards to include first responders shall request the alleged victim and ensure the abuser does not take any action that could destroy physical evidence, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Once revised, the facility must submit documentation which confirms all staff, to include non-security staff, have received training on updated EPSPC policy 2.11.

§115.65 - Coordinated response.

Outcome: Does Not Meet Standard

Notes:

(a)(b): EPSPC policy 2.11 states, "The EPC must use a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a security staff member, and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise." The Auditor reviewed the facility coordinated response plan and confirmed the plan takes a multidisciplinary team approach to responding to sexual abuse. The plan coordinates the actions taken by facility responders to include first responders, medical and mental health staff, investigators, and the facility leadership in response to an incident of sexual abuse; however, the plan is not in compliance with standard §115.64 and the actions to be taken by first responders and non-security responders. Interviews with six random DOs confirmed if detainee reported an allegation of sexual abuse to them, they would separate the detainee, call for backup, secure the scene, and ensure the detainee victim and abuser does not take any action that could destroy physical evidence. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed the facility utilized a coordinated, multidisciplinary response, in responding to each allegation.

(c)(d): EPSPC policy 2.11 states, "If a victim is transferred between detention facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services (unless the victim requests otherwise in the case of transfer to a non-ICE facility). If the receiving facility is unknown to the sending facility, the sending facility shall notify the FOD, so that he or she can notify the receiving facility." In an interview with the PSA Compliance Manager, AHSA, and an LPN it was confirmed they were knowledgeable in the requirements of subsections (c) and (d) of the standard by indicated if a detainee victim of sexual abuse is transferred to a facility covered by DHS PREA, they would provide the receiving facility of the incident and the detainee's need for medical or social services and if the facility is not covered by DHS PREA they would provide the information unless the detainee requests otherwise; and therefore, in review of the EPSPC policy 2.11, and staff interviews, the Auditor finds the facility in substantial compliance with subsections (c) and (d) of the standard.

Recommendations (c)(d): The Auditor recommends the facility update the coordinated response plan to include the verbiage, "If a victim of sexual abuse is transferred between facilities covered by 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's

potential need for medical or social services" and "if a victim is transferred from a DHS immigration detention facility to a facility not covered by) 6 CFR part 115, subpart A or B, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise;" to coincide with the facility's practice.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. Although the Auditor confirmed the coordinated response plan coordinates the actions taken by facility responders to include first responders, medical and mental health staff, investigators, and the facility leadership in response to an incident of sexual abuse, a review of the plan confirms the plan is not in compliance with standard §115.64 regarding the actions to be taken by first responders. To become compliant, the facility must revise policy EPSPC policy 2.11, which serves as the facility coordinated response plan, to include first responders shall request the alleged victim and ensure the abuser does not take any action that could destroy physical evidence, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Once revised, the facility must submit documentation to confirm all security first responders have received training on the updated policy EPSPC 2.11. If applicable, the facility must submit all sexual abuse allegation investigations which occur during the CAP period.

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

Outcome: Meets Standard

Notes:

EPSPC policy 2.11 states, "Staff suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." EPSPC policy 2.11 further states, "Contractors suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation." Interviews with the AFOD, PM, PSA Compliance Manager, and the HRM, indicated staff are removed from contact with detainees pending the outcome of the investigation. The Auditor reviewed six staff-on-detainee sexual abuse allegation investigation files and confirmed in all instances the staff member had been removed from detainee contact pending the outcome of the investigation.

Corrective Action:

No corrective action needed.

§115.67 - Agency protection against retaliation.

Outcome: Meets Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "Staff, contractors, and volunteers 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 abuse as a result of force, coercions, threats, or fear of force. The EPS shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. For at least 90 days following a report of sexual abuse or assault, the facility, in concert with ICE, shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff, and facility shall monitor to see if there are facts that may suggest possible retaliation and shall act promptly to remedy any such retaliation. Items the facility should monitor include a detainee disciplinary reports, housing, or program changes or negative performance reviews or reassignments by staff. The facility shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." An interview with the PSA Compliance Manager/Investigator, indicated that he is responsible for retaliation monitoring of detainee victims of sexual abuse, or detainees and staff who witness or cooperate with an investigation. An interview with the PSA Compliance Manager/Investigator, further indicated when a detainee

reports an allegation of sexual abuse, the detainee victim would be separated from the abuser, monitoring of the detainee victim will begin immediately, he will meet with the detainee victim every week for up to 90 days, or longer if needed, he will review the detainee's housing record, disciplinary record, or any program changes that may have occurred, and will offer both the detainee victim and staff member emotional support services. In addition, an interview with the PSA Compliance Manager/Investigator confirmed when monitoring staff his review would include confirming there have not been negative reviews or reassignments because of reporting an allegation of sexual abuse or cooperating in an investigation. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed all files contained documentation confirming retaliation monitoring began immediately and continued for 90 days.

Corrective Action:

No corrective action needed.

§115.68 - Post-allegation protective custody.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): EPSPC policy 2.11 states, "Victims and vulnerable detainees shall be housed in a supportive environment that represents the least restrictive housing options possible (e.g., in a different housing unit, transfer to another facility, medical housing, or protective custody), and that will, to the extent possible, permit the victim the same level of privileges he/she was permitted immediately prior to the sexual assault. This placement should consider any ongoing medical or mental health needs of the victim. Victims may not be held for longer than five days in any type of administrative segregation for the protective purposes, except in highly unusual circumstances or at the request of the victim. The EPC shall notify the appropriate ICE FOD whenever a detainee victim, or detainee placed due to vulnerability to sexual abuse or assault, has been held in administrative segregation for 72 hours. A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper reassessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault." Interviews with the AFOD, Program Manager, PSA Compliance Manager, and a Segregation Supervisor indicated a detainee victim of sexual abuse has not been placed into administrative segregation during the audit period; however, if a detainee victim of sexual abuse were to be placed into segregated housing the ICE FOD would be notified immediately. Interviews with the AFOD, Program Manager, PSA Compliance Manager, and a Segregation Supervisor further indicated a detainee victim of sexual abuse would be placed in a supportive environment which represents the least restrictive housing available and would not exceed five days. In an interview with the Classification Officer, it was indicated a detainee victim of sexual abuse would not be returned to general population until a reassessment was conducted taking into consideration any increased vulnerability of the detainee as a result of sexual abuse. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed no detainee victim of sexual abuse had been placed in administrative segregation or protective custody due to being a victim of sexual abuse.

Corrective Action:

No corrective action needed.

§115.71 - Criminal and administrative investigations.

Outcome: Meets Standard

Notes:

(a)(b)(e)(f): EPSPC policy 2.11 states, "The EPC shall coordinate with ICE and other appropriate investigative entities to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse. All investigations must be prompt, thorough, objective, fair, and conducted by specially trained, qualified investigators." EPSPC policy 2.11 further states, "Upon conclusion of a criminal investigation where the allegation was substantiated, or in instances where no criminal investigation has been completed, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation

was unsubstantiated, the EPC shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Substantiated allegation means an allegation that was investigated and determined to have occurred. An unsubstantiated allegation means an allegation that was investigated, and the investigation produced insufficient evidence to make a final determination as to where or not the event occurred. Administrative investigations shall be conducted after consultation with the appropriate investigative office with DHS, and the assigned criminal investigative entity." EPSPC policy 2.11 further states, "The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse and assault, the EPC shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." An interview with the PSA Compliance Manager/Investigator indicated the facility will complete an administrative investigation on allegations of sexual abuse reported at the facility and should the allegation be criminal in nature ICE OPR/JIC will notify the FBI. In an interview with the AFOD and PSA Compliance Manager/Investigator it was indicated they would remain in contact with the FBI and an investigation will begin once the FBI indicates it is safe to do so. In an interview with the AFOD and PSA Compliance Manager/Investigator it was further indicated an investigation would be completed regardless of whether the detainee, or the perpetrator, were no longer being housed or employed at the facility. The Auditor reviewed and confirmed the four facility investigators have received specialized training in sexual abuse and effective cross-agency coordination and general PREA training as required by §115.31. The Auditor reviewed 11 sexual abuse allegation investigations and confirmed all investigators, including investigators assigned to ICE ERO AIU had completed the specialized training, as required by the standard and all investigations were completed promptly, thoroughly, and objectively.

(c): EPSPC policy 2.11 states, "Administrative investigation procedures include: a. Preservation of direct and circumstantial evidence, including any available physical DNA evidence and any available electronic monitoring data. b. Interviewing alleged victims, suspected perpetrators, and witnesses. c. Review prior complaints and reports of sexual abuse or assault involving the suspected perpetrator. d. Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee and without requiring any detainee who alleged sexual abuse or assault to submit to a polygraph. e. An effort to determine whether actions or failures to act contributed to the abuse. f. Documentation of each investigation by written report shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. g. Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five (5) years. h. Coordination and sequencing of administrative and criminal investigations to ensure that a criminal investigation is not compromised by an internal administrative investigation." An interview with the PSA Compliance Manager/Investigator confirmed he was knowledgeable in the standard's requirements for conducting an administrative investigation. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed each investigation was documented in a written report which included a description of the physical and testimonial evidence, the reasoning behind credibility assessments, a review of prior complaints, reports of sexual abuse involving the abuser, efforts to determine whether staff actions or failures to act contributed to the abuse, and the investigative facts and findings.

Corrective Action:

No corrective action needed.

§115.72 - Evidentiary standard for administrative investigations.

Outcome: Meets Standard

Notes:

EPSPC policy 2.11 states, "Following an investigation conducted by the EPC into a detainee's allegation of sexual abuse, the EPC shall notify the FOD of the results of the investigation and responsive actions taken so that information can be reported to ICE headquarters and to the detainee." An interview with the facility PSA Compliance Manager/PREA Investigator indicated the facility does not impose a standard higher than a

preponderance of evidence to substantiate an allegation of sexual abuse. The Auditor reviewed 11sexual abuse allegation investigation files and confirmed the facility did not impose a standard higher than a preponderance of evidence when determining the outcome of the administrative investigation.

Corrective Action:

No corrective action needed.

§115.73 - Reporting to detainees.

Outcome: Meets Standard

Notes:

EPSPC policy 2.11 states, "Following an investigation conducted by the EPC into a detainee's allegation of sexual abuse, the EPC shall notify the FOD of the results of the investigation and responsive actions taken so that information can be reported to ICE headquarters and to the detainee." An interview with the PSA Compliance Manager indicated that notification is made to each victim of an alleged sexual abuse and of any responsive action that is taken on the case. The Auditor submitted the Notification to Detainee of PREA Investigation Results form to the ERAU TL and confirmed detainee notification had been made in 10 of the 11 allegations of sexual abuse investigations. In addition, during the on-site audit, the Auditor reviewed 11 sexual abuse allegation investigation files and confirmed the detainee was notified in 10 of the 11 reviewed files; and therefore, the Auditor finds the Agency in substantial compliance with standard 115.73.

Corrective Action:

No corrective action needed.

§115.76 - Disciplinary sanctions for staff.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): EPSPC policy 2.11 states, "Staff shall be subjected to disciplinary or adverse action, up to and including removal from their position, for substantiated allegations of sexual abuse or for violating ICE or facility sexual abuse rules, policies, or standards. Removal from their position is the presumptive disciplinary sanction for staff who have engaged in, attempted, or threatened to engage in sexual abuse, as defined under the definition of staff-on-detainee abuse in Section II, paragraphs (a)-(d) and (g)-(h). The EPC shall report all incidents of substantiated sexual abuse by staff, and all removals of staff, or resignations in lieu of removal for violations of sexual abuse policies, to appropriate law enforcement agencies unless the activity was clearly not criminal. The EPC shall also report all such incidents of substantiated abuse, removals, or resignation in lieu of removal to the FOD, regardless of whether the activity was criminal, and shall make reasonable efforts to report such information to any relevant licensing bodies, to the extent known." Interviews with the AFOD, PSA Compliance Manager, and the HRM indicated staff are subject to discipline, including removal from their position with federal service if they engage in sexual abuse or are in violation of the SAAPI policy. Although a review of EPSPC policy 2.11 indicated it does not require the adverse action to include removal from federal service, termination is greater than removal from Federal Service; and therefore, the Auditor finds EPSPC policy 2.11 in substantial compliance with the wording required by subsection (b) of the standard. Interviews with the AFOD and the PSA Compliance Manager further confirmed they would notify any licensing body necessary if a licensed staff member is removed or resigns in lieu of removal for violating the facility sexual abuse policies. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed there has not a substantiated allegation against a staff member or a contractor. In an interview with the AFOD it was confirmed EPSPC policy 2.11 has been submitted and approved by the Agency.

Corrective Action:

No corrective action needed.

§115.77 - Corrective action for contractors and volunteers.

Outcome: Meets Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "Contractors suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The EPC shall take appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractor or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The EPC shall also report such incidents to the FOD regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known." An interview with the AFOD and the PM indicated any contractor or volunteer suspected of perpetrating sexual abuse would be removed from all duties involving detainee contact and law enforcement would be notified, the incident would be reported to the contractor's employer, and any other licensing bodies. An interview with the AFOD and the PM further indicated if a contractor violated any other provisions of facility policies, they would be removed from the facility and any further contact with detainees, pending the outcome of the investigation. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed none of the allegations involved a contractor or a volunteer.

Corrective Action:

No corrective action needed.

§115.78 - Disciplinary sanctions for detainees.

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f): EPSPC policy 2.11 states, "Detainees will be subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse or assault. The EPC shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse or assault made in good faith based upon a reasonable belief that the alleged conduct occurred will not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. If a detainee is mentally disabled or mentally ill but competent, the disciplinary process will consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed." Interviews with the AFOD and the PSA Compliance Manager/Disciplinary Officer indicated detainees are subject to disciplinary sanctions pursuant to a formal disciplinary system which includes reviews, appeals, and documentation procedures for an administrative or criminal finding the detainee had engaged in sexual abuse. Interviews with the AFOD and the PSA Compliance Manager/Disciplinary Officer further indicated detainees are not disciplined for reports made in good faith based on a reasonable belief the conduct had occurred nor are they disciplined for making a false allegation or lying regarding an allegation of sexual abuse. In addition, interviews with the AFOD and the PSA Compliance Manager/Disciplinary Officer indicated a detainee's mental disabilities are considered if sanctions are to be imposed. In an interview with the PSA Compliance Manager/Disciplinary Officer it was indicated a detainee would not be disciplined for sexual contact with a staff member unless it was confirmed staff did not consent to such conduct. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed no detainee had been found to have engaged in sexual abuse; and therefore, no disciplinary records were reviewed.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff will, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate. When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral." An interview with the PSA Compliance Manager indicated the facility implemented the Detainee Risk Classification Assessment in June 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the Detainee Risk Classification Assessment is completed during the detainee's intake into the facility; however, neither Processing Officer could articulate what steps to take should the risk assessment identify the detainee as likely to be a sexual aggressor or sexual abuse victim except for notifying the PSA Compliance Manager and medical staff if a detainee was identified as a sexual abuse victim. Interviews with the AHSA and an LPN indicated medical staff conducts an assessment regarding sexual abuse during the detainee's intake into the facility; however, a review of the IHSC medical assessment indicated the assessment does not include all elements required by subsection (c) of standard 115.41. A review of the medical assessment further indicates if a detainee reports prior victimization and it is within six months, "refer for mental health assessment" and "if the medical assessment indicates the detainee has previously sexually assaulted anyone "refer for a mental health assessment." An interview with an LPN, indicated he would refer all detainees who report prior victimization or previously sexually assaulted someone for a mental health and medical assessment and the detainee would be seen by medical staff for an evaluation within two working days. An interview with an LPN further indicated mental health staff are notified via telephone when a detainee needs a mental health assessment, and the notification would be entered into the medical computer system. An interview with a LCSW indicated she immediately gets notification of all mental health telephone encounters and will conduct a mental health assessment of the detainee within 24 hours. The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff during the booking process, while many other detainees indicated the questions had been asked by medical staff only. The Auditor reviewed 32 detainee files which included the files and corresponding mental health files of 3 detainees who identified as having experienced prior victimization during the Detainee Risk Classification Assessment. A review of the three files, and corresponding mental health files confirmed the detainee had been seen by mental health staff within 24 hours. In addition, the Auditor reviewed two detainee mental health files where the detainee had been identified on the Detainee Risk Classification Assessment as likely to be a sexual aggressor and confirmed the detainee had not received a mental health assessment within 72 hours. The Auditor reviewed the corresponding medical risk assessment and confirmed the medical risk assessment indicated the detainee had not answered in the positive when asked by the medical staff; and therefore, although the Detainee Risk Classification Assessment identified the detainee as a being a perpetrator of sexual abuse, medical staff did not refer the detainee to mental health as required.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. An interview with the PSA Compliance Manager indicated that the facility implemented the Detainee Risk Classification Assessment in June 2024, approximately one month prior to the facility on-site audit. Interviews with two Processing Officers indicated the assessment is completed during the detainee's intake into the facility; however, neither Processing Officer could articulate what steps are to be taken if the risk assessment indicates the detainee is likely to be an aggressor or a sexual abuse victim; however, they indicated they would notify the PSA Compliance Manager and medical staff, if a detainee was identified as a sexual abuse victim. Interviews with the AHSA and an LPN indicated medical staff conducts an assessment regarding sexual abuse, during the detainee's intake into the facility; however, a review of the IHSC medical assessment indicated the assessment does not include all elements required by

subsection (c) of standard 115.41. A review of the medical assessment further indicates if a detainee reports prior victimization and it is within six months, "refer for mental health assessment" and "if the medical assessment indicates the detainee has previously sexually assaulted anyone "refer for a mental health assessment." The Auditor interviewed 21 random detainees and confirmed some of the detainees indicated the questions had been privately asked by the processing staff, during the booking process, while many other detainees indicated the questions had been asked by medical staff only. The Auditor reviewed 32 detainee files which included the files and corresponding mental health files of 3 detainees who identified as having experienced prior victimization during the Detainee Risk Classification Assessment. A review of the three files, and corresponding mental health files confirmed the detainee had been seen by mental health staff within 24 hours. In addition, the Auditor reviewed two detainee mental health files where the detainee had been identified on the Detainee Risk Classification Assessment as likely to be a sexual aggressor and confirmed the detainee had not received a mental health assessment within 72 hours. The Auditor reviewed the corresponding medical risk assessment and confirmed the medical risk assessment indicated the detainee had not answered in the positive, when asked by the medical staff; and therefore, although the Detainee Risk Classification Assessment identified the detainee as a being a perpetrator of sexual abuse, medical staff did not refer the detainee to mental health as required. To become compliant, the facility must implement a process to ensure if the Detainee Risk Classification Assessment identifies a detainee has experienced prior sexual victimization or perpetrated sexual abuse, the detainee is immediately referred to a medical and/or mental health practitioner for follow-up. Once implemented, the facility must submit documentation which confirms all applicable staff, to include Intake, Medical, and Mental Health have received training on the implemented process. If applicable, the facility must submit 10 detainee files, and the corresponding medical and/or mental health records, who based on the Detainee Risk Classification Assessment, were identified to have experienced prior sexual victimization or perpetrated sexual abuse.

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

Outcome: Meets Standard

Notes:

(a)(b): EPSPC policy 2.11 states, "Detainee victims of sexual abuse and assault shall have timely, unimpeded access to emergency treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care." EPSPC policy 2.11 further states, "All treatment services, both emergency and ongoing, shall be provided to the victims without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident." Interviews with the AHSA and an LPN indicated detainee victims of sexual abuse have timely, unimpeded access to emergency treatment provided in accordance with professionally accepted standards of care, at no cost to the detainee, even if he/she refuses to name the abuser or cooperate with an ongoing investigation. Interviews with the AHSA and an LPN further indicated if an incident were to occur at the facility, the detainee victim would be brought to the medical department to receive emergency medical care, once stable, the victim would be transported to the UMC of El Paso, for a SANE Exam. An interview with the Trauma Manager for Education Injury Prevention and SANE, indicated if a detainee victim were to be brought to UMC, they would go through the emergency room and once medically cleared will be brought to the SANE unit for a consult and, with consent, a SANE Examination. An interview with the Trauma Manager for Education Injury Prevention and SANE, further indicated Emergency contraceptives and sexually transmitted infections prophylaxis would be provided to the detainee. In addition, an interview with the Trauma Manager for Education Injury Prevention and SANE, indicated a victim advocate from CASFV would accompany the detainee for support and crisis intervention, during the SANE Exam. An interview with a CASFV victim advocate confirmed, a victim advocate will be dispatched to the UMC for crisis intervention services if a SANE exam is needed. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed all detainee victims had immediately been taken to and seen by medical and mental health staff after reporting an incident of sexual abuse. A review of 11 sexual abuse allegation investigation files further confirmed all detainee victims were provided a CASFV flyer and a DHS-prescribed SAA Information pamphlet. In addition, a review of 11 sexual

abuse allegation investigation files confirmed one detainee victim was transported to UMC for a SANE examination; however, he refused to participate.

Corrective Action:

No corrective action needed.

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

Outcome: Meets Standard

Notes:

(a)(b)(c)(d)(e)(f)(g): EPSPC policy 2.11 states, "The EPC shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention. The evaluation and treatment of such victims shall include, as appropriate follow-up services, treatment plans, and, when necessary, referral for continued care following their transfer to, or placement in, other facilities, or their release from custody. Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate. The EPC shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. All treatment services, both emergency and ongoing, shall be provided to the victims without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The EPC shall provide such victims with medical and mental health services consistent with the community level of care." Interviews with six random DOs indicated if they were to respond to a sexual abuse incident the detainees would be separated and immediately taken to medical for an evaluation and treatment. Interviews with the AHSA and an LPN, indicated a detainee victim of sexual abuse would be offered a medical and mental health evaluation and if needed, the evaluation and treatment would include follow-up services, treatment plans, and referrals for continued care and if a sexual assault were to occur at the facility, the detainee victim would be transported to UMC for a SANE exam. Interviews with the AHSA and an LPN, further indicated all female detainee victims would be offered a pregnancy test and if positive, the medical staff would provide comprehensive information about pregnancy related services available to the detainee. In addition, interviews with the AHSA and an LPN indicated services provided by medical staff and mental health staff are at no cost to the detainee victim and is consistent, if not better, than services a detainee would receive in the community. An interview with a LCSW indicated a mental health evaluation of all known detainee-on-detainee abusers would be conducted within 60 days of learning of the sexual abuse, and if the detainee abuser agreed to participate, a treatment plan would be established. An interview with the Trauma Manager for Education Injury Prevention and SANE, indicated if a detainee victim were to be brought to UMC, they would go through the emergency room and once medically cleared will be brought to the SANE unit for a consult, and with consent, a SANE Examination. An interview with the Trauma Manager for Education Injury Prevention and SANE, further indicated emergency contraceptives and sexually transmitted infections prophylaxis would be provided to the detainee. An interview with a victim advocate from CASFV indicated CASFV would provide emotional support services to the detainee victim, during the SANE examination, and any investigatory interviews and court hearings. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed all detainee victims had been taken to medical and seen by medical and mental health staff. A review of 11 sexual abuse allegation investigation files further confirmed one detainee victim of sexual abuse was transported to UMC for a SANE examination; however, he refused treatment. In addition, a review of 11 sexual abuse allegation investigation files confirmed there were no substantiated detainee-on-detainee allegations; and therefore, a mental health examination or treatment plan for the alleged abuser was not required.

Corrective Action:

No corrective action needed.

§115.86 - Sexual abuse incident reviews.

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): EPSPC policy 2.11 states, "The facility shall conduct a sexual abuse and assault incident review at the conclusion of every investigation of sexual abuse or assault. For any substantiated or unsubstantiated allegations, the facility shall prepare a written report within 30 days of the conclusion of the investigations 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. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so in a written response. Both the report and the response shall be forwarded to the FOD, or his or her designee, for transmission to the ICE PSA Coordinator. The facility shall also provide any further information regarding such incident reviews as requested by the ICE PSA Coordinator. The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the AFOD and the FOD, or his or her designee, for transmission to the ICE PSA Coordinator." An interview with the PSA Compliance Manager/Incident Review Team, indicated the facility has established a review team that consists of upper-level management and allows for input from the custody staff, investigators, medical and mental health practitioners and utilizes a Sexual Abuse or Assault Incident Review form to document the review. An interview with the PSA Compliance Manager/Incident Review Team further indicated a review is completed within 30 days after the Agency closes the investigation and the review includes a recommendation for improvement and will document the reasons if the recommendations are not followed. The Auditor reviewed the Sexual Abuse or Assault Incident Review form and confirmed the review team considers whether the incident or allegation was motivated by race; ethnicity; gender identity: lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. In addition, the review includes recommendations for improvement. The Auditor reviewed 11 investigative files and confirmed 5 of the sexual abuse incident reviews were completed within 30 days of the Agency closure of the investigative file, 3 of the reviews were completed after 30 days (2 of the 3 were completed 6 months after the closure by the Agency), and 3 sexual abuse allegation investigation files did not include documentation to confirm a sexual abuse incident review had been completed even though the Agency sexual abuse allegation investigation files had been closed for more than 60 days. A review of 11 sexual abuse allegation investigation files further confirmed for the 5 files which included a sexual abuse incident review, the review had been forwarded to the AFOD and the Agency PSA Coordinator. An interview with the PSA Compliance Manager confirmed the facility's 2023 PREA Data Review, dated March 27, 2024, had not been forwarded to the Agency PSA Coordinator; however, during the on-site audit, the facility forwarded the annual review to the Agency PSA Coordinator and provided the Auditor with the email documentation, confirming compliance.

Corrective Action:

The facility is not in compliance with subsection (a) of the standard. The Auditor reviewed 11 investigative files and confirmed 5 of the sexual abuse incident reviews were completed within 30 days of the Agency closure of the investigative file, 3 of the reviews were completed after 30 days (2 of the 3 were completed 6 months after the closure by the Agency), and 3 sexual abuse allegation investigation files did not include documentation to confirm a sexual abuse incident review had been completed even though the Agency sexual abuse allegation investigation files had been closed for more than 60 days. To become compliant, the facility must develop and implement a process to ensure a sexual abuse incident review is completed within 30 days of the conclusion of

each sexual abuse allegation investigation. Once implemented, the facility must submit documentation which confirms all applicable staff have received training on the implemented process. If applicable, the facility must submit any closed sexual abuse allegation investigation files and the corresponding incident review which occur during the corrective action plan (CAP) period.

§115.87 - Data collection.

Outcome: Meets Standard

Notes:

(a): EPSPC policy 2.11 states, "The EPC shall maintain in a secure area all case records associated with claims of sexual abuse or assault, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary. Detainee Sexual Abuse and Assault files will be stored indefinitely." An interview with the PSA Compliance Manager indicated all case records associated with allegations of sexual abuse are maintained in his office under lock and key. He further indicated (b) (7)(E) . During the on-site audit, the Auditor observed the area where the sexual abuse allegation investigation files are maintained and confirmed they were locked in a filing cabinet in the PSA Compliance Manager's office. The Auditor reviewed 11 sexual abuse allegation investigation files and confirmed none of the investigations had been conducted by the DHS OIG.

Corrective Action:

No corrective action needed.

§115.201 - Scope of audits.

Outcome: Meets Standard

Notes:

(d)(e)(i)(j): During all stages of the audit, including the on-site audit, the Auditor was able to observe all areas of the facility and review all available policies and procedures, memos, and other relevant documentation required to make an assessment on PREA Compliance at EPSPC. Interviews with staff and detainees were conducted in private while on-site and remained confidential. The Auditor observed the notification of the audit posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. No detainees, outside entity, or staff correspondence was received prior to, during, or following the on-site audit.

Corrective Action:

No corrective action needed.

AUDITOR CERTIFICATION:

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

Robin Bruck 9/6/2024

Auditor's Signature & Date

(b) (6), (b) (7)(C) 9/6/2024

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 9/6/2024

Assistant Program Manager's Signature & Date

U.S. Immigration and Customs Enforcement

Office of Professional Responsibility