PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	7/16/2019	**To:**	7/18/2019
AUDITOR INFORMATION			
Name of auditor:	Sabina Kaplan	**Organization:**	Creative Corrections LLC.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	914-474-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections LLC.
mail address:	(b) (6), (b) (7)(C)	**Telephone number:**	202-381-(b) (6), (b) (7
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Newark Field Office
Field Office Director:	John Tsoukaris
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	970 Broad Street, Newark, New Jersey 07102
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Essex County Correctional Facility		
Physical address:	354 Doremus Avenue, Newark, New Jersey 070152		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	973-274-7818		
Facility type:	IGSA		
PREA Incorporation Date:	1/9/2016		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director of Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	973-274-(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Special Assistant to Director
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	973-274-(b) (6), (b)

ICE HQ USE ONLY	
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Notes:	

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The Prison Rape Elimination Act (PREA) audit of the Essex County Correctional Facility (ECCF) was conducted on July 16-18, 2019 by Lead Auditor Sabina Kaplan and team member (b) (6), (b) (7)(C) U.S. Department of Homeland Security (DHS) and Department of Justice (DOJ) certified PREA Auditors for Creative Corrections, LLC. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ and DHS certified PREA Auditor. The Program Manger's role is to provide oversight to the ICE PREA audit process and liaison with the Immigration and Custom Enforcement (ICE) External Reviews and Analysis Unit (ERAU). Essex County Correctional Facility is a county jail operated by the Essex County Sheriff's Office. The facility has a contract with ICE for the housing of adult male detainees. The purpose of the audit was to determine compliance with DHS PREA Standards. This was the first DHS PREA audit of the facility. The audit period covered the previous twelve months from July 16, 2018 through July 18, 2019.

About two weeks prior to the audit, ERAU Team Lead, (b) (6), (b) (7)(C) provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency policies, available facility policies, and other pertinent documents. The documentation was provided through the ICE ERAU SharePoint. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and Document Request, DHS Immigration Detention Facilities form and within folders for ease of auditing. The main policy that provide facility's direction for PREA is the facility's Policy Statement Custody Policy (PS. CUS.) 051 Sexual Abuse Assault Prevention & Intervention (SAAPI). All the documentation, policies, and PAQ were reviewed by the Lead Auditor. The Auditor communicated with the ERAU Team Lead requesting further documentation for clarification and review on June 28, July 7, 10, 11, 12, and 15, 2019. A few responses to the request were provided pre-audit by the ERAU Team Lead due to the lack of response by the facility. Facility staff provided additional documentation during the on-site portion of the audit, including a revised PAQ, and the Auditor was approved for an extra week to review documentation that was provided during the course of the on-site audit. During the post audit review the Auditor continued to request documentation from the facility through the ERAU Team Lead. The auditor also reviewed the facility's website. A tentative daily time schedule was provided by the ERAU Team Lead for the on-site audit.

Before the start of the audit, the Auditors met with agency and facility staff. The team lead opened the entry briefing at 8:00 A.M. on the first day of the on-site visit. In attendance were:

- (b) (6), (b) (7)(C) Management and Program Analyst/Team Lead, Office of Professional Responsibility (OPR)/ERAU, ICE
- (b) (6), (b) (7)(C) Deputy Director, ECCF
- William J. Anderson, Warden, ECCF
- (b) (6), (b) (7)(C) Detention Services Monitor (DSM), ICE
- (b) (6), (b) (7)(C) Assistant to the Director/PSA Compliance Manager, ECCF
- (b) (6), (b) (7)(C) Captain, ECCF
- (b) (6), (b) (7)(C) Captain, ECCF
- (b) (6), (b) (7)(C) Lieutenant, Correctional Housing and Review Team, ECCF
- (b) (6), (b) (7)(C), Assistant Field Office Director (AFOD), ICE
- (b) (6), (b) (7)(C) Sergeant, Correctional Housing and Revenue Team Compliance Manager, ECCF
- (b) (6), (b) (7)(C) Sergeant, Correctional Housing and Revenue Team, ECCF
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO), ICE
- (b) (6), (b) (7)(C) Officer, ECCF

Brief introductions were made and the detailed schedule for the audit was covered. The Auditor provided an overview of the on-site audit process and methodology used to demonstrate PREA compliance. The auditor explained that the audit process is designed to not only assess compliance through written policies and procedures but also to ascertain whether such policies and procedures are reflected in the knowledge and day-to-day practices of staff at all levels. The Auditor further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, additional on-site documentation review, and conducting both staff and detainee interviews. It was shared that one piece of correspondence was received from a detainee. The correspondence was forwarded to the facility and an investigation started. The correspondence, however, was not included on the original ICE list of investigations; but added during the on-site audit. The detainee was interviewed during the audit. A second letter was received after the on-site audit. The correspondence was forwarded to ERAU to share with the facility. It was a report of sexual abuse at another facility. During the length of the audit, the facility provided most of the requested information to be used for the random selection of detainees and staff to be interviewed (random and specific category) including an alphabetic listing and a list of all detainees housed at the facility by housing unit, lists of staff by duty position and shifts, and a list of volunteers/contractors on-site during the audit. Lists of detainees for specific categories to be interviewed was not provided. The lead Auditor informed the staff, an Auditor will observe the intake and classification process.

A facility tour was completed by the Auditors with key staff which included one of two Wardens, a Captain, Special Assistant to the Director/PSA Compliance Manager, two Lieutenants, Sergeant, two officers, ICE AFOD, ICE DSM, and ICE SDDO. All housing units were toured, as well as, program areas, service areas, food service, control center, booking/intake, and medical areas. All areas of the facility where detainees are afforded the opportunity to go or where services would be provided were observed by the Auditors. During the tour, the Auditors made visual observations of the program/service areas and housing units including bathrooms, officers post sight lines, and camera locations. Sight lines were closely examined, as was, the potential for blind spots throughout the areas where the detainees are housed or have accessibility. The Auditors spoke to random staff and detainees regarding PREA education and facility practices during the tour. Reviews of the housing unit logbooks were conducted to verify staff rounds for security staff and supervisors. All facility staff, with the exception of gaining access to some records and requested lists, were very cooperative and informative during the audit process.

The facility was constructed in 2004 and is a multi-level building. The facility has a design capacity of 2,434 adults. The custody levels range from high, medium high, medium low, and minimum. The facility houses no females or juveniles. On the first day of the audit, the facility's ICE detainee population was 734. The average detainee population for the last twelve months was 803. The average time in custody is 24 days. The top three nationalities of the detainee population are Mexican, Honduran, and Salvadoran.

The facility has contracts for healthcare with Center for Family Guidance, Professional Corporation (PC), commissary with Keefe, food service through Gourmet Dining, and Maintenance through DCO Energy. Volunteers provide religious services and re-entry programming.

The mission of the Essex County Department of Corrections is to ensure that all persons committed to Essex County's correctional institutions are confined with the level of custody necessary to protect the public while providing care, discipline, training, and treatment in preparation for reintegration into the community.

Entrance in the facility for staff and visitors is through the front entrance. The facility administrative offices and ICE offices are located in the administrative section of the facility. To enter the secure section of the building, entrance is through a secure door adjacent to the visit processing area controlled by the control center. The design of the secure section of the facility is made up of a main hallway with housing units and service/program areas located off each hallway. The housing consists of seven dorms (one unoccupied), and seven multiple occupancy housing units all under direct supervision. Each of the housing unit types (cell housing units and dorms) are constructed in the same layout).

Each multiple occupancy housing unit can house up to 64 detainees. These consist mainly of two-bed housing cells. Each housing unit has an open design with the officer's post inside the doorway facing the dayroom and housing cells. There are two single person showers on each unit affording one detainee the opportunity to shower at a time. The showers are covered with a curtain that allows for privacy by covering the detainee from the shoulder area to below the knee (PREA privacy curtain). Toilets are located in individual cells. (b) (7)(E) All housing units have their meals delivered. The pantry area where the meals are prepared for delivery onto the unit presented a blind spot. The facility quickly rectified the noted blind spot by adding an adequately placed mirror. Within the dayrooms are telephones and PREA information that is easily assessable on the housing unit bulletin boards. According to upper level staff, the policy is to play a PREA video every morning and to log that it was played. A review of the logbooks did not contain documentation that the video was being played. A review of facility written policy did not include direction to play the video on the housing unit or to record that it was played.

The dorms house 408 detainees of all custody levels. Dorms 1-6 houses 60 detainees each. Dorm 7, which houses 48 detainees, is presently closed. The officer's post is located inside the doorway of each dorm facing the beds. (b) (7)(E) Except for two urinals on each dorm 1 – 6, all showers and toilets are private. The toilets are individual stalls and the showers have PREA privacy curtains. The two urinals did not provide privacy. The facility has started the process to make each urinal an individual stall. Dorm 7; designed for female occupants did not contain urinals. (b) (7)(E) All showers have privacy curtains.

The restricted housing unit (HU 2D3-1) consists of eight ICE single occupancy housing cells. (b) (7)(E) The camera is monitored by the control center. Rounds are verified through a logbook. The showers all are equipped with PREA privacy curtains. Telephone access is afforded seven days a week for 1.5 hours and upon request. The unit was empty during the on-site audit.

The unit phones, which include the accessibility to the PREA Hotline, are only available for reporting from 6:30 am – 9:45 am, 10:15 am – 1:30 pm, 3:15 pm – 6:45 pm, and 7:15 pm – 10:30 pm during the times the detainee has access to the dayrooms. Signs are posted on the bulletin boards that state "With the exception of legal calls, phone calls are subject to monitoring at all times." Although phone calls to Rape, Abuse, and Incest National Network (RAINN) are monitored, there is no information specific to the monitoring of phone calls to RAINN either posted or when dialing the number. As facility postings state all calls except legal calls are monitored, this could cause detainees to believe their calls to RAINN are being monitored. The Warden was advised of this issue. PREA information posters/brochures posted on the bulletin boards include the PREA posters; information on correspondence including the addresses and phone numbers of outside reporting agencies; how to report outside the facility; victim services through Essex County Rape Crisis Center (ECRCC) and RAINN; and foreign consulates with addresses and phone numbers. During the audit, it was discovered that ECRCC had blocked the facility's calls. According to the Warden, via email after the on-site audit, all information regarding that organization was removed from facility postings and pamphlets.

Other holding areas include the intake/processing area and medical. The ICE intake/processing area has three holding cells with a total capacity of 38. In the case of overflow, there are two separate holding cells located in county intake area with a capacity of 28. The holding cells have toilets that are private from staff. (b) (7)(E) The camera is monitored by central control and does not show the toilet area. Detainees do not remain in holding cells longer than 12 hours. The medical area contains 12 medical housing cells with 8 for suicide watch. There are four negative pressure cells. Each cell is frosted to provide privacy to use the toilet. Each cell has a call button that rings into the Central Control for response. (b) (7)(E) The area is monitored by medical and security staff.

During the tour the Auditors observed intake processing. Upon arrival, the detainees are brought in from the intake yard to the intake sally port. The restraints are removed. The detainees are brought in one at a time to go through the metal detector and screened with the boss chair, a metal detection device that the detainees sit on prior to receiving a pat search. Forms including the Sexual Violence Screening Form, are completed, as well as, fingerprints and photographs. The Auditor noted that during the screening the detainee was not afforded a private area to answer the PREA questions. This was immediately rectified by bringing the detainee to the booking officer's desk. A PREA video is played in English, Spanish, and French while the detainee is being processed through medical. The volume, however, was very low and at times the sound went out and nothing is heard. The Lead Auditor recommended that the facility look at better ways of providing the education, including but not limited to, the use of detainee educators. The facility advised that they can use the Language Line for limited English proficient (LEP) detainees, however, a review of detainee files demonstrated that even non-English speaking detainees are being checked as English speaking without a need to use the language line. The Auditor attempted to interview a LEP Chinese speaking detainee who was marked as English proficient, however, he refused an interview.

During the tour, the Auditors reviewed housing unit logs for unannounced rounds by supervisors and housing unit rounds by officers. Although policy requires supervisory rounds on each shift; the logbook sign-ins were sparse, with most days only recording one unannounced round. The Warden was informed by the Auditor of the lack of recorded rounds during the on-site audit.

The areas where detainees work is the detainee intake area, kitchen, housing unit pantry, laundry area, and warehouse. The kitchen has 22 contracted Gourmet Dining staff and is also supervised by two officers, one lieutenant, and one sergeant. There is a minimum of 20 detainee workers with a maximum of 22. Meals are prepared in the kitchen and delivered to the dayrooms. The coolers and freezers are always locked and opened only by staff. Detainees are directly supervised while in these areas. (b) (7)(E) (b) (7)(E) (b) (7)(E)

(b) (7)(E) The warehouse is staffed with two security and one civilian contract worker. There are four detainee workers assigned who are always under direct supervision of staff. There are no cameras in the area.

During the tour the auditor noted one sight line concern in the kitchen pantries in each of the multiple housing units. In addition, the urinals in Dorms 1-6 had visible viewing of two urinals. Since the on-site audit, the facility has notified the auditor, via email that they have begun to install individual stalls for each urinal. The facility installed mirrors in the housing unit kitchen pantry areas which are located immediately outside the housing unit, which eliminated the blind spot within the pantry. Picture documentation was forwarded to the auditor, via email, after the on-site audit.

(b) (7)(E) The cameras do not have sound capability. (b) (7)(E) (b) (7)(E) (b) (7)(E) The Auditors observed the camera monitoring displays in the master control center. (b) (7)(E) Cameras operate on a 30-day recording system and video is stored on the facility's server system for 30 days unless downloaded and saved. The cameras have pan-tilt-zoom ability. (b) (7)(E)

All required facility staff and detainee interviews were conducted on-site during the three-day audit. Thirty-four formal detainee interviews were conducted, and 18 detainees were informally interviewed during the facility tours, (7.1% of the 734-detainee population). Random detainee interviews from different housing units (26), LEP (4), detainees with disabilities (2), and reported sexual abuse (2) were interviewed. Six detainees refused interviews. Detainees were selected randomly by the Auditor from each housing unit and from the lists provided for the specialized interviews. The Auditors utilized Language Services Associates (LSA) through the Creative Corrections LLC contract for translation services for all LEP detainees interviewed. The language line was utilized for detainees that spoke Spanish. Interviews were not conducted for detainees who filed a grievance, placed in segregation housing for risk, transgender/intersex, and who reported a history of sexual victimization. The facility did not have any detainees housed that were placed in segregation housing for risk or transgender/intersex. The detainee who reported a grievance refused an interview. As the facility was not being advised of detainees who reported sexual victimization from the medical department, they could not provide a listing of any detainees who reported victimization. Upon recommendation of the Auditor, the Sexual Violence Screening Form was modified to collect this data at intake. The suggestion was noted and was implemented during the on-site audit. The facility is an adult facility only and does not house juvenile detainees, therefore, no juvenile interviews were conducted.

A total of 35 staff were formally interviewed and an additional 17 informal staff interviews were also conducted during the facility tours (7% of the 745 staff who may have contact with detainees). Twelve security staff were randomly selected from each of the three shift rosters. Additionally, specialized staff were interviewed including the Warden (1), PSA Compliance Manager (1), First Line Supervisors (5), Medical and Mental Health (2), Administrative/Human Resources (1), Volunteers/Contractors (2), Investigator (1), Training Supervisor (2), Grievance Coordinator (1), Classification Supervisor (4), and Intake staff (3).

There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit. No allegations were reported to the Essex County Prosecutor. The three closed cases were also investigated by ICE staff and found unsubstantiated.

The Auditors also reviewed staff personnel records, staff training records, and detainee files. There were no reclassifications available to observe during the on-site audit.

An exit briefing was conducted by the auditors at the completion of the on-site audit. The following participants were in attendance:

- (b) (6), (b) (7)(C) Management and Program Analyst/Team Lead, OPR ERAU, ICE
- (b) (6), (b) (7)(C) Deputy Director, ECCF
- William J. Anderson, Warden, ECCF
- (b) (6), (b) (7)(C) DSM, ICE
- (b) (6), (b) (7)(C) Assistant to the Director/PSA Compliance Manager, ECCF
- (b) (6), (b) (7)(C) Lieutenant, ECCF
- (b) (6), (b) (7)(C) SDDO, ICE
- (b) (6), (b) (7)(C) SDDO, ICE
- (b) (6), (b) (7)(C) Officer, ECCF
- (b) (6), (b) (7)(C) SDDO, ICE
- (b) (6), (b) (7)(C) Training Officer, ECCF

While the Auditors could not give the facility a final finding per standard, due to not having the majority of the documentation prior to or during the audit, the Auditors did provide a preliminary status of their findings based merely on the on-site visit. They further advised the facility that the preliminary status of their findings was based only on what was observed during the on-site tour. Recommendations were shared with the facility that will be addressed under the appropriate standard in the narrative section. The Auditor suggested the facility continue to expand their operating policies and procedures, including the development of an actual SAAPI plan, which would provide step by step written procedures that the facility staff could follow in the case of a sexual assault. The policies are more policy statements of the standards than procedures.

The Auditors shared with those in attendance the appreciation of the hospitality received and for the professionalism provided by all staff during the visit. The Auditors observed interactions between staff and detainees in a positive manner throughout the audit. The Auditors thanked the Essex County Correctional Facility staff, Deputy Director, Warden, and Assistant to the Director/PSA Compliance Manager for their effort and commitment to the Prison Rape Elimination Act.

After the on-site audit, additional information was provided by the facility and provided to the Auditor through the ICE ERAU Share Point.

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.

Exceeds Standard: 2
115.31 Staff training
115.32 Other training

Meets Standard: 17
115.18 Upgrades to facilities and technologies
115.33 Detainee education
115.35 Specialized training: Medical and mental health care
115.54 Third party reporting
115.61 Staff and agency reporting duties
115.62 Protective duties
115.63 Reporting to other confinement facilities
115.64 Responder duties
115.66 Protection of Detainees Against Retaliation
115.72 Evidentiary standard for administrative investigations
115.73 Reporting to detainees
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
115.87 Data collection
115.201 Scope of audits

Does Not Meet Standard: 21
115.11 Zero tolerance of sexual abuse
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
115.21 Evidence protocols and forensic medical examinations
115.22 Policies to ensure investigation of allegations and appropriate agency oversight
115.34 Specialized training: Investigations
115.41 Assessment for risk of victimization and abusiveness
115.42 Use of assessment information
115.43 Protective custody
115.51 Detainee reporting
115.52 Grievances
115.53 Detainee access to outside confidential support services
115.65 Coordinated response
115.67 Agency protection against retaliation
115.68 Post-allegation protective custody
115.71 Criminal and administrative investigations
115.76 Disciplinary sanctions for staff
115.81 Medical and mental health screenings; history of sexual abuse
115.86 Sexual abuse incident reviews

Not Applicable Standard: 1
115.14 Juvenile and Family Detainees

PROVISIONS

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

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(c) The facility has a written policy PS. CUS. 051 Sexual Abuse Assault Prevention & Intervention mandating zero tolerance towards all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, reporting, and responding to sexual abuse and harassment. The policy provides definitions of sexual abuse and general PREA definitions. Through observation of bulletin boards, posters, educational handouts and materials, review of detainee handbooks, and interviews with staff and detainees, it was apparent that the agency and the facility is committed to zero tolerance of sexual abuse, sexual assault, and sexual harassment. Each staff member also carries an informational card that outlines first responder requirements and how to report an incident of sexual abuse including the employee hotline for anonymous reporting. The zero-tolerance policy is publicly posted on the Essex County Department of Corrections website.

(d) Although the position of Agency PREA Coordinator exists, per the facility PSA Compliance Manager, he does not report to anyone. A review of the organization chart shows his position as Special Assistant to the Director. The policy PS CUS 051 does not provide confirmation of the reporting hierarchy. The facility PSA Compliance Manager is responsible for collecting and analyzing PREA data and preparing required reports. In addition, the PSA Compliance Manager is responsible for ensuring facility compliance including policies and procedures relative to PREA. The PSA Compliance Manager stated most of his time is related to PREA including making housing recommendations, communication with staff regarding detainees, logging and tracking all allegations, and incident review team duties. During the interview with the PSA Compliance Manager, he appeared to lack knowledge regarding his responsibilities for coordinating the facility's efforts to comply with the PREA standards. He indicated he coordinates the facility's efforts by reviewing cases and keeping track of grievances and PREA allegations.

Does Not Meet: The PSA Compliance Manager indicated that he did not report to anyone at the facility or the agency. After some confusion, the facility indicated that the position of Assistant to the Director noted on the organizational chart was the position designated as the PSA Compliance Manager. This position reports directly to the Facility Director. The facility must provide a PSA Compliance Manager who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures and understand the position's role for accomplishing the facility's efforts including communication with facility administration on PREA efforts. The standard requires that the PSA Compliance Manager serve as the point of contact for the agency's PSA Coordinator. The interview with the PSA Compliance Manager confirmed a relationship has been established with an agency representative, as he noted he does not report to the agency. The facility needs to ensure the PSA Compliance Manager clearly understands the PSA Compliance Manager's position responsibility as the point of contact with the appropriate agency staff, including serving as the point of contact for the agency's PSA Coordinator.

§115.13 - Detainee supervision and monitoring.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Although the facility presented a staffing plan, it could not be determined how the facility staffing plan was developed. The Warden, being new to the facility, indicated that he was unsure, and therefore, could not offer insight into its development. Documentation presented to the Auditor was dated 1/1/2019 and was titled "2018 Staffing Recap." It was authored by a Captain and forwarded directly to the Facility Director. It could not be determined through interviewing the Warden or PSA Compliance Manager, or documentation, when the last review occurred. The 2019 Staffing Analysis indicated 614 positions and showed 604 filled. It could not be determined through interviews, or by the document presented, what bottom line staffing needs were used to develop the plan. The review did indicate the required staff needed for correctional officers was 540 and for sergeants 49. The document presented did not take into consideration the need for video in the development of the plan. A review of the PAQ indicated the facility's staffing level is 745 staff that may have recurring contact with detainees. The facility's security staff is comprised of 619 ECCF staff; 401 males and 218 females. Security staff work three 8-hour shifts; 6 am – 2 pm (day), 2 pm – 10 pm (second), and 10 pm – 6 am (night). Sufficient supervision of detainees was observed through on-site observations of security, program, and medical staff supervising and interacting with detainees. The Auditor reviewed daily security shift rosters/assignments for all shifts and determined the facility is ensuring staffing levels are being maintained in accordance with the standard. (b) (7)(E) [redacted] In contrast, all reviewed incident reviews, and the 2018 Annual PREA Review Meeting Minutes state, "There was sufficient video coverage of detainee housing and work areas. Through the review of the sexual abuse incident reviews, the incident review team reviewed staffing levels and were found adequate in all reviews.

(b) The facility's officer's post orders outline the comprehensive detainee supervision guidelines to meet detainee supervision needs. There is at least one assigned officer to each housing unit who provides direct supervision of detainees. The Warden indicated that all essential posts are filled daily. If there is a staff shortage, coverage is provided through mandatory or volunteer call-in overtime. Video cameras operate 24 hours a day, 7 days a week, and are monitored through the Master Control center. The post orders outline the responsibilities of detainee supervision including frequent and unannounced security inspections on day and night shifts; the unannounced security inspections are logged in the housing unit assigned logbook by housing unit staff. The duty supervisor is also required to make a round into each housing area at least once per shift which is also logged into the specific housing unit logbook. Policy PS CUS 051 indicates "that supervisory rounds overtime should cover all shifts and all areas"; which conflicts with the facility post orders which require once per shift. Interviews with supervisory staff confirmed confusion on when rounds are to be made. The supervision guidelines (post orders) are distributed on an annual basis. The annual review was completed on April 9, 2019 with approval from both the Warden and the ICE AFOD. All post orders reviewed by the Auditor have been reviewed and approved within the previous year. The previous year's review was on October 18, 2018. During the review of the sexual abuse incident reviews, the incident review team reviews staffing supervision requirements. A review of incident reviews indicated no staffing deficiencies. The practice is monitored through the review of housing unit logbooks by security supervisors and administrative staff.

Recommendation: Supervisory staff are being directed regarding supervisory rounds by the facility post orders that state, "rounds are to be conducted once per shift" and PS CUS 051 which states, "supervisory rounds overtime should cover all shifts and all areas." Policy should be consistent, and clear, both in frequency and how to document that the rounds are being conducted. Supervisory staff should attend refresher training on what constitutes an unannounced round, when to conduct it, and how to document that they are being completed.

(c) Although the facility had developed a staffing plan, it could not be determined that the development of the plan was based on the seven criteria of the standard to include generally accepted detention and correctional practices; any judicial finding of inadequacy; the physical layout, 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 facility custody. The staffing plan was developed by the Captain, with no input from the Administration or the PSA Compliance Manager; and forwarded to the Director. There is no documentation of a collaborative effort, review, or approval of the plan. The Warden indicated in his interview that the staffing plan is reviewed on a daily basis to ensure the safety and security of staff and detainees is maintained. All posts are filled daily. If there is a staff shortage, coverage is provided through overtime (mandatory or volunteer call-in). The last Annual PREA Facility Assessment was completed July 3, 2019. It should be noted that the initial minutes provided to the Auditor prior to the on-site audit were not in compliance with the standard. Upon request for documentation to confirm compliance with the seven required aspects of the standard, the minutes were resubmitted during the on-site audit noting the seven criteria verbatim. The interview with the Warden could not verify the meeting minute's accuracy. The facility has no judicial findings of inadequacy. The review indicated the staffing plan was completed; stating no changes were needed and there were no staff deviations. This was the facility's first Annual PREA Assessment. The investigations files and incident reviews were reviewed by the Auditor, all stated there was no need for any additional staff and video monitoring. It was determined by the facility the need for additional video monitoring outside the realm of the incident reviews.

Does Not Meet: The staffing plan lacks review of the required standard criteria in its development. In addition, the staffing plan is developed solely by the Captain with no apparent input from administrative staff or the PSA Compliance Manager. The Annual PREA Assessment Meeting minutes were resubmitted verbatim and could not be verified as accurate by the Warden during his interview. Based on the review of the staffing plan, interviews with staff, and the Annual PREA Review Meeting minutes, dated July 3, 2019, it is clear that the staffing plan, while being developed does not take into account appropriate staffing to protect detainees against sexual abuse and the need for additional video monitoring as required by the standard. (b) (7)(E) , neither the staffing plan nor the Annual PREA Meeting minutes indicate there is a need. The staffing plan provided by the facility lacks a clear coordination between protecting detainees from sexual abuse and its development. Further, the Warden's interview could not confirm how the staffing plan was developed, approved, or reviewed. In the annual staffing plan development, the facility must take into consideration the seven criteria in the standard and document the consideration of each criteria; determine sufficient staffing levels for the protection of detainees against sexual abuse, and obtain review and approval of the Warden.

(d) Supervisors and administrative staff conduct unannounced rounds. Housing unit staff are required by post orders to make frequent unannounced security rounds on day and night shifts. All supervisors are required by policy PS CUS 051 to make security rounds. Policy PS CUS 051 states, "Overtime the unannounced rounds shall cover all shifts and all areas of ECCF", therefore rounds are not required one time per shift by policy. The Auditor reviewed housing unit logbooks to confirm the practice of rounds and found non-compliance with the post orders which indicate once per shift. A sampling of logbook documentation indicated one round on 7/10/19 (6:43 am), one round on 7/11/19 (8:05 am), one round on 7/14/19 (8:05 pm), and one round on 7/15/19 (3:30 pm). Policy PS CUS 051 indicates that supervisory rounds shall cover all shifts and all areas overtime which conflicts with the facility post orders which require once per shift. All rounds, although documented in housing unit logbooks in red ink, are not documented consistently using different verbiage other than "unannounced." The first line supervisors interviewed had different ideas as to when to conduct their rounds. Some said daily, some said on two shifts, one gave specific times that rounds were conducted daily. All indicated that they used random routes. The facility's policy PS CUS 051 and post orders prohibits staff from alerting other staff members that supervisory staff rounds are occurring. Supervisors also indicated in the interviews that if a staff member was alerting other staff progressive discipline action could be started on the employee.

Does Not Meet: While the standard requires that unannounced security inspections shall be implemented for night, as well as day shifts, a review of random housing unit logbooks indicate that supervisory rounds, on most occasions, are being conducted one time per day. Supervisory staff are being directed regarding supervisory rounds by the facility post orders that state, "rounds are to be conducted once per shift" and policy PS CUS 051 which states, "supervisory rounds overtime should cover all shifts and all areas." Policy should be consistent and clear both in frequency and how to document that the rounds are being conducted. Supervisors must conduct unannounced rounds on all shifts per policy and standard. The facility staff needs refresher training on what constitutes an unannounced round, when to conduct it, and how to document that they are being completed.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

The Essex County Correctional Facility does not house juvenile and family detainees. At the time of the audit, there were no individuals housed under the age of 18, all were adults. Review of the PAQ and interviews with the Warden and PSA Compliance Manager confirm the facility does not house juveniles nor family detainee units.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(b/c/d) Policy PS CUS 051 states "Cross-gender pat searches of male/female detainees shall not be conducted unless after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances." Policy PS CUS 046 "Contraband and Search of Inmates/ICE Detainees and Facility, states "In cases of cross-gender pat-down searches the search shall be documented." Policy PS CUS 051 states, "all cross-gender pat-down searches of female inmates/ICE detainees will be documented." The policies contradict each other. Post and shift assignments are completed to ensure that there is always male staff on duty on all three shifts. This was confirmed through review of the shift rosters. Staff interviewed indicated that they had not conducted or were aware of any cross-gender pat-down searches conducted. They indicated that male staff are always present to pat down a male detainee. During the audit year, there were no cross-gender pat-searches conducted. This was supported by a memo to file, PAQ, and interviews. Pat-down searches observed during the audit were conducted by the same sex staff member. Female detainees are not housed at ECCF.

Recommendation: The Auditor recommends that Policy PS CUS 051 be updated to require "all cross-gender pat-down searches to be documented" to provide consistency in the polices and standard language. In addition, Policies PS CUS 051 and PS CUS 046 should be updated to include the procedure for documenting cross-gender pat-down searches to include how and where to document.

(e/f) Policy PS CUS 051 limits cross-gender strip searches and body cavity searches to cases of emergency or other extraordinary or unforeseen circumstance. Policy PS CUS 051 further states, that in case of an emergency, a staff member of the same gender of the inmate/ICE detainee shall be present to observe a strip search performed by an officer of the opposite gender. According to the facility, the policy that allows opposite gender strip frisks during an emergency while a member of the same sex observes is in accordance with the 2016 Performance-Based National Detention Standards (PBNDS) that per contract the facility must follow. Policy PS CUS 051 does not include the use of medical practitioners in conducting body cavity searches. Policy PS CUS 046 stipulates that strip searches may be conducted by custody staff of the opposite gender under emergency conditions as ordered by the Director or Warden. Policy PS CUS 046 outlines that body cavity searches of detainees shall not be conducted unless authorized by the custody supervisor in charge and by a licensed medical professional who must be of the same sex as the detainee. Interviews with medical staff and security staff confirmed staff are aware of facility protocols for conducting strip or body cavity searches, and if performed shall be approved by a supervisor and documented by incident reports. During the audit year no cross-gender strip or body cavity searches were conducted; this was documented through a memo to file and interviews. The facility does not house juveniles.

Recommendation: The auditor recommends the facility update policy PS CUS 051 to include procedures regarding the use of medical practitioners during body cavity searches, to update policy PS CUS 051 to include the procedure for documenting body cavity searches, and to update policies PS CUS 051 and PS CUS 046 to include the procedure regarding documenting strip searches.

(g) The facility's policy PS CUS 051 states, "Staff members may not visually observe inmates/ICE detainees while they change clothing perform bodily functions or shower." Detainees interviewed indicated they felt they had enough privacy to change their clothes, shower, and perform bodily functions. They were not observed by staff of the opposite gender. Staff also confirmed the detainees have privacy for these functions. In the multi-detainee housing units, there are shower curtains in front of all showers and toilets are located in the cells with closed doors for privacy. Upon request, detainees can re-access their cells when outside of the cells for services, programming, or recreation. The toilets in the medical housing cells and the intake holding cells were observed during the tour and provide privacy. In six of the seven dorms there are two urinals that did not provide privacy. The facility has started the process to make each urinal an individual stall. Policy PS CUS 051 also requires staff of the opposite gender announce their presence when entering detainee housing areas; this was observed during the audit. Detainees interviewed stated that staff of the opposite gender announce when entering the housing unit by loudly stating "female on the unit". Staff indicated that announcements are made upon entering the housing units.

Does Not Meet: In six of the seven dorms there are two urinals that did not provide privacy. The facility must complete the urinal stall installations on dorms 1-6 to afford privacy to the detainee from cross-gender viewing.

(h) This section is non-applicable. The facility is not a Family Residential Facility.

(i) The detainee handbook and policy PS CUS 046 states, "The ECCF shall not search or physically examine an inmate/ICE detainee for the sole purpose of determining the inmate's/detainee's genital characteristics." However, policy PS CUS 051 states, "Medical practitioners conduct examinations of transgender individuals to determine genital status only in private settings and only when an individual's genital status is unknown" and "Examinations of detainees to determine genital status shall be conducted in private and by medical practitioners." The review of the training lesson plans, PREA ICE Facilities and Pre-Service Prison Rape Elimination Act ICE 2017, documented these policies are covered in annual training. During interviews with staff, they were aware of the policy and indicated only medical could conduct such search. No searches have occurred in the audit period per documentation memo and interview with PSA Compliance Manager. There were no transgender or intersex detainees housed during the audit to interview.

Does Not Meet: Policy PS CUS 051 states, "Medical practitioners conduct examinations of transgender individuals to determine genital status only in private settings and only when an individual's genital status is unknown" and "Examinations of detainees to determine genital status shall be conducted in private and by medical practitioners", thus allowing for the examination of transgender/intersex detainees to determining genital status by facility policy. The facility's policy and practice needs to be updated to address the standard language; if the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning the information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner.

(j) Policy PS CUS 051 states that all staff shall receive training on conducting cross-gender pat-down searches and searches of transgender and intersex inmates/ICE detainees in a professional and respectful manner, consistent with security needs. Other than annual training, this training is also part of the initial pre-service training and covered in shift briefings. Interviews with the Training Supervisor and staff confirmed these practices, as well as, the review of the training lesson plans reinforcing these policies in the annual training, and review of staff training records. The facility could not present the Auditor with a full staff listing of staff who completed the training. When staff were randomly asked how a transgender pat-down search would be completed, they indicated the transgender/intersex detainee could request the gender of the officer to conduct the pat-down search, however, some were unclear about the difference of using the blade of the hand.

Recommendation: The review of 17 random training records, and staff interviewed, confirmed that the facility provides training on how to conduct pat-down searches of transgender/intersex detainees, however, some staff were unclear of the requirement to use the blade of the hand, therefore it is recommended that the facility conduct refresher training for staff regarding pat-down searches of transgender/intersex detainees.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's policy PS CUS 051 states, "Inmate/ICE detainee notification, orientation, and instruction must be in a language or manner that the inmate understands," and, "Inmates'/ICE detainees' education is available in accessible formats for all inmates/ICE detainees including those who are; limited English proficient (LEP), deaf, visually impaired, otherwise disabled and limited in their reading skills." Policy PS CUS 051 outlines that oral interpretation or assistance shall be provided to any inmate/ICE detainee who speaks another language in which written material has not been translated or who is illiterate and dictates that ECCF is in compliance with Federal Law and DHS policy to take reasonable steps to provide meaningful access to the facility's Sexual Abuse and Assault Prevention and Intervention Program for inmate/ICE detainees with LEP. Policy PS CUS 051 further

dictates that ECCF make available competent foreign language and sign language interpreters to ensure effective communication with inmates/ICE detainees with LEP and disabilities. Policy PS CUS 023 Deaf, Hard of Hearing, Visually Impaired and Disabled Inmates/ICE Detainees states that videotapes will be shown with a closed-captioned feature during any program, service, or activity at the facility. The lack of close-captioned features on the housing unit TVs designated to play a reoccurring PREA video and the TV in Intake designated to play the PREA orientation video for new arrivals was viewed during the on-site tour. Addendums for the hard of hearing from policy PS CUS 023 only mention inmates and were not observed or presented in Spanish or any other language. Interviews with intake staff confirm there is no viable orientation for the disabled, including those who are blind and those with low vision as the pre-booking PREA video had significant sound issues that interviews with staff and detainees confirmed has been on-going for two years. According to an email from the facility post audit the sound issue has been fixed. Detainees who are deaf or hard of hearing would be provided the ICE National Detainee Handbook and access to interpreters who can interpret effectively, accurately, and impartially. ECCF reported the use of three certified sign language interpreters on staff, however this Auditor has not been provided with documentation of their certification as requested, prior to, and post on-site visit to verify the resource the facility states are utilized for interpretation. Staff during interviews had some difficulty explaining the steps that would be taken to effectively communicate with disabled detainees when necessary. They were unsure how detainees who have limited reading skills or blind would be provided this information. Intake staff indicated they would also be able to listen to the PREA video, however, as indicated above, the intake PREA video had significant sound issues. Most staff indicated being able to utilize social service and mental health staff to deliver explanations to detainees with intellectual disabilities and mental health staff to ensure that the detainee comprehends the information. Intake staff indicated that the orientation video is available in Spanish and English. The Auditors only viewed an English orientation video with significant sound issues. The ICE Detainee National Handbook is readily available in seven different languages English, Spanish, Portuguese, Haitian/Creole, French, Arabic, and Vietnamese at the facility. Copies of the Chinese, Hindu, Punjabi, and Russian are available upon request off the ICE website. The facility has a contract with Language Line Services Inc. for interpretation services. A copy of the contract was provided for documentation. The facility also has bilingual staff on all three shifts. There were two detainees identified that had disabilities during the on-site audit to interview. One detainee presented with a mental health issue and indicated he had no difficulty communicating with staff. The second detainee was hard of hearing and LEP. Through a staff interpreter he indicated that he had no problem communicating with staff and was housed in the infirmary due to being hard of hearing. The Auditors identified detainees with disabilities during the on-site tour even though the facility indicated there were no detainees with disabilities during the on-site audit and during the tour. It should be noted that policy PS CUS 023 does not reference ICE detainees, it only references inmates in the body of the policy.

Recommendation: The Auditor recommends that the facility expand the policy to include the procedural details practiced of how to provide communication options for detainees with disabilities. Policy PS CUS 023 is not followed in regard to the required use of closed-caption TV when presenting information to detainees; the facility should come in compliance with their own policy. Policy PS CUS 023 does not include detainees in the body of the policy and is strictly directed to inmates. The policy should be expanded to reference detainees other than just in the title or note that inmate and detainee is interchangeable to clarify the policy/procedures also applies to detainees. Also the facility should maintain a list of certified interpreters. The facility could not provide documentation of the three staff certified sign language interpreters as noted in the pre-audit documentation to verify the resource the facility states is utilized for interpretation.

Does Not Meet: The PREA video presentation that plays at intake, although the facility reported it has been fixed, had significant sound issues for two years as documented through detainee and staff interviews. Although the facility indicated by email that the significant sound issues in intake have been repaired, there is no documentation that repairs have been completed. The facility needs to provide documentation that the detainees are provided information in a manner they understand, and documentation of the video presentation sound has been repaired.

(b) Policy PS CUS 051 states, "All written materials provided to inmate/ICE detainees shall generally be translated into Spanish. Where practicable provisions for written translation shall be made for other significant segments of the population with limited English proficiency," and "Inmate /ICE detainee notification, orientation, and instruction must be in a language or manner that the inmate/ICE detainee understands. Policy PS CUS 051 further states, "Oral interpretation or assistance shall be provided to any inmate/ICE detainee who speaks another language in which written material has not been translated or who is illiterate." ECCF has access to Language Line Services, Inc. The detainee must ask for the service, which according to staff interviews, will be arranged for him to use in the sergeant's office located in the area. On tour, the auditors observed the intake process. The intake officer asked the incoming detainee if he understands English and has the detainee sign a Non-English Speaking/Reading Detainee "Language Assistance Utilized" Form indicating a need, or no need for the Language Line. Procedure dictates that for those detainees who indicate a need for the Language Line, the line is to be provided at intake. A review of a LEP detainee's file, who spoke Chinese, documented the staff completed a Language Assistance Utilized form signed by the detainee indicating that the detainee spoke/read English/Spanish and did not need assistance from the Language Line. This review caused concern for the Auditor in that the process is not properly implemented. The Auditor attempted to interview the detainee, the detainee refused an interview. Each housing unit also employs a detainee housing unit representative who is available to assist detainees in their housing unit with interpreting written material. DHS/ICE PREA posters in English and Spanish, containing the name of the facility PSA Compliance Manager are posted throughout the facility, including on all bulletin boards in the housing units. Also, posted in the housing units are ICE ERO Language Line posters and contact information for victim advocacy services through RAINN. According to intake staff, the PREA orientation education video is available in Spanish and English. Due to time constraints, the Auditor did not have an opportunity to view the Spanish version. The ICE National Detainee Handbook includes a section (language identification guide) in the front of the handbook which outlines multiple languages to assist detainees who do not speak English or Spanish. During the audit, four interviews were conducted with LEP detainees. The language line was utilized for all four detainees that spoke Spanish. The detainees indicated they had difficulty communicating with staff when they first arrived. Two stated that they were provided the ICE National Detainee Handbook in English. All detainees indicated that they communicate through Spanish speaking staff and friends. They also indicated they would report an allegation of sexual abuse to an officer. These detainees indicated they received PREA education through written materials (posters) in their language, they knew they could report to staff, and Spanish speaking staff, and their friends were able to assist when requested.

(c) The policy PS CUS 051 states, "ECCF prohibits use of inmate/detainee interpreters, inmate/ICE detainee readers, or other types of inmate/ICE detainee assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's/ICE detainee's safety, the performance of first response duties under, or the investigation of the inmate's/ICE detainee's allegations." The facility has a contract with Language Line Services Inc. for translation services effective July 13, 2013. A copy of the contract was provided for documentation. The facility also has bilingual staff on all three shifts. This allows multiple methods that allow detainees to communicate with someone other than another detainee. Staff interviewed indicated a detainee would request a staff member for translation or the use of the language line. The detainees interviewed with limited English proficiency indicated they would communicate with a staff member for the need of a translation services or have another detainee that spoke English tell an officer the need for the services.

Recommendation: Although staff demonstrated an ability to utilize the Language Line, policy PS CUS 051 should include written procedure for staff in the use of the "Language Line Assistance" form. Training should be provided to all intake staff on how to recognize detainees who are non-English speaking, and, the importance of adequately assessing and documenting a non-English and Spanish speaking detainee's communication needs.

§115.17 - Hiring and promotion decisions.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b/d) Through review of policy PS CUS 051, it was determined that the facility has established a system of conducting criminal background checks for new employees and contractors who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The policy does not include volunteers, however, interviews with the human resource staff, and record review does confirm that the facility does background checks that include volunteers. The job application form requires the employee to answer questions of: have not engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution and have not been civilly or administratively adjudicated or convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to refuse. However, these questions need only be answered if the employee answers affirmative as an adult having ever been arrested, indicted, convicted for any violation of the criminal law, which are the questions relating to sexual abuse. Therefore, any incidents of sexual abuse as a juvenile, or incidents of sexual abuse which did not lead to an arrest would not be captured. This form is utilized for new hires. In the case of promotions, the facility utilizes the Essex County Department of Corrections form, that includes questions that ask the promotion applicant if he/she ever engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The form further asks if the promotion applicant has ever engaged or attempted to engage in any sexual advances or harassment incidents including unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. The background investigation questionnaire states the candidate will undergo a thorough background investigation including but not limited to the FBI, State Police, Local Police, Schools, Credit Bureaus, employment, family, etc. Policy PS CUS 051 indicates "that before hiring, consistent with Federal, State, and local law, makes its best effort to contact all prior institutional employees for information on substantiated cases of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse." The facility will contact prior institutional employers to obtain information on substantiated allegations of sexual abuse or any resignation during an investigation. All staff receive a copy of the Law and Regulations and sign that they received a copy. The Auditors attempted to select random employee files to review for the administrative adjudication check on the application form or as part of the hiring process paperwork and the background check prior to hiring. The facility was very reluctant to share employee personnel files. Finally, immediately prior to the exit close-out, the Warden personally went to Human Resources and pulled two random files for the Auditors to review. The two files were in compliance.

Background checks are also conducted through ICE prior to an ICE employee or ICE contractor being approved for hire. During a training session on September 25, 2018, and the training documentation available on the ERAU SharePoint site; the OPR Personnel Security Unit (PSU) Unit Chief explained that all ICE staff and any ICE contract employees must clear a background investigation through PSU before hiring or promoting any staff or contractor who may have contact with detainees. The contractor or staff complete an Electronic Questionnaires for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE; if it is a contract employee, the office informs the contractor that the employee cannot perform work on behalf of ICE. The Unit Chief explained the sexual misconduct questions are asked of the potential employee as part of the e-QIP. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a supervisor and is outlined in Knowledge of Law and Regulations. For this facility, ICE PSU conducts background checks on ICE employees. The Auditor submitted five ICE employee names to PSU to verify the background check process. All were compliant.

Does Not Meet: Standard requires that the facility shall ask all applicants who may have contact with detainees directly about previous misconduct in written applications or interviews for hiring or promotions. Although the facility has established a questionnaire that is presented to all promotional candidates, it does not utilize the form for new staff hires; the facility depends solely on the on-line application results which allows the applicant to skip the PREA questions if they have never been arrested, indicted, and convicted of a crime. Per Human Resource staff, and the provided promotional questionnaire, the facility includes all volunteers in their background checks, therefore policy PS CUS 051 should be updated to include volunteers. The facility must develop a process to ensure all new hires who may have contact with detainees are directly asked about previous misconduct in written applications or interviews for hiring or promotions. The facility must demonstrate the new process and provide documentation for review.

(c) Policy PS CUS 051 states, "Before hiring new employees who may have contact with inmate/ICE detainees, Essex County Department of Corrections (ECDOC) performs a criminal background check," and "The ECDOC performs a background check of current employees, which shall be ran annually by birth month." Staff interviewed and a review of the records confirmed this practice. Background checks are also conducted through ICE prior to an employee being approved for hire and again within five years. The Auditors attempted to select random employee files to review for the administrative adjudication check on the application form or as part of the hiring process paperwork and the background check prior to hiring. The facility was very reluctant to share employee personnel files. Finally, immediately prior to the exit close-out the Warden personally went to Human Resources and pulled two random files for the Auditors to review. The two files confirmed that background checks were completed prior to the hiring date. The Auditor provided five ICE employee names to OPR PSU to verify background checks were completed within five years. All were completed within the five-year period. During a training session on September 25, 2018, OPR PSU Unit Chief explained that all ICE and contract employees must clear a background investigation and as part of the continuous evaluation program a background check will be conducted every five years to ensure an employee's retention is clearly consistent with the interests of the agency and national security.

(e) The employment application contains a statement indicating the applicant agrees that all information must be true and accurate. If the applicant does falsify or omit information, he will be rejected from the selection process. The Human Resource staff interviewed confirmed the wording on the application and that a person would not be hired or would be terminated for falsifying information. During the review of the employee personnel files, the wording was verified on the employee application forms.

(f) Policy PS CUS 051 indicated that unless prohibited by law, the ECDOC provides 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. A review of the two employee personnel folders provided to the Auditor indicated the applicant is asked if he/she would approve the facility to contact former employers.

§115.18 - Upgrades to facilities and technologies.

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

Notes:

(a) The facility was constructed in 2004, no expansions or modifications have occurred at the facility. A memo to file and the interview with the Warden confirms no expansions or modifications have occurred. Policy PS CUS 051 indicates the facility will take into effect any design planning, modifications, or expansions to protect detainees from sexual abuse.

(b) The facility had a video management system upgrade in July of 2018 upon discovery that not all dorms were monitored by video. In May of 2019, during the ICE Pre-audit, it was discovered that there were additional blind spots in the detainee kitchen areas and (b) (7)(E) The cameras do not have sound capability. (b) (7)(E) (b) (7)(E) The cameras are monitored through (b) (7)(E) The Auditors observed the camera monitoring displays in the master control center. Cameras are placed in a position that allows privacy to the detainees for showering, changing clothes, and performing bodily functions. Cameras operate on a 30-day recording system and stored on the facility's server system for 30 days unless downloaded and saved. The cameras have (b) (7)(E ability. An interview with the Management of Information Systems Specialist provided the information regarding the video system upgrade. (b) (7)(E) The Lead Auditor requested documentation upon completion.

Recommendation: The last PREA related tour prior to the on-site audit suggested the need for additional cameras in the kitchen area which the facility quickly moved forward with by adding the additional cameras. (b) (7)(E) and the 2018 Annual PREA Review Meeting minutes indicating there was sufficient video coverage of detainee housing and work areas, the facility moving forward must document that they have considered all blind spots and other PREA related information when adding to the video monitoring system as required by the standard and stated in facility policy PS CUS 051.

§115.21 - Evidence protocols and forensic medical examinations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Agency policy 11062.2 outlines the agency's evidence and investigation protocols. The facility's policy PS CUS 051 states "The facility shall establish a protocol to ensure that each allegation of sexual abuse is investigated by the facility, or referred to an appropriate investigative authority", and "The facility is responsible for investigating allegations of sexual abuse involving a uniform evidence protocol that maximizes the potential for obtaining useable physical evidence for administrative proceeding and criminal prosecutions." The Auditor had requested a protocol be presented prior to, during the on-site audit, and post-audit for review. The facility did not present a protocol but referred the Auditor to Policy Statement Administration (PS ADM) 038 Processing & Control of Evidence policy which does not include sexual assault. The facility utilizes a PREA allegation checklist that is not covered by policy or procedure. The facility does not house juvenile detainees

Does Not Meet: Although, PS CUS 051 states verbatim the standard requirements, the facility does not have an actual uniform protocol to follow that maximizes the potential for obtaining useable physical evidence for administrative and criminal prosecutions. When requested by the Auditor, the facility referred the Auditor to another policy PS ADM 038 that did not include sexual assault evidence collection either. The facility must establish a uniformed evidence protocol for investigating allegations of sexual abuse. The facility investigators must be trained on the process and protocol.

Recommendation: Policy PS CUS 051 indicates that the facility shall establish a protocol to ensure that each allegation of sexual abuse is investigated by the facility or referred to an appropriate investigative authority. The facility through the ECDOC SID investigates all PREA cases, therefore the policy should be revised to match practice.

(b/d) Policy PS CUS 051 states, "A contractual agreement may be developed with a rape crisis center or other available community medical service to enhance facility medical services." The facility has no memorandum of understanding (MOU) agreement with Essex County Rape Crisis Center (ECRCC), nor is there documentation that the facility attempted to establish an MOU. Efforts to contact ECRCC revealed that ECRCC had blocked the facility's phone number. Through a phone call to ECRCC, they confirmed they have blocked the facility's calls. The facility does utilize RAINN; however, RAINN does not provide on-site services. The facility indicated that the hospital would contact victim advocacy services if a detainee was taken to the outside hospital. The one investigation file reviewed where a detainee was taken for outside medical services was determined that an assault did not occur, and victim advocacy services were not noted in the file. The facility has mental health staff on-site that detainees are referred to after a reported allegation, however, the Auditor was not provided documentation that mental health was appropriately trained to provide victim advocate services.

Does Not Meet: Policy PS CUS 051 indicated that the ECRCC will provide outside victim services after an incident of sexual abuse. Attempts to call the rape crisis hotline revealed that the center has blocked the facility's calls. There is no MOU in place or attempt for victim advocacy services. There is no documentation to verify victim advocacy services being provided by the local hospital or through another method as a result of an incident of sexual abuse. The facility must establish procedures to ensure that victim advocate services are available following incidents of sexual abuse and forensic exam through outside community resources or through a qualified community-based organization and/or facility staff member. The facility needs to provide documentation that victim advocacy services are available in the areas of crisis intervention and counseling during a forensic exam and as needed. If the mental health staff are to provide victim advocacy services, they must have received education concerning sexual assault and forensic examinations in general. The facility needs to provide documentation of the training.

(c) All alleged victims of sexual assault who require a forensic exam are taken to University Hospital on Newark, New Jersey for completion of the forensic exam and emergency medical healthcare at no cost to the detainee. The facility could not provide an MOU with the hospital for Sexual Assault Nurse Examiner (SANE) services. Services are available through the emergency department 24-hours a day, 7 days a week. The medical staff interviewed indicated all detainee victims would be transported to University where a SANE staff are on-call. The Auditor was not provided a contact at University Hospital to interview regarding Sexual Assault Forensic Examiner (SAFE)/SANE availability. Of the one victim that was transported to University Hospital, once arriving at the hospital it was determined the incident was not PREA, and therefore, forensic services were not required.

Recommendation: The Auditor recommends that the facility include in the development of an evidence protocol to clearly define, the hospital's SANE/SAFE, or other qualified health care personnel role in the event of an allegation of sexual abuse.

(e) Policy PS CUS 051 requires that all allegations are immediately and effectively reported to the appropriate ICE Authority. In turn, the appropriate ICE Authority will report the allegation as a significant incident and refer the allegation for investigation. Staff indicated that all of the PREA allegations are investigated through SID. The PSA Compliance Manager stated that OPR always assigns the incident a case number. There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit. If criminal charges are recommended, the Essex County Prosecutor's Office will be notified. No cases were referred to the Essex County Prosecutor's Office. The three closed cases were also investigated by ICE staff and found unsubstantiated.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Policy PS CUS 051 states, "all staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault and the facility administrator shall promptly report the incident to the appropriate ICE Authority and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation." Policy PS CUS 051 dictates that the facility shall report all allegations immediately and effectively to the appropriate ICE authority who will report the allegation as a significant incident and refer the allegation for investigation. The facility will complete the investigation by a specially trained investigator. Staff indicated that all the PREA allegations are investigated through SID, ECDOC investigative staff members assigned to the facility. SID will conduct all investigations including criminal. In practice, all allegations are reported to the facility's SID who investigates all allegations of sexual abuse and assault. All nine allegations were investigated by SID. Following the investigation, should criminal charges be warranted, the case is referred to the Essex County Prosecutor's Office for prosecution. Attorney General Law Enforcement Directive No. 2018-5, Directive Implementing Procedures and Protocols for Sexual Response and Referrals outlines the Prosecutor's role in cases of sexual abuse. The agency policy 11062.2 outlines the agency's evidence and investigation protocols. Once the investigation allegation is reviewed and accepted by the agency OPR investigator, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If the investigation is not conducted by the ICE, the facility will complete the investigation by a specialized trained investigator. The Auditor had requested an investigation protocol be presented prior to, during the on-site audit, and post-audit. The facility did not present a protocol but referred the Auditor to policy PS ADM 038 Processing & Control of Evidence which does not include sexual assault. The facility utilizes a PREA allegation checklist that is not covered by policy or procedure. Per policy PS CUS 051, a staff member must immediately report an allegation through the chain of command (first line supervisor), or to the PREA Coordinator, Internal Affairs Bureau (IAB), PREA Hotline, or to any facility PREA Liaison. The policy further indicates that the facility administrator shall promptly report the incident to the appropriate ICE authority; and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. As previously stated, facility SID staff are responsible for conducting all administrative and criminal investigations of incidents that occur at ECCF. Policy PS CUS 051 dictates that the facility will document all investigation referrals. The allegations are referred to ICE. The investigator stated that OPR will review all cases to determine if an investigation is required by the agency. All allegations involving staff are investigated by trained facility SID staff. Staff indicated that all of the PREA allegations are investigated through SID. There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit. No allegations were reported to the Essex County Prosecutor. The three closed cases were also investigated by ICE staff and found unsubstantiated. Upon review of the investigation files, notifications were made to ICE, however, not all case numbers were assigned. All nine allegations were referred for facility investigation. A review of the PREA Allegation Spreadsheet provided to the Auditor confirmed three cases were investigated by ICE. The spreadsheet did not note the other six allegations that were reported to ICE by the facility. The notifications to the appropriate ICE authority were documented through emails in the facility allegation/investigation files. The Auditor asked for information on the six allegations to clarify why they were not on the spreadsheet. This issue was being addressed during the on-site audit. The Auditor did not receive any clarification on the inconsistency between the allegations reported to ICE and listed on the spreadsheet of ICE investigations completed. The Auditor received further documentation of a detainee grievance that alleged sexual abuse. The grievance was investigated by the facility and the allegation was reported to the ICE field office. The JIC was not notified by the ICE field office for agency review of the allegation and investigation process. This allegation was not listed on the spreadsheet.

Does Not Meet: The facility does not have a written investigation protocol to ensure that each allegation of sexual abuse is investigated by the facility or agency. Policy PS CUS 051 dictates that the facility administrator shall refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. Interviews with security staff confirm that practice is to refer all cases to SID for investigation, who in turn, if criminal charges seem warranted, will refer the investigation to the Essex County Prosecutor. The facility does not utilize an outside law enforcement agency to complete investigations, other than ICE; SID conducts all investigations including criminal. The facility must develop a written investigation protocol to ensure that each allegation of sexual abuse is investigated administratively and/or criminally. The facility staff need to be trained on the written protocol.

The agency must develop a process to ensure all allegations are reported from the field offices to the JIC. Documentation is needed to provide the investigation action taken by ICE after an allegation is reported by the facility to ensure the investigation process of each allegation.

(b/d) Policy PS CUS 051 states, "The facility is responsible for investigating allegations of sexual abuse involving detainees and shall follow a uniform evidence protocol that maximizes the potential for obtaining useable physical evidence for administrative proceedings and criminal prosecutions", and "ECCF shall ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for investigation by SID, and shall document such referrals." In addition, PS CUS 051 does not clearly outline the agency's responsibilities other than the facility administrator will coordinate as necessary with the OPR. Policy PS CUS 051 dictates that investigations of sexual abuse and sexual harassment involving staff are referred to the Essex County Prosecutor's Office. According to interviews with Investigative staff, PSA Compliance Manager, and Warden, only incidents of sexual abuse or assault that are found to be criminal in nature by SID are referred for prosecution. Policy PS CUS 051 also states that the agency shall retain copies of all administrative and criminal reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, and that the facility shall maintain sexual abuse data collected for at least ten years after the date of initial collection, unless federal, state, or local law requires otherwise. The PSA Compliance Manager indicated that all investigations are maintained in accordance with policy covering retention of records.

Does Not Meet: The facility does not have a written protocol to outline the facility's responsibilities for sexual abuse investigations and reports other than the facility administrator will coordinate as necessary with the OPR.

Recommendation: Policy PS CUS 051 dictates that investigations of sexual abuse and sexual harassment involving staff are referred to the Essex County Prosecutor's Office. This however, according to Investigative Staff, PSA Compliance Manager, and Warden interviews is not the practice, as not all staff allegations are referred to the prosecutor's office. Only incidents of sexual abuse or assault that are found to be criminal in nature by SID are referred for prosecution. The facility should update the policy to reflect current practice.

(c) The ICE website, www.ice.gov/prea includes information on the agency's PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE Detainee National Handbook, ICE PREA poster, and ICE PREA Sexual Assault Awareness Information pamphlet. On the Essex County Corrections website, essexcountynj.org, is a webpage dedicated to PREA. The webpage contains the zero-tolerance policy and how to report sexual abuse or sexual harassment. There is a sentence that explains that all allegations will be referred for investigation, and, that ECCF will impose discipline for sexual misconduct, up to and including termination and criminal prosecution for staff, as well as, discipline for offenders who victimize other offenders. The website does not include detainees and refers strictly to offenders. There are no sexual abuse investigation protocols posted.

Does Not Meet: The facility's website does not include detainees. The facility's website does not make the sexual abuse investigative protocol available to the public through the website or another method. The facility must make the sexual abuse investigative protocol for detainee investigations available to the public through the facility's website or another method.

(e/f) Policy PS CUS 051 requires that all allegations are immediately and effectively reported to the appropriate ICE Authority. Interviews with the Warden and PSA Compliance Manager and provided documentation confirms the reporting is done via the ICE email distribution. The SID Investigative staff is also notified. The facility does utilize a checklist, however, there is no procedure available to staff on how to utilize the checklist. A review of the checklist by the Auditor confirmed that it is being utilized and does include the requirement to contact ICE when an allegation is made. Following an investigation by SID staff, any potential criminal case will be forwarded to the Essex County Prosecutor for prosecution. A review of the three closed investigation cases confirmed that notifications are made to the appropriate ICE authority and SID staff. ICE investigators completed investigations on three of the nine allegations reported. Upon review of the investigation files, notifications were made to OPR, however, not all allegations reported were documented on the PREA Allegation Spreadsheet verifying the investigation assignment or process or case numbers assigned. Of the three closed cases, one allegation was not reported promptly. The allegation was reported at the facility on August 24, 2019 and the facility reported to ICE on August 27, 2019.

Does Not Meet: The facility must promptly report to the JIC, the ICE OPR, or the DHS OIG, as well as, to the appropriate ICE FOD an incident of sexual abuse.

Recommendation: The investigation protocol should be developed to provide staff the steps to take should there be an allegation of sexual abuse that needs to be reported to the Joint Intake Center, OPR, or OIG, as well as, the appropriate ICE Field Director.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a/b/c) The facility's policy PS CUS 051 and training curriculum Sexual Abuse and Assault Prevention and Intervention (PREA) address all the PREA training components listed in the standard provision and outlines the training requirements. Seventeen training records, staff interviews, and the training curriculum review indicated the training includes the zero tolerance policy; definitions and examples of prohibited and illegal sexual behavior; right of detainees and staff to be free from sexual abuse and from retaliation for reporting of prohibited and illegal sexual behavior; recognition of situations where sexual abuse may occur; recognition of physical, behavioral, and emotional 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; and requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes. The initial training begins when the staff person is assigned to Essex during facility orientation. The training is also provided annually through the annual in-service training for all staff with each quarter covering a certain number of staff. Each employee is required to attend in-service annually. Additional training occurs during staff briefing with different PREA topics refreshers. Security and contract staff during interviews acknowledged the numerous methods they received training. The PAQ indicated all staff had completed training. After interviews with the PSA Compliance Manager, the Warden, and the Training Supervisor, it was determined all facility staff have received training. A selection of twelve staff training records was reviewed; all had completed the pre-service training and annual in-service. All staff training is maintained manually for each employee. Staff document the completion of training through a signature on the quarterly in-Service Training Form and the ICE Best Practices Form depending on the subject topic. Each staff member is provided and must carry the Sexual Abuse First Responder Duties card that outlines general PREA information and first responder duties. The facility exceeds the training standard by requiring all staff to complete annual training instead of the standard's two-year requirement, refresher training at staff briefing, and the PREA informational card carried by staff. Recommendation: PS CUS 051 should be updated to include that staff document through signature the understanding of the training received as review of documentation indicates that this is the procedure.

Recommendation: The Auditor recommends that PS CUS 051 be updated to include that staff document through signature the understanding of the training received as review of documentation indicates that this is the procedure.

§115.32 - Other training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a/b) All contractors and volunteers who have contact with detainees receive PREA training prior to assuming their responsibilities. The commissary, mental health, medical, and food services are provided by contractors. Volunteers are utilized for religious services. Policy PS CUS 051 and lesson plan PREA Awareness covers the PREA training requirements of volunteers and contractors and states training will be held annually. The annual training is divided into quarters and is on-going throughout the year. This was confirmed through the interviews with the volunteers and contractors and review of three volunteer and two contractor training files. This training includes the agency's policy and procedures regarding sexual abuse and sexual harassment prevention, detention, and response; their roles and responsibilities in sexual abuse prevention, detection, and intervention; reasons why

and situations where sexual abuse and/or assault may occur; examples of barriers to detainee reporting; zero tolerance; first responder requirements; reporting methods and requirements; and PREA definitions. Interviews were conducted with two contractors and two volunteers who when interviewed stated the training is conducted in a classroom setting with the use of a PowerPoint presentation, video, and discussion. They were knowledgeable on PREA, their responsibilities for reporting, the reporting process, who to report to, and the facility's and facility's and agency's zero tolerance policy. They indicated they would report to their direct supervisor immediately. The training is conducted by the facility's training officer and Lieutenant. Three volunteer training records were reviewed and confirmed the training with the exception of one volunteer who received only initial orientation. The volunteer received the training post on-site audit as verified by email dated 7/24/19. The facility exceeds the standard by providing annual training and refresher training as needed to all volunteers and contractors.

(c) Policy PS CUS 051 states that ECCF shall maintain written documentation verifying staff member, volunteer and contractor training. Volunteers and contractors document the completion of training through a signature on the Quarterly In-Service Training Form. Training records are maintained by the Training Supervisor. Training records of five contractors and volunteers were reviewed and documented compliance with the exception on one volunteer who had missed annual trainings and was provided training post on-site visit.

§115.33 - Detainee education.

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

Notes:

(a/d/e/f) The facility provides a PREA education video to the detainee population beginning at intake into the facility. The facility policy PS CUS 051 address the PREA education requirements for detainees at intake. At intake into the facility, staff provide detainees information through the ICE Detainee National Handbook; PREA pamphlet Sexual Assault Awareness Information, and the Detainee Orientation Video. The ICE Detainee National Handbook is readily available in seven different languages English, Spanish, Portuguese, Haitian/Creole, French, Arabic, and Vietnamese at the facility. Copies of the Chinese, Hindu, Punjabi, and Russian are available upon request off the ICE website. During the intake process, the Detainee Orientation Video is playing that includes PREA information. The intake staff interviewed indicated the video is played on a loop in English and in Spanish. The Auditor observed the video being played. At times the sound would go out and the content of the video could not be heard. The video and handbook include information on sexual abuse prevention, sexual abuse reporting, and sexual abuse treatment and counseling. The Detainee Handbook contained information on the grievance process. The PREA pamphlet Sexual Assault Awareness Information is available in Spanish and English. Intake staff utilized a staff interpreter and the language line to communicate the PREA education to the detainee with the detainee signing acknowledging receiving the handbooks and pamphlet and the need for the language line. The Auditor reviewed five detainee intake files and discovered that at least one verified non-English speaking detainee signed that he understood English and did not need the line. The Auditor attempted to interview the detainee; however, he refused an interview. During the audit period, 2,849 detainees were booked at the facility. Based on the intake process the auditor observed, all detainees receive the PREA information during the intake process. The 26 random detainees interviewed acknowledged receiving education on the same day as intake into the facility through the video, handbook, and postings on the walls. Two detainees, however, did note the issue with the sound. According to an email from the facility the issue with the video sound has been resolved. The Auditors also during the tour viewed DHS/ICE PREA posters in English and Spanish, containing the name of the facility PSA Compliance Manager posted throughout the facility, including on all bulletin boards in the housing units. Also, posted in the housing units are ICE ERO Language Line posters and contact information for victim advocacy services through the local rape crisis center, Essex County Rape Crisis Center and RAINN. As it was discovered during the on-site audit that the Essex County Rape Crisis Center blocked the facility's number. It was recommended that the information regarding the Center be removed from the detainee information pamphlets and posters. According to an email from the facility, all information regarding the Essex County Rape Crisis Center has been removed.

(b) The ICE Detainee Handbook is available in English and Spanish. Staff during interviews explained the steps that would be taken to effectively communicate with disabled detainees when necessary. Detainees who are deaf or hard of hearing would be provided the handbook and access to facility staff who were certified trained sign language interpreters who can interpret effectively, accurately, and impartially. The Auditor requested documentation of certification before, during, and after the audit, however, this information was not made available to verify the resource the facility states is utilized for interpretation. Detainees who have limited reading skills or blind would have social services staff meet with them to read and explain the materials to them. The social service staff are service providers hired by the facility for services.

Recommendation: Also the facility should maintain a list of certified interpreters. The facility could not provide documentation of the three staff certified sign language interpreters as noted in the pre-audit documentation to verify the resource the facility states is utilized for interpretation.

(c) The detainees sign acknowledging the receipt of the handbooks and PREA Sexual Assault Awareness Information pamphlet during the intake process. Five detainee files were reviewed for documentation of PREA information provided during the intake process and showed compliance. All orientation was conducted on the day of intake and documented through signature of the detainee. Policy PS CUS 051 also outlines the requirement of maintaining documentation of detainee participation.

§115.34 - Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility's policy PS CUS 051 reflects that investigators are to be trained in conducting sexual abuse investigations in confinement settings. The specialized training lesson plan, National Institute of Corrections (NIC) PREA: Investigating Sexual Abuse in a Confinement Setting includes sections on techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The facility has five specialized trained investigators who have completed the general PREA training and the required specialized training for investigators. The specialized training is provided electronically through the NIC website. The training was conducted in January 2015. The specialty training was verified through the interviews with investigative staff and review of five specialized training records, including training certificates and training attendance record forms with signatures. A review of investigative files indicated that they were completed by trained facility investigators. The three ICE staff that completed the investigations on the three closed cases had not completed specialized investigation training.

Does Not Meet: All ICE staff completing investigations must receive specialized investigation training.

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

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

Notes:

(a/b) There are no ICE Health Services Corps staff working at the facility making this section non-applicable. The medical and mental health staff are contractors.

(c) Although the facility does not have IHSC staff or required to comply with section B of the standard, PS CUS 051 requires that all full-time medical and mental health practitioners who work regularly in the facility receive specialized training in addition to the general training mandated for employees. There is no documentation, however, that any specialized training is conducted at the facility. Training records were reviewed showing compliance of health care staff completing the general PREA training. The interviews with mental health and medical staff stated staff must complete PREA pre-service training when hired and then complete annual in-service. Healthcare staff do not conduct forensic exams. All alleged victims of sexual assault who require a forensic exam are taken to University Hospital for completion of the forensic exam and emergency medical healthcare. Policy PS CUS 051 has been reviewed and approved by the ICE Field Office Director (FOD) as part of the annual policy review noted on the front page of the policy.

Recommendation: As facility policy PS CUS 051 dictates that all medical and mental health staff receive specialized training, the facility should provide the training to both medical and mental health staff for compliance with the facility policy.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The screening process for the risk of victimization and abusiveness are outlined in the policy PS CUS 051. This screening occurs at intake into the facility with the use of the Essex County Sexual Violence Screening Form Risk Assessment Tool developed by Essex County Department of Corrections. The policy requires that each new arrival will be kept separate from the general population until the detainee is classified and may be housed according. The initial pre-booking process and housing assignment shall be completed within 12-hours of admission. This risk screening is conducted for all detainees during intake into the facility by the intake staff. This screening assists with determining a detainee's vulnerability or tendencies of acting out with sexually aggressive behavior. Interviews with 26 random detainees indicated the screening occurred prior to the placement in general population and was completed within 12-hours from admission. The Auditors reviewed five random detainee files selected by the Auditors. All files documented the risk screening occurring within 12-hours of admission and completed prior to the detainee being transferred to general population housing. Intake staff stated that detainees are asked about housing placement and if they have a concern for their safety. If the detainee is identified at high risk of sexual victimization or a potential sexual abuse victim, the detainee is referred through the PREA Referral Form to the PSA Compliance Manager, medical, and mental health for further screening. The PSA Compliance Manager indicated during the interview that he determines all housing placement for detainees who are at risk.

(c/d) The Auditors observed the intake process including the intake staff completing the Sexual Violence Screening Form and providing PREA orientation information to the detainee. At the arrival to the facility, the intake staff completes the Sexual Violence Screening Form as part of the intake paperwork process. The Sexual Violence Screening Form did not conform to the PREA standard requirements as it did not contain a question regarding whether the detainee has self-identified as having previously experienced sexual victimization. The Auditors were advised that the question regarding victimization was asked during the medical screening which took place upon completion of the intake screening. Interviews with medical staff confirmed that they did ask the detainee whether he has ever previously experienced sexual victimization, however, they did not share the information with other staff making housing decisions at the facility. During the on-site audit the risk assessment tool was modified to include the question regarding previous victimization. Facility staff presented the document in place and being utilized prior to the end of the on-site audit. The screening form did include all other questions including questions regarding mental, physical, and developmental disabilities; age of the detainee; physical build of the detainee; whether the detainee has been previously incarcerated; whether the detainee's criminal history is exclusively nonviolent; whether the detainee has prior convictions against an adult or child; whether or not the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; and the detainee's own concerns about his physical safety. The revised tool has ten questions to assess the detainee's risk for victimization and risk of abusiveness. Information is provided through an interview with the detainee. The risk screening tool is scored based on the number of yes responses. Policy PS CUS 051 states that the form will be utilized; but does not provide direction on how to use the form or the information gathered by filling out the form. In both section one and section two, it is unclear as to what represents an alert that a detainee is either a victim or a predator. The detainee signs the tool acknowledging the answers are correct. A detainee that scores at risk are referred to mental health. There is no clear indication on the form as to when a detainee would require a referral to medical. During the random detainee interviews, most detainees indicated they remember being asked these questions on the day of their arrival. The Lead Auditor reviewed the Sexual Violence Screening Forms within five detainee files and found all files compliant and risk assessments completed within the appropriate timeframes.

Recommendation: The Auditor recommends that PS CUS 051 be updated to include procedures on how to fill out the Sexual Violence Screening Form and when to make recommendations based on detainee answers to the questions required by standard. In Addition, the Sexual Violence Screening Form should be updated to give clear directions of what the value of the point system refers to and what constitutes a need for a referral to the PSA Compliance Manager for housing placement and medical and mental health staff for follow-up.

(e) Per policy PS CUS 051, the ECDOC requires the facility to reassess each inmate's/ICE detainee's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the inmate/ICE detainee's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The policy further states that an inmate's/ICE detainee's risk level is reassessed again, only if it is warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that impacts the inmate's/ICE detainee's risk of sexual victimization or abusiveness. The standard requires that each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon receipt of additional, relevant information or following an incident of abuse or victimization. Based on the wording of the standard that requires all ICE detainees be reassessed, the policy PS CUS 051 that requires reassessment not to exceed 30 days based upon any additional, relevant information received by the facility since the intake screening, falls short of compliance. Interviews with detainees indicated that a sergeant met with a majority of them approximately one month prior to the on-site audit for reassessment. Interviews with staff indicated that the process had just begun, and that the facility was reassessing all detainees at once. A review of five random detainee files confirmed that the reassessments had just begun with a large amount of assessments in a pile for filing.

Does Not Meet: Although the reassessment timing noted in the policy PS CUS 051 of requiring reassessment no later than 30 days from intake, it does not require all detainees be reassessed. There is no clear procedure in place delegating the reassessment to any particular staff person. In addition, the procedure had just begun with a sergeant interviewing all detainees at once to come into compliance. The reassessments that had been

completed were done utilizing the questions asked at intake. According to the PAQ the average time in custody is 24 days, however, the majority of the detainees interviewed had been detained for six months or more. The facility needs to update the policy to include reassessments for detainees within the 60-90-day period from the date of the initial assessment and develop a process to ensure the reassessments are completed. Staff need to be trained on the updated policy and process.

(f) Through review of policy PS CUS 051 and confirmed through intake staff interviews, disciplining detainees for refusing to answer or not providing complete information in response to certain screening questions is prohibited. The Intake Supervisor and PSA Compliance Manager stated the detainee does not have to answer questions and can refuse.

(g) Policy PS CUS 051 and staff interviews confirmed appropriate controls have been implemented to ensure that sensitive information is not exploited by staff or other detainees. The Intake Supervisor indicated the Sexual Violence Screening Form is in the detainee's facility file which are maintained in a lock room in the intake area for active files. The Auditor toured the area and it was in fact secure. Information is shared via closed email to upper level security staff, administrative staff, social services, medical, mental health, classification, and the PSA Compliance Manager on a need to know basis in order to make security and management decisions.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's policy PS CUS 051 addresses the assessment process and the use of the screening information to determine housing, recreation, voluntary work, and other activities to ensure the safety of the detainee. If the detainee is identified at high risk of sexual victimization or a potential sexual abuse victim, the detainee is referred by the intake officer through the PREA email to the PSA Compliance Manager, medical, and mental health for further screening. The PSA Compliance Manager with input from medical and mental health will determine housing. During the site visit, the auditor observed the classification officer completing the risk assessment process with a detainee, the detainee score did not identify the detainee at risk and general housing was assigned. The interviews with the Intake Supervisor and PSA Compliance Manager indicated that housing assignments are made on a case by case basis with consideration of custody level and PREA risk factors. In review of five recently completed risk assessments in the detainee files, the Auditor determined the facility is utilizing collected data, such as the detainee's physical characteristics (build and appearance), age, whether the detainee has mental, physical or development disability, previous assignment in specialized housing, alleged offense and criminal history, whether the detainee is perceived to be Lesbian/Gay/Bi-Sexual/Transgender/Intersex (LGBTI) or is gender non-conforming to determine housing, recreation, work, and other activity decisions. Through staff interviews and observing a classification, it was determined that the facility addresses the needs of the detainee consistent with the security and safety of the individual detainee when it pertains to housing. Based on interviews with intake staff and the PSA Compliance Manager, the risk screening is not utilized regarding recreation, voluntary work, and other activities.

Does Not Meet: Although policy PS CUS 051 requires the facility to utilize the risk screening form to determine housing, recreation, volunteer work, and other activities. Interviews with Intake staff and the PSA Compliance Manager indicated that they utilize the risk screening only to determine housing which falls short of the requirements of the standard. The facility needs must utilize the information from the risk screening to make informed individualized determinations to ensure the safety of each detainee including recreation, volunteer work, and other activities per the facility's policy and PREA standard.

(b) The facility's policy PS CUS 051 indicates that ECCF staff when making assessment and housing decisions for a transgender or intersex inmate/ICE detainee shall consider the detainee's gender self-identification and make housing assignments for a transgender and/or intersex detainee on a case-by-case basis based on the detainee's health and safety. In addition, the policy dictates that placement of a transgender or intersex inmate/ICE detainee shall be consistent with the safety and security considerations of the facility. When a detainee self-identifies as a transgender/intersex during the intake process the facility shall consult a medical or mental health professional as soon as practicable on this assessment. The policy does not define "as soon as practicable" and does not indicate where the transgender or intersex detainee will be housed during the assessment. According to interview with the PSA Compliance Manager, he, with input from medical and mental health, is responsible for housing determinations for all detainees. He did not provide information as to what information is considered when making transgender or intersex detainee housing determinations. The policy dictates that all housing and programming assignments shall be reassessed at least twice each year to review any threats to safety experienced by the inmate/ICE detainee. At the time of the on-site audit, there were no transgender or intersex detainees housed. The PSA Compliance Manager indicated there were no transgender or intersex detainees housed during the audit period.

Does Not Meet: The Auditor interviewed the PSA Compliance Manager to ascertain compliance with the standard and determined that the PSA Compliance Manager, whose responsibility it is to determine housing for all detainees, was unfamiliar with the intent of the standard, and therefore, the Auditor finds the facility does not meet the standard. The Auditor recommends that Policy PS CUS 051 be updated to include the procedure used, what criteria needs to be followed, and how reassessments will be completed, in determining housing and programming needs for transgender and intersex detainees on a case by case basis and consideration of the detainee's gender self-identification.

(c) Transgender and intersex detainees have the opportunity to shower separate from other detainees. Interviews with the random staff and PSA Compliance Manager noted that transgender/intersex detainees may shower in the housing unit in one of the single use showers. The Auditor noted during the tour that all showers are individual and have privacy curtains, which would provide privacy to the detainee. Policy PS CUS 051 supports this practice.

§115.43 - Protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) Policies PS CUS 051 and PS CUS 038 Special Housing Unit (SHU) outlines the written procedures for protecting a detainee that is vulnerable to sexual abuse or assault. The policies were approved by the Wardens and ICE FOD during the on-site audit. Policy PS CUS 051 states that ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there is no available alternative means of separation from likely abusers. Policy PS CUS 038 states any inmate/ICE detainee who is found to be vulnerable to sexual abuse or assault will be immediately controlled by staff and, for cause and with supervisory approval, placed in the Close Custody SHU with documented detailed reason(s) for placement. The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Policy PS CUS 038 states in

another section that an inmate/ICE detainee shall be placed in protective custody status in the Close Custody SHU only when there is documentation that is warranted and that no reasonable alternatives are available. The two policies, PS CUS 051 and PS CUS 038, are in direct conflict of reviewing for alternative placements and the type of custody housing; with policy PS CUS 038 in direct conflict with itself. A review of the investigative files indicates that all detainees who alleged sexual abuse, or sexual assault were immediately placed in closed custody. One detainee was moved to another cell in the evening and moved to closed custody in the morning even though there was no indication that the current cell move would not suffice. All such placements were documented.

Does Not Meet: The standard requires that the use of administrative segregation to protect detainees vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing. The facility needs to review and update the policies to be compliant with the standard and provide consistency among the facility's polices. The facility needs to develop a process and practice that reviews all alternative means of separation instead of just placing all detainees who are vulnerable to sexual abuse or assault in administrative segregation/protective custody/close custody SHU.

(c) The policy PS CUS 038 directs that if a detainee is placed in segregation housing for protective custody, the detainee would have access to programs, visitation, counsel, and other services to the extent possible. The Warden indicated detainees maintain all program, privileges, and services available to the general population detainees; unless warranted through a disciplinary case. If a restriction would occur, it would be based on a discipline case and would be documented through that an incident report and disciplinary process. At the time of the on-site audit there were no detainees confined to close custody due to an incident of sexual abuse, so there were no detainees to interview. Detainees held during the audit year were afforded privileges as required by standard.

(d) Policy PS CUS 038 states that the SHU Supervisor shall conduct a review within 72 hours of the detainee's placement into administrative segregation to determine whether segregation is still warranted. The review includes an interview with the detainee. The review will be documented on the Special Housing Unit Review Form indicating the decision made and the justification. A supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in administrative segregation, and seven days thereafter for the first two months and every ten days thereafter. This policy was put into effect just prior to the on-site audit. However, the previous section of the policy still indicates inmates/ICE detainees shall have a review at least every thirty days thereafter and not seven. Also, PS CUS 051 states, "If an involuntary protective custody housing assignment is made, ECCF affords each such inmate/ICE detainee a review every 30-days." In cases of involuntary protection, the Special Housing Review Form will be reviewed and signed by the Warden upon completion. As no detainees remained in administrative segregation or protected custody for seven days or more, there was no documentation to review to determine compliance.

Does Not Meet: The standard requires written policy and procedures, although the facility has written policy and procedures, the policy language conflicts with the standard language. The standard calls for 10-day reviews after the first 30-days. The policies PS CUS 051 and PS CUS 038 indicates a review every 30-days and included conflicting direction for reviews. The practice could not be determined during the on-site audit. The facility needs to update the policies to address the proper time frames per standard and ensure all conflicting procedures are removed from policies. The facility staff need to be trained on the policy and procedure changes.

(e) Per policy PS CUS 038 states that "the appropriate ICE authority and the ICE detainee shall be immediately provided a copy of the SHU order describing the reasons for the ICE detainee's placement in the Close Custody SHU." A review of investigative files and interviews with staff indicates compliance.

§115.51 - Detainee reporting.

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

Notes:

(a) The facility has established procedures allowing for multiple internal and external ways for detainees to report sexual abuse, retaliation, staff neglect, and violations of responsibilities that may have contributed to such incidents. PREA reporting methods are shared with detainees at intake including through the ICE National Detainee Handbook, PREA Sexual Assault Awareness Information pamphlet, and the Detainee Orientation Video. Reporting information is also available on the DHS/ICE PREA posters in English and Spanish, containing the name of the facility's PSA Compliance Manager posted throughout the facility, including on all bulletin boards in the housing units. The Auditors during the tour viewed information on reporting methods posted on the bulletin boards in the housing units. Detainees can report verbally and in writing to facility staff; report through the grievance process; utilize third party reporting; call the ECCF Sexual Assault Hotline, the office of the PSA Compliance Manager, New Jersey's Coalition Against Sexual Assault, New Jersey's Crime Victim's Law Center, National Sexual Assault Hotline (RAINN), and call or write a Consular Official. The Warden also showed the Auditors tablets in the housing units that detainees may use to email staff including reporting an incident. The facility's Detainee Handbook, ICE National Detainee Handbook, PREA Sexual Assault Awareness Information pamphlet, and PREA poster outline the reporting methods available to the detainee population. During the formal detainee interviews the detainees acknowledged receiving information on how to report at intake, in the handbooks and on posters. They were able to identify reporting methods including telling a staff member, calling the toll-free hotline, writing a grievance, and/or telling family or friends. Also, during the informal interviews with detainees while touring the facility, they indicated they knew the reporting process and felt comfortable reporting to a staff member. The initial PAQ submitted by the facility indicated that there were six allegations reported during the audit time frame. The PAQ indicated that one was reported by a staff member. The PAQ did not address how the others were reported. According to the ICE OPR, and the revised PAQ submitted to the Auditor on-site, there were nine allegations during the audit time frame. Of the three closed allegations reviewed by the auditor; one allegation was submitted by a third party and two allegations were submitted by a staff member. The allegation submitted by a third party was through another detainee. An Auditor tested the RAINN Hotline and the ECCF Sexual Assault Hotline during the tour. The local advocacy hotline, Essex County Rape Crisis Center did not work. Follow-up revealed that the rape crisis center had blocked the facilities number. The hotline number to the National Advocacy Center, RAINN, was also not working. The IT staff were contacted, and the issue was rectified during the on-site audit by implementing the proper way of dialing the RAINN hotline number so that it would go through. The new dialing directions were posted through the housing units which was verified by photo sent to the Auditor by email after the on-site visit. These reporting methods were demonstrated through review of policies and procedures, detainee handbooks, posters throughout the facility, review of investigation files, and interviews with detainees and staff.

(b) Detainees can write a letter to a Consular Office or call the national victim advocate group, RAINN. The ICE National Detainee Handbook, PREA Sexual Assault Awareness Information pamphlet and posters provide information to the detainee on how to report anonymously. There is a poster posted in each housing unit that provides toll-free phone numbers to numerous outside agencies including Consulates, ICE, RAINN, and the New Jersey Crime Victim Law Center. The DHS OIG PREA poster provides a hotline and states calls can be made anonymously and confidentially. The detainee may

report anonymously by phone by pressing 415 852 753 as their alien number and entering the speed dial number from a provided list followed by the # sign. This number would not identify a detainee. The PSA Compliance Manager indicated anonymous reports could be made through the phone system, in writing to staff, medical, and by third party. The Auditor attempted to interview RAINN staff but was sent to an answering machine. The message did provide directions of what to do in the case of an emergency. The phone call is not recorded. Upon review of the three closed investigation files, no allegations were reported outside the facility.

(c) Staff indicated through interviews they were aware of the methods available to them to report sexual abuse allegations. Staff were also knowledgeable on the methods the detainees could report to staff and their responsibility in the process. Staff acknowledged through interviews that they would report immediately any allegation to a supervisor and document it through an incident report. Policy PS CUS 051 indicates that staff shall be allowed to privately report sexual abuse to the PSA Compliance Manager, IAB, 24/7 Employee Hotline, and through the facility's website. The reporting requirements and process is provided to staff through training, policy PS CUS 051, and the PREA Staff Responsibility Card. During the audit time frame, of the three closed investigations two allegations were reported to staff who reported it immediately as documented by the incident reports in the investigation files.

§115.52 - Grievances.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility's policy PS CUS 051 states the ECCF shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint. Policy PS CUS 017, Inmate/ICE Detainee Grievance, and the Detainee Handbook addresses the administrative procedure for detainee grievances regarding sexual abuse. The facility does not impose a time limit for the submission of a grievance regarding an allegation of sexual abuse. A detainee can file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or compliant. The Grievance Coordinator stated there were no time limits for a grievance regarding an allegation of sexual abuse. The handbook states there is no time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse. Interviews with staff, the Grievance Coordinator, and the PSA Compliance Manager indicated that all grievances are submitted through the detainee tablet. During the interview with the Grievance Coordinator, the Auditor reviewed the procedure and found it in compliance, however, PS CUS 017 is outdated and does not properly outline the current procedure for filing grievances, stating that the detainee is to file an Inmate/ICE Detainee Grievance form and for the form to be processed it must be placed into the Housing Unit Mailbox marked "Grievance." During the tour, the Auditor inquired about the grievance box and staff indicated that it is no longer used and advised the auditor that all the grievances are submitted through the detainee tablet.

Recommendation: The facility should update PS CUS 017 to be consistent with PS CUS 051 and to dictate procedure currently being followed by staff and detainees.

(c) The facility's policy PS CUS 017 and Detainee Handbook provides written procedures and timeframes for handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. If staff identify the grievance involves an immediate threat to an inmate's/ICE detainee's health, safety, and welfare the grievance is to be handled as a time-sensitive emergency grievance. Policy PS CUS 017 does not reference incidents of substantial risk of imminent sexual abuse to the detainee under "Emergency Grievances." PS CUS 017 further states that the emergency grievance may be brought by an inmate/ICE detainee to a designated staff or social worker, Penal Counselor, Inmate Advocate, or designee, and directly to the Office of the Warden or designee. In the absence of these personnel, the inmate/detainee may inform a shift supervisor. Policy PS CUS 017 does not mention the tablet as a way to report an emergency grievance even though through staff interviews, it was determined that this was the current procedure. The grievance is forwarded to the Warden or designee for immediate corrective action to protect the alleged victim. Per policy PS CUS 017, all requests designated as "General" must be answered within 5 business days from the date the request is forwarded, and requests designated as "Medical" must be received by the Medical Department within 24 hours from the date the request is forwarded or the next business day, with a response from medical staff within 5 working days, where practicable. The policy does not provide timeframes for time sensitive grievances. There was one grievance regarding an allegation of sexual abuse. This grievance was received on 1/9/19 and referred for investigation on the same day. The grievance was against a staff member and involved an improper pat-down search by a staff member. Although reported to the appropriate ICE authority, the allegation is not included on ICE OPR list of PREA and Sexual Abuse/Assault Allegations provided by the Team Lead. The facility provided the Auditor an email that was sent to ICE to document the reporting process as reviewed during the investigation file review. The grievance was investigated by the facility with an outcome of unfounded. Although the allegation was reported to the ICE field office, the ICE field office did not notify the JIC for agency review of the allegation and investigation process; therefore, this allegation was not listed on the spreadsheet. Furthermore, The agency did not provide an outcome since an investigation was not conducted by the agency. The Auditor attempted to interview the detainee; however, he refused an interview. The Grievance Coordinator indicated that she receives immediate notification by email of an allegation of sexual abuse/assault grievance and it is handled immediately. If it is a non-workday, she would begin the process by reporting the allegation to the facility.

Does Not Meet: The standard requires that the facility implement written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related sexual abuse. Policy PS CUS 017 does not include reference to incidents of substantial risk of imminent sexual abuse to the detainee under "Emergency Grievances." Policy PS CUS 017 is outdated on how to report an emergency grievance by not including use of the detainee tablet, which as determined by staff interviews, is the current procedure to report.

Recommendation: The facility should update the policy to reflect specific timeframes for handling time-sensitive grievances that deal specifically with incidents of substantial risk of imminent sexual abuse.

(d) Policy PS CUS 017 states medical emergencies shall be brought to the immediate attention of proper medical personnel for further assessment. The standard does not differentiate between medical emergencies and medical emergencies as the result of an allegation of sexual abuse/assault. The Detainee Handbook indicates the detainee will be offered protection, receive a medical examination, and offered mental health counseling. One grievance regarding an allegation of sexual abuse was received during the audit period. The detainee was seen by medical and mental health the same day the grievance was received. This was documented in the investigation file.

Recommendation: The Auditor recommends that Policy PS CUS 017 be updated to include medical emergencies as a result of an allegation of sexual abuse/assault.

(e) The facility's policy PS CUS 017 and Detainee Handbook provides written procedures and timeframes for handling grievances. The facility shall issue a decision on the grievance within five days of receipt and the facility Grievance Appeal Board (GAB) shall respond to an appeal of the grievance decision within five days. The interview with the PSA Compliance Manager confirmed this procedure indicating that in the case of an allegation of sexual abuse, the grievance would be closed immediately and referred for investigation. The PSA Compliance Manager further indicated that the detainee would be notified. If the detainee does not agree with the decision of the GAB, the detainee has the option of appealing to the Office of the Warden, who in some cases in conjunction with the Field Office Director, shall review the grievance appeal and issue a decision within five days of receipt of the appeal. Policy PS CUS 017 indicates that ECCF shall send all grievances related to sexual abuse and assault and the facility's decision with respect to such grievances to the appropriate ICE authority at the end of the grievance process. The Auditor reviewed the one grievance and investigative report which was determined unfounded, however, the allegation was not included on the ICE OPR PREA allegation report. It was reported to ICE.

(f) The facility's policy PS CUS 017 and Detainee Handbook indicates that detainees may obtain assistance in preparing a grievance; including from another detainee, staff, family members, attorneys, and outside organizations. The random detainees interviewed were aware that assistance could be utilized or requested. This information is provided to the detainees in the handbook. The random staff interviews were consistent in their responses that they will accept a sexual abuse report made through the grievance system if submitted to them and immediately notify and submit the grievance to the PSA Compliance Manager.

§115.53 - Detainee access to outside confidential support services.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) The facility's policy, PS CUS 051 states the facility shall have representatives from outside entities that provide relevant services, expertise and actions to be coordinated but not be limited to having a victim advocate available to the inmate/ICE detainee victim during the forensic medical exam, providing crisis intervention counseling for the victim before and after the forensic medical exam. Policy PS CUS 051 also states that, ECCF shall provide victims with community-based victim support services based on contractual or other arrangements (i.e. MOU) with local organizations and a contractual arrangement may be developed with a rape crisis center or other available community to enhance facility medical needs. Based on an interview with the PSA Compliance Manager, no MOU exists with an outside community-based support service, nor is there documentation that the facility attempted to develop an MOU. The PSA Compliance Manager did state that Essex County Rape Crisis Center was contacted and refused to enter an MOU due to the requirement of background checks. There was not any written documentation to verify that this attempt was made. An interview with the Health Services Administrator indicated that she was unfamiliar with the availability of outside resources offered at the hospital. A review of investigative reports does not document that an outside local support service was offered. An attempt to contact the Essex County Rape Crisis Center via the PREA Hotline was unsuccessful. Further investigation revealed that the Center blocked the facility's telephone number. The facility provides hotline services through RAINN; an American nonprofit anti-sexual assault organization, the largest in the United States. RAINN operates the National Sexual Assault Hotline, as well as the Department of Defense Safe Helpline, and carries out programs to prevent sexual assault, help survivors, and ensure that perpetrators are brought to justice through victim services, public education, public policy, and consulting services. However, there is no MOU in place, or is there a documented attempt to enter an MOU to outline services to be provided. An attempt to call the RAINN hotline was also unsuccessful due to issues with the dialing instructions. This issue was resolved during the on-site audit, and information regarding dialing instructions were posted on all housing units post on-site audit. Picture of the postings were provided to the Auditor via email. Interviews with two detainees who reported sexual abuse revealed that neither were provided with information on how to contact someone from the community to provide emotional support, counseling, or legal advice. Of the 26 random detainees interviewed 11 detainees knew of the PREA hotline having seen the poster on the bulletin board in the housing unit. The other 15 detainees were not aware of information about organizations that can provide support services for sexual abuse victims.

Does Not Meet: The facility does not have a MOU in place or documentation of an attempt to obtain a MOU for community resources and services. In the investigative reports reviewed, there is no documentation of crisis intervention being offered to victims while at the outside hospital emergency room. The facility must establish procedures to make emotional support services available following incidents of sexual abuse through an outside community resources or through a qualified community-based organization and/or facility staff member to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to mot appropriately address victims' needs. The facility needs to provide documentation of obtaining emotional support services or attempts of an MOU/agreement with community service providers.

(c) The facility provides detainees information about local and national organizations that can assist detainees who have been victims of sexual abuse. Victim advocacy service information is provided to the detainees on posters on the housing unit bulletin boards and in the Detainee Handbook. There is a poster posted on the bulletin board that provides toll-free phone numbers to outside agencies including RAINN and Essex County Rape Crisis. There were two noted 24-hour hotline numbers in English and Spanish, and an address. The Auditors observed the posters during the tour. Attempts to call both hotlines failed. Regarding the local organization, the Essex County Rape Crisis Center, it was determined through investigation that the local center blocked the facility's phone number. The facility indicated through email that all references to the Essex County Rape Crisis Center were removed from all pamphlets and posters. Written documentation of pamphlets and posters was provided to the auditor post on-site audit. The attempt to call the RAINN hotline also failed due to incorrect dialing instructions. This issue was resolved during the on-site audit. Most detainees interviewed were not aware of outside support services available to them. However, the facility provides this information in multiple ways to the detainees including the Detainee Handbook and posters throughout the facility.

(d) There is a posting in the housing units that states all telephone calls at the facility are subject to being recorded, except legal calls. According to the Warden, via a post on-site audit email received by the Auditor, there is no posting regarding to what extent communications are monitored for the hotline calls to RAINN, however, they are not recorded. He further stated, as there is no recording prior to the call going through, this indicates to the detainee the call is not being recorded. A review of the PREA Sexual Assault Awareness Information pamphlet, ICE National Detainee Handbook, PREA posters, and policy PS CUS 051 addendum does not provide information to the detainee of the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The DHS poster provides ways to make anonymous phone calls by entering 415 852 753 as their alien number. Also, the detainee handbook and PREA pamphlets inform detainees that staff members are required to keep the reported information confidential and only discuss it with the appropriate officials on a need-to-know basis. The Warden indicated, via email, that the RAINN Hotline number is not monitored. The Auditors suggested that a notice be posted that informs the detainees to the extent the phones are monitored including that hotline numbers for sexual abuse reporting are not monitored.

Does Not Meet: The standard requires that the detainees are informed, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. A review of available documentation, including the ICE detainee handbook, PREA poster, and policy indicates that although the detainee is informed that the information he reports can be done anonymously and will be only be discussed with those on a need-to-know basis; the information does not inform the detainee the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The facility needs to develop a method to inform detainees prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

§115.54 - Third-party reporting.

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

Notes:

Policy PS CUS 051 states that ECCF accepts third-party reports of sexual abuse and shall make available to the public information on how to report sexual abuse on behalf of the detainee. ECCF's website provides information regarding reporting sexual abuse. The site states "If you have information regarding an ECDOC offender who has been the victim of sexual misconduct while under ECDOC custody, you may: Contact the ECDOC PREA Coordinator at 973-274-7733; Contact the ECDOC Internal Affairs Bureau at 973-274-7557; or Contact the ECDOC Warden's Office at 973-274-7761. Of the three closed allegations, one was reported by a third party which was referred for investigation.

§115.61 - Staff reporting duties.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) Policy PS CUS 051 states all staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault through, or outside, the ECCF's chain of command, and, 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. Employees are required to report any information to the PSA Compliance Manager, SID, PREA Hotline, or any facility PREA liaison. The facility administration shall promptly report the incident to the appropriate ICE Authority and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency, SID, having jurisdiction for the investigation. The policy was approved by the Wardens and the ICE FOD during the on-site audit. Reporting requirements are covered in the annual in-service training, pre-service training, and shift briefings for all staff. Specialized and random staff interviews confirm that staff are knowledgeable in their reporting duties, the process of reporting, and to whom to report. Random staff interviewed indicated they would report immediately to their supervisor and the PSA Compliance Manager and then write an incident report. This reporting information is also provided on the staff's PREA Staff's Responsibility Card. Per policy PS CUS 051, staff shall be allowed to privately report sexual abuse to the PSA Compliance Manager, IAB, 24/7 Employee Hotline, through the website, or to any facility PREA liaison. During the interviews, most staff indicated they would report privately through the hotline. The Auditor received further documentation of a detainee grievance that alleged sexual abuse. The staff member that was informed of the allegation initially did not report the incident immediately. The staff member left the facility for the day and did not report the allegation until days later.

Does Not Meet: The staff must must immediately report any known or suspected incidents or allegations of sexual abuse or assault to the PSA Compliance Manager, SID, PREA Hotline, or any facility PREA liaison. The facility must provide updated training with staff to ensure staff are aware of the reporting requirements.

Recommendation: The Staff Responsibility Card provides The GEO Group website for reporting, www.reportlineweb.com/geogroup. The facility should establish their own Staff Responsibility Card that provides their facility specific information.

(c) The policy PS CUS 051 states that information concerning the identity of an inmate/ICE detainee victim reporting a sexual assault, and the facts of the report 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. Reporting requirements including confidentiality are covered in the annual in-service training, pre-service training, and shift briefings for all staff. Staff interviewed indicated information would only be shared with the supervisor and other staff on a need-to-know basis.

(d) ECCF does not house juvenile and family detainees. At the time of the audit, there were no individuals housed under the age of 18, all were adults. Review of the PAQ and interviews with the Warden and PSA Compliance Manager confirm the facility does not house juveniles nor family detainee units. The Warden stated a vulnerable detainee, as defined under a State or local vulnerable persons statute, would be identified upon entrance via Sexual Violence Screening Form and would be immediately separated from the intake population. Medical, mental health, PREA Coordinator, administration and classification would be notified and would conduct an interview and evaluation to assess the individual for proper housing. Upon medical, mental health and classification clearance, the detainee would be assigned housing but not placed with detainees who have exhibited or have had previous predatory behavior. If the determination is to not house the detainee in a general population setting, the detainee would be housed in the least restrictive housing available. This is to ensure that the detainee has the opportunity to take advantage of all the services provided to general population detainees. ICE (Newark ERO) would be notified and transfer to another facility might be warranted. Mental health will conduct consults with the individual for 90 days to determine how the detainee is assimilating to the facility. PREA reassessment would be conducted between 60-90 days. If a PREA allegation arises, notifications would be made to Administration, PREA Coordinator, Internal Affairs (Investigative Unit), medical, and mental health. The Essex County Prosecutor's Office Sexual Crimes Bureau would be notified by the IAB Unit along with any outside agencies. There are no cases reported in the last 12 months concerning vulnerable detainees.

§115.62 - Protection duties.

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

Notes:

The policy PS CUS 051 requires that when the facility determines that an inmate/ICE detainee is subject to a substantial risk of imminent sexual abuse, ECCF shall take immediate action to protect the inmate/detainee. Staff interviewed indicated they would take immediate action to protect the detainee by separating the detainee from other detainees and maintain the detainee in a safe location. Then report the incident to the supervisor for further action and write an incident report. These responsibilities are covered in the annual in-service training, pre-service training, and shift briefings for all staff. The PSA Compliance Manager stated a PREA investigation would be assigned, a change in housing may occur, and immediate medical and mental

health referrals would be made. All security staff interviewed knew the steps to take to protect a detainee at risk for sexual abuse; to immediately separate the detainee from the area to keep the detainee safe and separate from other detainees; notify the supervisor; and write an incident report. Through the review of three closed investigation reports, it appeared that the alleged victims were removed from the area immediately to a safe location and an investigation was started.

§115.63 - Report to other confinement facilities.

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

Notes:

(a/b) Policy PS CUS 051 states that when a staff member receives an allegation that an inmate/ICE detainee was sexually abused while confined at another facility, staff shall notify their supervisor immediately with this information. In turn, the supervisor will notify the PSA Compliance Manager, who will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred, and such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. The Warden and PSA Compliance Manager indicated that the notifications would be made immediately to the other facility and ICE. They also indicated there were no instances this audit period, as also noted on the PAQ.

(c) The notifications will be documented by email. Copies of the notifications are forwarded to the PSA Compliance Manager. The interview with the PSA Compliance Manager confirmed the practice, as well as, policy PS CUS 051.

(d) The PSA Compliance Manager interview further indicated if the facility was to receive notification from another facility of an allegation of sexual abuse that occurred at the facility, an investigation would immediately be initiated. Notification would also be made to the appropriate ICE authority. This is supported by policy PS CUS 051.

§115.64 - Responder duties.

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

Notes:

(a) Policy PS CUS 051 specifies the detailed procedures for security and non-security staff when responding to an allegation of sexual abuse. The first security staff member to respond to the allegation is required to separate the alleged victim and abuser; immediately notify a first line supervisor; and shall refer the inmate/ICE detainee for a medical examination and/or clinical assessment for potential negative symptoms; and preserve and protect the crime scene. It states that staff shall request that the alleged victim not take any action that could destroy physical evidence and that staff shall ensure the alleged abuser does not take any action that could destroy physical evidence. The PREA Staff's Responsibility Card states that the first security staff member to respond to the report is required to separate the alleged victim and abuser; immediately notify the on-duty security supervisor and remain on scene until relieved by responding personnel; preserve and protect the crime scene; and ensure the alleged victim and alleged abuser to take no action to destroy evidence. Through interviews with supervisors and random staff it was demonstrated that staff was knowledgeable in the steps as a first responder: to separate the alleged victim and abuser; preserve and protect the crime scene; and request the alleged victim and alleged abuser to take no action to destroy evidence and contact a supervisor. First responder responsibilities are covered in the annual in-service training, pre-service training, and shift briefings for all staff. The first responder responsibilities are also outlined on the PREA Staff's Responsibility Card carried by all staff. During the review of the investigation files, it documented that staff took the appropriate steps when notified of an allegation. Of the three closed investigation allegations, two were reported to a security staff member, one was reported by a third party. Two detainees who were interviewed indicated that they were immediately separated, but not advised not to shower, etc. to preserve evidence.

(b) Policy PS CUS 051 also outlines that if the first responder is not a security staff member, the staff shall request that the alleged victim not take any actions that could destroy physical evidence, and then notify a security staff member. The random non-security staff interviewed indicated they would contact a security staff member immediately. They also stated they would remain with the alleged victim until a security staff member arrived.

Recommendation: The Auditor recommends Policy PS CUS 051 be updated to be consistent with the PREA Staff's Responsibility Card recently handed out to staff. A protocol should be developed that contains clear direction to staff as to what to do in the case of an incident of sexual assault/abuse, including but not limited to how to separate the victim/abuser, how to ensure that evidence is preserved, and how to preserve a crime scene pending SID arrival to investigate. The facility should establish their own Staff Responsibility Card that provides their facility specific information.

§115.65 - Coordinated response.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) Policy PS CUS 051 dictates that staff members must use a coordinated, multidisciplinary team approach responding to sexual abuse, such as a Sexual Assault Response Team (SART). Although policy PS CUS 051 dictates a plan be developed, the facility has not presented a written institutional plan to coordinate actions taken by the multidisciplinary team including first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The facility does utilize a PREA Response Checklist for Incidents of Sexual Abuse to document the activities of staff, but it is not incorporated in a plan that could guide users on how and when the checklist should be utilized. A review of the checklist indicated it does not include the use of outside community support organizations for those ICE detainees taken to an outside hospital for emergency treatment or forensic examination.

Does Not Meet: Policy PS CUS 051, updated during the on-site audit, dictates that staff members must use a coordinated, multidisciplinary team approach responding to sexual abuse, such as a Sexual Assault Response Team (SART). Although policy PS CUS 051 dictates a plan be developed, the facility has not presented a written institutional plan to coordinate actions taken by the multidisciplinary team including first responders, medical and mental health practitioners, and facility leadership in response to an incident of sexual abuse. The facility must develop a written institutional plan to coordinate actions taken by first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. With the policy being updated during the on-site audit, there was no demonstrated practice or documentation provided to determine compliance with the standard and policy.

(c/d) Policy PS CUS 051, updated during the on-site audit, addresses the reporting requirements if a victim of sexual abuse is transferred between DHS Immigration Detention Facilities and a non-DHS facility. The facility shall, as permitted by law, inform the receiving facility of the incident and victim's potential need for medical or social services. The only exception is to a non-DHS facility, a victim can request information not be shared. The PSA Compliance Manager stated the facility would be informed through email. He stated the full investigation may be shared if requested at the most, and

at the minimum, details about the incident and the victim's need for medical or social services. There were no instances of transfers during this audit period.

Recommendation: The Auditor suggests the facility expand the policy to include ICE Holding and ICE Staging Facilities to encompass all of ICE facilities.

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

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

Notes:

Policy PS CUS 051 states staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any "no contact" orders shall be documented. It also states that neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any inmates/ICE detainees pending the outcome of an investigation or of a determination of whether or not and to what extent discipline is warranted. The Warden stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact detainee post until the investigation is completed. If the case was substantiated, the staff member would be terminated. A volunteer's clearance would be revoked allowing no contact with the facility until the investigation is completed. According to the PAQ, there were no instances where a staff member, volunteer or contractor was removed for allegations of sexual abuse. The three closed investigations reviewed were detainee on detainee incidents.

§115.67 - Agency protection against retaliation.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The facility's policy PS CUS 051 states that all detainees and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations are protected from retaliation from the other inmates/ICE detainees or staff. The policy does not include contractors or volunteers. The policy designates the SID Unit to monitor retaliation. The Warden did not know who was actually designated to monitor retaliation. The PSA Compliance Manager indicated he is responsible for monitoring detainees. When questioned about staff, he further indicated he does monitor staff also. Staff is informed of protection from retaliation through training in pre-service and in-service. Of the three closed cases this audit period, no monitoring was conducted. Two detainees who reported sexual abuse were interviewed. Neither indicated that they were being monitored for retaliation.

Does Not Meet: Policy PS CUS 051 dictates that the SID staff conduct retaliation monitoring. Interviews with staff indicated clearly that staff was unaware of the procedure for monitoring retaliation and who is responsible for monitoring of detainees and staff for retaliation. A review of the investigative files revealed no monitoring was being conducted for those who reported sexual abuse. Interviews with detainees that reported sexual abuse stated they were not being monitored. The policy does not include contractors or volunteers. The facility needs to update the policy to include contractors and volunteers. Also, the policy needs to be updated to indicate what designated staff member is responsible for monitoring if SID is not conducting the monitoring as policy states. The facility needs to establish a process for monitoring for retaliation and the staff responsible for monitoring detainees and staff for retaliation.

(b) Policy PS CUS 051 states that ECCF has implemented multiple protective measures, such as housing changes or transfers for inmate/detainee victims or abusers, removal of alleged staff or inmate/ICE detainee abusers from contact with victims, and emotional support services for inmates/ICE detainees or staff who fear retaliation for reporting sexual abuse of sexual harassment or for cooperating with investigations. The PSA Compliance Manager and Warden indicated protective measures would be taken immediately and an investigation would be started. The Warden stated any allegation involving a staff member, the staff member would be moved to a non-detainee post during the investigation for retaliation. There were no cases that were monitored presented for review. Although, mental health staff are available to assist detainees and staff who required emotional support following an incident, it could not be determined through interviews, policy, or documentation what type of support services would be offered to staff or if trained to provide the services.

(c) Policy PS CUS 051 outlines the monitoring timeframes. During the interview with the Warden and PSA Compliance Manager both were unsure of the procedure to monitor staff and/or detainees who fear retaliation for reporting sexual abuse of sexual harassment or for cooperating with investigations. Although PS CUS 051 dictates that SID is responsible for this task, neither knew what the policy required. During the interview with the PSA Compliance Manager he first stated that he "did not know" when asked who was responsible for monitoring staff. He further stated that he monitors detainees by making phone calls to the housing unit security staff to "see how the detainee is doing." He did not indicate that he would meet with the detainee at any time during the monitoring. He stated he would request input from housing unit staff, monitor disciplinary reports, and housing unit and program changes, however, he did not state that he would monitor other possible suggestions of retaliation such as grievances, hotline calls, change in detainee behavior, and monitoring of phone calls and mail. The Warden indicated that the PSA Compliance Manager would monitor, and that staff would interview the detainee. The Warden did not know the required timeframe for the monitoring to take place. The PSA Compliance Manager indicated that the monitoring just started prior to the on-site audit and that there was no log or other documentation to verify monitoring takes place. Of the three closed cases reviewed there was no indication of monitoring implemented for either the staff or the detainee involved in the allegation. Of the two detainees who reported sexual abuse, they stated they were not monitored or knew what staff member would monitor. The PSA Compliance Manager was less than knowledgeable of the monitoring responsibilities.

Does Not Meet: The staff member assigned for monitoring for retaliation should meet with the individual and review documentation to determine if retaliation is occurring, and not rely on phone calls to the housing unit security staff, who could be the one retaliating. The facility must create a process for monitoring retaliation of staff, contractors, volunteers, or detainees that report, complains about, or participates in an investigation of sexual abuse. This process must include time frames for monitoring and documentation.

§115.68 - Post-allegation protective custody.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Policy PS CUS 038 Special Housing Unit (SHU) states "The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged", and "An inmate/ICE detainee shall be placed in Protective Custody status in the Close Custody SHU only when there is documentation that it is warranted and that no reasonable alternatives

are available." The policy also indicates that Protective Custody is also referred to as Administrative Segregation. The two sections of the standard, as noted above, appear to be in direct conflict with unclear direction to staff. Policy PS CUS 051 states that ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there is no available alternative means of separation from likely abusers. The direction of policy PS CUS 051 is in direct conflict with sections of policy PS CUS 038. A review of the three closed investigative files indicates that the detainee is placed immediately into Administrative Segregation/Protective Custody as procedure. One file reviewed showed the detainee made an allegation against his cell mate during the overnight shift. He was moved into a separate cell during the overnight and immediately placed into Administrative Segregation/Protective Custody the following morning when the day shift staff arrived. Staff interviewed indicated he was moved during the day shift due to the fact that it became clear that the detainee made a sexual abuse allegation against his cell mate. Policy PS CUS 038 is compliant with the requirements of 115.43. The PSA Compliance Manager stated the facility tries to avoid protective custody. This was not confirmed with the review of the closed investigation files. In fact, the review indicated that immediately placing the detainee in administrative segregation/protective custody is ECCF procedure. A review of the three closed cases note that the facility had immediately placed all alleged detainee victims in administrative segregation/protective custody following the allegation. There were no detainees identified to interview.

Does Not Meet: Although Policy PS CUS 051 states that ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made; and a determination has been made that there is no available alternative means of separation from likely abusers, policy PS CUS 038 states the facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abuses can be arranged. The PSA Compliance Manager indicated that the facility tries to avoid protective custody. This was not however, verified by a review of the three closed investigations that showed that the reporting victim was immediately placed in administrative segregation/protective custody. The facility needs to review and update the policies to be complaint with the standard and provide consistency among the facility's polices. The facility needs to develop a process and practice that reviews all alternative means of separation instead of just placing all detainees who alleged sexual abuse in closed custody.

(b) Policy PS CUS 038 states that the facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Facility policy PS CUS 051 states that victims may not be held longer that five days. The two policies are conflicting as one allows for five days and one allows for 30 days. The PSA Compliance Manager stated the detainee could be held up to five days, however, the general practice would be to find appropriate housing within 48 hours and transfer the detainee from protective custody. This may be a housing change. There were no identified detainees to interview that were housed in administrative segregation/protective custody.

Recommendation: The policies PS CUS 051 and PS CUS 038 should be reviewed and updated to eliminate conflicting direction for staff and the timeframes for placement.

(c) Policy PS CUS 038 states that the facility should assign detainees vulnerable to sexual abuse or assault to Administrative Segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Policy PS CUS 051 states that if an involuntary protective custody housing assignment is made, ECCF affords each such inmate/ICE detainee a review every thirty (30) days to determine whether there is a need for separation from the general population. Neither policy addressed a reassessment, taking into consideration any increased vulnerability of the detainee as a result of sexual abuse before returning to general population. The PSA Compliance Manager stated there would be a reassessment, however, could not offer any additional information. There was no written documentation to review to determine compliance in the three reviewed closed investigations. There were no identified detainees to interview that were housed in administrative segregation/protective custody.

Does Not Meet: Policies PS CUS 038 and PS CUS 051 do not require a reassessment of the detainee who is being released to general population. The facility must establish a process for completing reassessments of detainees prior to returning to general population. Staff must be trained on the process.

Recommendation: The policies PS CUS 051 and PS CUS 038 should be reviewed and updated to include the requirement of a reassessment of the detainee who is being released to general population to provide consistent direction to staff and to the process.

(d) Policy PS CUS 038 requires facility administrator, or designee, to notify the appropriate ICE FOD in writing, as soon as possible, but no later than 72 hours after the initial placement of an ICE detainee. The Warden stated the notification would be made by email. A review of the three closed investigative files confirmed compliance.

§115.71 - Criminal and administrative investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Although the facility has the responsibility for investigating allegations of sexual abuse, a review of policies provided to the Auditor indicates that the facility does not have a written policy that requires that all investigations must be prompt and thorough. Policy PS CUS 051 does dictate that investigations shall be conducted by trained investigators. Policy PS CUS 051 further states that the facility administration shall promptly report the incident to the appropriate ICE Authority and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. The policy was approved by the Wardens and the ICE FOD during the on-site audit. The facility's practice however, requires all allegations be referred to the facility's SID for investigation. The allegations are referred to the appropriate ICE authority and SID staff for investigation. There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit. No allegations were reported to the Essex County Prosecutor. The three closed cases were also investigated by ICE staff and found unsubstantiated. A review of training records confirms all SID staff are trained investigators. The facility has five specialized trained SID staff members. The three ICE staff which completed the closed investigations had not completed specialized training. The Investigator stated that investigations are started immediately, as soon as reported and are objective based on evidence. The review of the investigations showed that investigations are started promptly.

Recommendation: The Auditor recommends the facility expand policy PS CUS 051 to require all investigations will be prompt and thorough.

Does Not Meet: All investigations must be completed by specialized trained investigators. All ICE staff conducting investigations must complete specialized investigation training.

(b) The Warden and PSA Compliance Manager stated in cases, where upon conclusion of a criminal investigation that was found to be unsubstantiated, the facility would conduct an administrative investigation. The PSA Compliance Manager stated in cases where upon conclusion of a criminal investigation that was found to be substantiated, an administrative investigation would be conducted. Section XVIII of policy PS CUS 051 states that upon a conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted, and, upon conclusion of a criminal investigation where the allegation was unsubstantiated the facility shall review any criminal investigation reports to determine whether an administrative investigation is necessary, or appropriate. This verbiage was added during the on-site audit. There is no SAAPI Coordinated Response Plan, or policy, that directs staff to begin an investigation, when to conduct the investigation, or in what timeframe the investigation is to begin or be completed. Also, added to policy PS CUS 051 during the on-site audit; the administrative investigations shall be conducted after consultation with the appropriate investigation office within DHS or DOJ and the assigned criminal investigative entity. Of the three closed allegations, all investigations were completed by facility SID staff and ICE. The PSA Compliance Manager indicated that the SID consults with the Essex County Prosecutor's Office. According to the PAQ and PSA Compliance Manager there were no allegations of sexual abuse referred for prosecution during the audit year.

Does Not Meet: The updated policy of the SAAPI Coordinated Response Plan does not include procedural direction of when, how, and in what timeframe the administrative investigation should be conducted. Interviews with the Warden and PSA Compliance Manager could not determine implemented practice. The facility needs to demonstrate compliance with the updated policies and the process developed to ensure the practice of referring investigations for administrative investigations as necessary or appropriate. The facility must also provide training to staff on the policy changes and the process developed.

(c) Policy PS CUS 051 states the facility shall develop written procedures for administrative investigations, including all items required for investigations as listed in the standard. There is no written protocol that provides procedural direction to staff. It also states an investigation report shall be written for all investigations of sexual abuse utilizing the investigative report template, PREA Investigation Report. The PSA Compliance Manager and Investigator shared that the following information and evidence would be collected: statements, interviews, evidence, logbooks, video footage, forensic evidence from the hospital, telephone calls, and review of detainee history. Of the three completed allegations, all investigations were completed by the facility SID and ICE. The facility does not have in policy or plan, information on how to coordinate and sequence the two types of investigations in accordance with paragraph (b) as dictated by the standard.

Does Not Meet: Policy PS CUS 051 states the facility shall develop written procedures for administrative investigations, including all items required for investigations as listed in the standard. There is no written protocol that provides procedural direction to staff. The facility does not have in policy or plan information on how to coordinate and sequence the two types of investigations in accordance with paragraph (b) as dictated by the standard. The facility must develop written procedures for administrative investigations which includes the provisions of the standard.

(e) Policy PS CUS 051 states an investigation will not be terminated just because the alleged abuser or victim departs from the employment or custody of ECCF. The Warden, PSA Compliance Manager, and Investigator shared that the investigation would continue until completion. Of the three investigations all were completed prior to the alleged victim being released.

(f) Interviews with Investigative staff indicate that all investigations are completed by the facility SID. The Investigator indicated in his interview that ICE does not investigate nor is information provided in regards to allegations that ICE may complete.

Does Not Meet: According to facility Investigative Staff (SID) they are responsible for all investigations at Essex. The facility needs to cooperate with outside investigators, including ICE, and shall endeavor to remain informed about the progress of the investigation.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Investigator stated the standard of proof for administrative investigations is a preponderance of evidence. Policy PS CUS 051 confirms that no standard higher than a preponderance of evidence will be imposed in determining allegations of sexual abuse as substantiated.

§115.73 - Reporting to detainees.

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

Notes:

Policy PS CUS 051 outlines the reporting of investigation outcomes to detainees. The detainee is notified whether the allegation was determined substantiated, unsubstantiated, or unfounded. Per the Warden, the detainee is interviewed and provided written notification. The detainee receives the original and a copy is maintained as part of the investigative file. The Warden stated detainees are notified of the investigation outcome if the detainee is still in detention at the facility or at the facility the detainee is transferred to. The Warden further expanded it is normal practice that a detainee would not be transferred if a case is still pending an open investigation. If by chance the detainee is transferred to another facility, we would alert that facility immediately and provide them with the results of the investigation. We would then forward at least two copies of the determination for the detainee's detention file and for the detainee's records. If the results determine that a criminal act has transpired, we would request the detainee be returned in order to proceed with prosecution should it be required. If the detainee has been released, we would attempt to contact that detainee via telephone call and also send a certified letter of the outcome to his last known address. Of the three completed investigative cases, all detainees were notified.

§115.76 - Disciplinary sanctions for staff.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a/b) Policy PS CUS 051 requirement for the discipline of staff for incidents of substantiated cases of sexual abuse is located in two sections. Section XXX does not include termination from Federal service; section XVIV, was added during the on-site audit, and does include termination from Federal Service. The Warden stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact detainee post until the investigation is completed. If the case was substantiated, the staff member would be terminated. Policy PS CUS 051 was reviewed and approved by the

Wardens and ICE FOD during the on-site audit. Of the three closed cases reviewed, there were no allegations of sexual misconduct by a staff member. There were no staff terminations, resignations, other sanctions this audit period per the Warden, memo to file, and PAQ.

Does Not Meet: The policy PS CUS 051 sections XXX and XVIV are contradicting. The policy does not include that removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse. The facility policy must be updated to address the provisions of the standard and ensure that the sections are not contradictory.

(c) Policy PS CUS 051 section XXX directs that the facility to report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to the Essex County Prosecutors Office, unless the activity was clearly not criminal. Policy PS CUS 051 section XVIV, added during the on-site audit, dictates that the facility reports all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to the appropriate law enforcement agency, unless the activity was clearly not criminal. The Warden stated notifications would be made to the Essex County Prosecutor's Office. The information will also be retained in the employee's human resource permanent file.

Recommendation: As noted in previous provision, policy PS CUS 051 sections XXX and XVIV should be reviewed and updated so as not to be contradictory.

(d) Policy PS CUS 051 section XXX does not include reporting removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known. Policy PS CUS 051 section XVIV, added during the on-site audit, directs that the facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known. The Warden stated notifications would be made to the Civil Service Commission.

Recommendation: As noted in previous provisions, policy PS CUS 051 sections XXX and XVIV should be reviewed and updated as not to be contradictory.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a/b) Policy PS CUS 051 details the corrective action for contractors and volunteers who have engaged in sexual abuse. Any contractor or volunteer who engages in sexual abuse will be prohibited from contact with inmates/ICE detainees and will be reported to the Essex County Prosecutor's Office, unless the activity was not criminal. Policy PS CUS 051 does not include direction to make all reasonable efforts to report to any relevant licensing bodies, to the extent known, incidents of sexual abuse by a contractor or volunteer. The Warden noted that a volunteer's clearance would be revoked allowing no contact with the facility until the investigation is completed. If substantiated, the volunteer or contractor shall be removed from all duties and clearance revoked. Also, noted by the Warden, and the PAQ, there were no instances where a volunteer or contractor was removed for allegations of sexual abuse.

Recommendation: The facility should create a written process and procedures of how notifications would be made to the licensing bodies by the facility.

(c) Policy PS CUS 051 states the facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with inmates/ICE detainees in the case of any other violation of agency and facility sexual abuse or sexual harassment policies by a contractor or volunteer. The Warden indicated that the contractor or volunteer would be removed from the facility until the investigation is completed.

Recommendation: Policy PS CUS 051 does not include volunteers in its direction to take appropriate remedial measures, or to consider whether to prohibit further contact with inmates/ICE detainees in the case of any other violation of agency sexual abuse or sexual harassment policies. The facility should create written process and procedures to include volunteers in its direction to take appropriate remedial measures, or to consider whether to prohibit further contact with inmates/ICE detainees, in the case of any other violation of agency sexual abuse or sexual harassment policies.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a) The facility's policy PS CUS 051 outlines the detainee disciplinary sanctions. It states a detainee is subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding the inmate/ICE detainee engaged in inmate/ICE detainee on inmate/ICE detainee sexual abuse or following a criminal finding of guilt for inmate/ICE detainee on inmate ICE detainee sexual abuse. The Warden stated the detainee discipline would be through the internal disciplinary process. If criminal in nature, the Essex County Prosecutor would be contacted.

(b) Policy PS CUS 051 notes that sanctions shall be commensurate with nature and circumstances of the abuse committed, the inmate/ICE detainee's disciplinary history, and the sanctions imposed for comparable offenses by other inmates/ICE detainees with the similar histories. Of the three closed investigative files reviewed, there were no detainees disciplined for engaging in sexual abuse. The Warden indicated in the interview that disciplinary sanctions would be commensurate with the act and that the sanction would be intended to encourage the detainee to conform to the rules in the future.

(c) The disciplinary process has progressive levels of review, appeals, procedures, and documentation of the process. Policy PS CUS 016 Inmate-ICE Detainee Disciplinary Procedures documents the standard requirement. The Warden confirmed the disciplinary process has progressive levels of review and appeals and a written report will be maintained in the detainee file.

(d) Policy PS CUS 051 states the disciplinary process shall consider whether an inmate's/ICE detainee's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed. The Warden stated that staff would review the mental health forensic roster prior to the disciplinary process. If the detainee is not on the roster, mental health will be contacted.

(e) Policy PS CUS 051 states an inmate/ICE detainee may be disciplined for sexual contact with staff only upon finding that the staff member did not consent to such contact. The Warden stated the detainee would not be disciplined for consensual sexual contact with a staff member. There were no instances to review.

(f) Policy PS CUS 051 states a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if the investigation does not establish evidence sufficient to substantiate the allegation. The Warden stated a detainee making an allegation in good faith would not be disciplined. There have been no detainees disciplined for falsely reporting. Of the two detainees who reported sexual abuse identified for interviews, they both indicated that they were not disciplined for reporting an allegation.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Policy PS CUS 051 directs that if the Sexual Violence Screening form indicates that an inmate/ICE detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the inmate/ICE detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up, as appropriate. In practice, the Intake Nurse, in addition to the Intake Officer, conducts the medical screening during the intake process prior to a detainee housing placement is made or moved from the intake area. If the detainee is determined at risk for either victimization or abusiveness, and/or has experienced prior victimization or perpetrated sexual abuse, the Intake Nurse immediately refers the detainee for assessment. In section 1 of the Sexual Violence Screening form, the booking officer makes an immediate referral to mental health if the detainee scores four or higher. In addition, a score of five requires the intake officer to immediately refer the detainee to mental health and isolate the detainee with notification to the area supervisor. As the medical Intake Nurse refers all detainees who experienced prior victimization, or perpetrated sexual abuse, for medical follow-up, they are not included for referral on the Sexual Violence Screening form. The Classification officer completes target questions that would require a referral to mental health if there is a yes response, however the form does not give clear direction that a referral must be made. Further, the form does not include a section that indicates a referral to mental health was made, date of the referral, or who the notification was made to. The HSA and Psychologist interviewed stated referrals are made immediately via telephone and through the PREA notification email system (PREAITK). The Auditor observed an intake screening during the intake process. The detainee did not score for a referral. The auditor reviewed the PREAITK email system. Documentation revealed that the detainee is referred from classification to medical and mental when targeted questions in section two warrants a referral be made. As the facility was not being advised of detainees who reported sexual victimization from the medical department, they could not provide a listing of any detainees who reported victimization. Upon recommendation of the Auditor, the Sexual Violence Screening Form was modified to collect this data at intake. The suggestion was noted and was implemented during the on-site audit.

Recommendation: The Auditor recommends that the Sexual Violence Screening form be reviewed and updated to provide clearer direction to staff in section two, targeted questions, and what constitutes a need for referral to include medical and mental health when scoring or when answers to targeted questions dictates a referral. The facility should create a process to identify and ensure detainees that disclose prior sexual victimization or perpetrated sexual abuse is immediately referred to a qualified medical or mental health practitioners for medical and mental health follow-up.

(b) Per PS CUS 051, when a referral for medical follow-up is initiated, the detainee receives a health evaluation no later than two working days from the date of assessment. The HSA stated the detainees from a referral would be seen within 72 hours and noted in the medical progress notes in the detainee's medical file. A referral would also be made to mental health if one was not made previously. During the audit period, a pre on-site memo to file indicated that a detainee was referred for medical follow-up during the assessment process, however, review of the medical file indicated that the detainee had a PREA score of zero and that the referral was not part of the intake process. The Auditor did not note any referrals to medical from the intake assessments while reviewing the detainee files.

Does Not Meet: The standard requires that the detainee will receive a health evaluation, no later than two working days from the date of assessment. Although the standard is supported by policy PS CUS 051, interviews with medical staff reveal that the practice is to see the detainee for evaluation within 72 hours. The facility must develop a process to ensure that detainees referred for follow-up will receive a health evaluation no later than two working days from the date of the assessment. The facility policy should be updated to reflect the new process and the required time frame per standard.

(c) When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours per policy PS CUS 051. An interview with the HSA indicated that mental health staff see the detainee within 24 hours after the referral is made. The Acting Director of Mental Health indicated that the detainee is seen immediately. As the auditor was not provided a list of detainees who reported prior victimization at intake, the auditor reviewed the file of a detainee who reported sexual abuse while housed at ECCF. Upon review of the file, the detainee was referred to mental health and was seen within 72 hours.

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

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

Notes:

(a) Policy PS CUS 051 states inmates/ICE detainee victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services as directed by medical and mental health practitioners. The services would include offering timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis. The HSA stated the alleged victim is brought to medical immediately for a timely medical assessment and treatment. This would include a quick assessment, provide any treatment necessary to stabilize the detainee for transport to the local hospital. If sent to the hospital, follow-up treatment would be offered upon return from the hospital to provide continuum of care. The hospital would complete the sexually transmitted diseases screening and provide sexually transmitted infections prophylaxis, if needed. Timely medical and mental services were provided to all the alleged victims from the three closed allegations for this audit period that were reviewed by the Auditor.

(b) Policy PS CUS 051 states emergency medical treatment services provided to the victim shall be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The HSA and Acting Mental Health Director interviewed stated healthcare treatment for detainees is free.

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

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

Notes:

(a) The HSA and Psychologist interviewed stated the alleged victims receive medical and mental health evaluations and treatment is provided, if needed. There is no cost to the detainee. Medical and mental services were provided to all the alleged victims from the three closed allegations this audit period as noted in the medical and investigation files reviewed. Policy PS CUS 051 supports the language of the standard and the practice as stated by the HSA and Psychologist.

(b) Policy PS CUS 051 language mirrors the standard. The HSA stated the alleged victim is brought to medical immediately for timely medical assessment and treatment. This would include a quick assessment, provide any treatment necessary to stabilize the detainee for transport to the local hospital. If sent to the hospital, follow-up treatment would be offered upon return from the hospital to provide continuum of care. The hospital would complete the sexually transmitted diseases screening and provide sexually transmitted infections prophylaxis, if needed. None of the alleged victims required outside emergency medical treatment nor sexually transmitted infections prophylaxis as reviewed in the detainee files. Mental health provided follow-up treatment to the detainees as needed.

(c) Policy PS CUS 051 states services shall be provided in a manner that is consistent with the level of care the individual would receive in the community. The healthcare staff, during their interviews, indicated that the healthcare services are consistent with the community level of care and in most cases better than the community since the detainee has immediate access to services.

(d) The standard provision is non-applicable. ECCF does not house female detainees.

(e) Prophylactic treatment of venereal diseases is offered to victims of sexual abuse and the detainee is scheduled for testing and education. The health care interviews indicated that the initial treatment would be provided at the local hospital. The treatment would continue through medical orders by the medical staff. Additional education, follow-up treatment, counseling, and testing are provided as needed as stated by PS CUS 051. None of the alleged victims this audit period required prophylactic treatment or testing.

(f) Policy PS CUS 051 states all services shall be provided without financial cost to the victim and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The HSA and Psychologist both stated there all services are provided without cost to the detainee.

(g) Policy PS CUS 051 states the facility shall attempt a mental health evaluation on all known inmate/ICE detainee-on-inmate/ICE detainee abusers within 60 days of learning of such abuse history and offer treatment deemed appropriate by mental health practitioners. There was one instance where a mental health assessment for a known detainee-on-detainee abuser was attempted but the detainee abuser refused. This was supported by the review of the mental health file.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) Policy PS CUS 051 outlines the requirement, procedures, and timeframes for sexual abuse incident reviews. The standard further requires that the facility shall implement the recommendations for improvement. Designated staff are required to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including unfounded. The inclusion of reviewing unfounded allegations was added during the on-site audit. Although policy PS CUS 051 states that the PSA Compliance Manager shall together with upper-level management officials, conduct a sexual abuse incident review, the Warden indicated during his interview, he has never seen a conducted review. The PSA Compliance Manager indicated that he conducts reviews of every case within three to six weeks of completion. He did not indicate that the report is to be shared with facility administration or the Agency PREA Coordinator. The PSA Compliance Manager indicated that he completes the incident reviews and files them. The PSA Compliance Manager utilizes an Incident Review Form to complete and document the review. The PSA Compliance Manager is responsible for implementing any recommendation for improvement or document its reasons for not doing so. The Auditor reviewed the sexual abuse incident reviews of the three closed investigative cases. There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit and ICE. In one closed file, the incident review was completed by the facility on 10/2/18 prior to the case being officially closed by ICE OPR on 3/21/19. There were no further reviews that took into consideration information regarding the ICE investigation. The facility is completing incident reviews upon completion of the facility investigation. In another case, the entire file was not afforded to the Auditor. Interview with a SID investigator revealed that the PSA Compliance Manager dictated to them what to include in the file presented for the Auditor review. All reviews indicated that the reviews occurred within 30 days and there were no deficiencies or need of improvement.

Does Not Meet: The standard requires that the facility shall conduct an incident review at the conclusion of every investigation of sexual abuse, and where the allegation is not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation. The requirement of all reviews, including cases determined to be unfounded, was added during the on-site audit. The facility must develop a review team consisting of upper level management officials that completes incident reviews and utilizes the review form to document the incident reviews within 30 days. The facility must also develop an incident review process that addresses the 30-day review timeframe and providing the report and response to the agency PSA Coordinator.

(b) An Incident Review Form is utilized to complete and document the review. All elements of the standard are addressed on the form. The PSA Compliance Manager confirmed all the elements are reviewed and documented on the form. The standard is supported through policy PS CUS 051, however, the interview with the PSA Compliance Manager indicates that he files the form upon completion. Interview with the Warden indicates he has never seen an incident review form.

Does Not Meet: The facility through interviews with the Warden and PSA Compliance Manager does not have a review team as required by standard and as outlined in PS CUS 051. The facility must develop a review team that completes incident reviews by utilizing the Incident Review form to review the incident in order to identify issues and develop recommendations to assist in reducing incidents of sexual abuse and/or sexual assault in the facility.

(c) Policy PS CUS 051 outlines the procedures for conducting an annual review of all sexual abuse investigations and resulting incident reviews. The 2018 Annual Review of Sexual Abuse Investigations was completed on July 3, 2019. The PSA Compliance Manager indicated that the annual report would be conducted in the first quarter. The document is in the form of meeting minutes dated July 3, 2019. The minutes included statistical data from 2018. The PSA Compliance Manager indicated that no improvements were needed, even though based on facility determination cameras were

needed in two of the dorms. (b) (7)(E) [redacted] There was no comparison of data from 2017 and 2018 as the presented meeting minutes were the first time an Annual Review was conducted by the facility. The Warden was shown a copy of the meeting minutes for clarification; in his interview he stated he had not seen minutes and could not confirm their accuracy. The Warden had been at the facility for about four months. The 2018 Annual Review of Sexual Abuse Investigations was filed and not forwarded to the ICE FOD and the agency PSA Coordinator.

Does Not Meet: The facility must develop a process to conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. The results and findings of the annual review must be provided to the facility administrator, FOD or his or her designee, and the agency PSA Coordinator. The facility must provide documentation of the process.

§115.87 - Data collection.

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

Notes:

(a) Policy PS CUS 051 outlines the procedures for data collection. The facility shall maintain in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling in a schedule as delineated by the Office of the Warden. The PSA Compliance Manager stated he is responsible for compiling data collected on sexual activity and sexual abuse incidents. The PSA Compliance Manager further stated that he maintains the PREA files in his office, SID maintains the investigative files, and medical maintains the medical files. The Auditor observed where the files were maintained. The established retention schedule is 10 years for these files.

§115.201 - Scope of audits.

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

Notes:

(d) During the audit, the facility and agency provided the auditors full access to all areas of the facility and the auditors were able to observe practices and tour the facility.

(e) The Auditor communicated with the ERAU Team Lead requesting further documentation for clarification and review on June 28, July 7, 10, 11, 12, and 15, 2019. A few responses to the request were provided pre-audit by the ERAU Team Lead due to the lack of response by the facility. Facility staff provided additional documentation during the on-site portion of the audit, including a revised PAQ. Not all documentation was provided or readily accessible to the Auditors during the on-site audit. The lead Auditor was approved for an extra week to review documentation that was provided during the course of the on-site audit. The Auditors attempted to select random employee files to review for the administrative adjudication check on the application form or as part of the hiring process paperwork and the background check prior to hiring. The facility was very reluctant to share employee personnel files. Finally, immediately prior to the exit close-out the Warden personally went to Human Resources and pulled two random files for the Auditors to review. The closed investigations were not fully provided to the Auditor for review, the SID investigator revealed in an interview, that the PSA Compliance Manager dictated to them what to include in the file presented for the Auditor's review. During the post audit review the Auditor continued to request documentation from the facility through the ERAU Team Lead.

(i) Private interview space was provided to the Auditors for conducting staff and detainee interviews. Staff interviews were held in administrative offices in the administration section of the facility. The detainee interviews were held in private offices located within a secure section of the facility.

(j) Posted signs advised detainees they could send confidential information or correspondence to the Auditor. The Auditor did receive one piece of correspondence from a detainee which was shared with the ICE ERAU Team Lead and facility administration. An investigation was initiated. A second letter was received after the on-site audit. The correspondence was forwarded to ERAU Team Lead to share with the facility. It was a report of sexual abuse at another facility.

Based on the above information, the agency/facility meets the Standard 115.201 Scope of Audits.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	2
Number of standards met:	17
Number of standards not met:	21
Number of standards N/A:	1
Number of standard outcomes not selected (out of 41):	0

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

Sabina Kaplan 2/19/2020

Auditor's Signature & Date

(b) (6), (b) (7)(C) 2/19/2020

PREA Program Manager's Signature & Date

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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Mark Stegemoller	**Organization:**	Creative Corrections LLC.
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	513-609-(b) (6), (b)

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

FIELD OFFICE INFORMATION	
Name of Field Office:	Newark Field Office
Field Office Director:	John Tsoukaris
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	970 Broad Street, Newark, New Jersey 07102
Mailing address: *(if different from above)*	

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Essex County Correctional Facility		
Physical address:	354 Doremus Avenue, Newark, New Jersey 070152		
Mailing address: *(if different from above)*			
Telephone number:	973-274-7818		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Director of Corrections
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	973-274-(b) (6), (b)
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Sergeant
Email (b) (6), (b) (7)(C)		**Telephone number:**	(973) 274-(b) (6), (b)

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

The Prison Rape Elimination Act (PREA) audit of the Essex County Correctional Facility (ECCF) was conducted on July 16-18, 2019 by Lead Auditor Sabina Kaplan and team member (b) (6), (b) (7)(C) U.S. Department of Homeland Security (DHS) and Department of Justice (DOJ) certified PREA Auditors for Creative Corrections, LLC of Beaumont, Texas. The Auditor was provided guidance during the report writing and review process by the ICE PREA Program Manager, (b) (6), (b) (7)(C) a DOJ, and DHS certified PREA Auditor. The Program Manger's role is to provide oversight to the ICE PREA audit process and liaison with the Immigration and Custom Enforcement (ICE) External Reviews and Analysis Unit (ERAU). Essex County Correctional Facility is a county jail operated by the Essex County Sheriff's Office (ECSO). The facility has a contract with ICE for the housing of adult male detainees. The purpose of the audit was to determine compliance with DHS PREA Standards. This was the first DHS PREA audit of the facility. The audit period covered the previous twelve months from July 16, 2018 through July 18, 2019.

The facility had 17 standards that Met, 2 standards that Exceed, 21 standards that Did Not Meet, and 1 standard that was Non-Applicable.

Standards that Did Not Meet:

115.11 Zero tolerance of sexual abuse
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
115.21 Evidence protocols and forensic medical examinations
115.22 Policies to ensure investigation of allegations and appropriate agency oversight
115.34 Specialized training: Investigations
115.41 Assessment for risk of victimization and abusiveness
115.42 Use of assessment information
115.43 Protective custody
115.52 Grievances
115.53 Detainee access to outside confidential support services
115.61 Staff and agency reporting duties
115.65 Coordinated response
115.67 Agency protection against retaliation
115.68 Post-allegation protective custody
115.71 Criminal and administrative investigations
115.76 Disciplinary sanctions for staff
115.81 Medical and mental health screenings; history of sexual abuse
115.86 Sexual abuse incident reviews

The Corrective Action Plan (CAP) period review was assigned to (b) (6), (b) (7)(C) DOJ and DHS PREA Auditor and Assistant Program Manager, contracted through Creative Corrections, LLC. for those standards found to be deficient during the facility's PREA audit. On May 18, 2020, the agency provided the Auditor the 180 Day CAP, with the corrective action period of July 16, 2019 – August 18, 2020. The Auditor reviewed the CAP and responded to the compliance measures taken by the facility through the completion of the Provisional Audit Report. In a review of the submitted documentation to demonstrate compliance with the deficient standards, the Auditor determined partial compliance with 17 of the standards and found that 4 standards still did not meet based on submitted documentation or lack thereof. The on-site reauditvisit was rescheduled several times due to the COVID-19 health pandemic and was finally conducted on May 11-12, 2021, once the facility determined the environment was safe for the Auditor, ICE staff, facility staff, and the detainees. The facility's detainee population on the first day of the reaudit was 155 male detainees. The facility was utilizing four housing units (H1, H2, H3, H4) for the confinement of detainees. A comprehensive analysis is provided for each standard within each standard narrative. Full compliance with each standard was contingent upon completing the on-site reauditvisit, which included staff and detainee interviews, additional on-site documentation review, and facility observations.

Before the start of the CAP reaudit site visit, the Auditor met with agency and facility staff. The Team Lead opened the entry briefing at 8:15 am on the first day of the on-site visit. In attendance were:

- (b) (6), (b) (7)(C) Inspections and Compliance Specialist, ICE/Office of Professional Responsibility (OPR)/ External Review and Analysis Unit (ERAU)
- (b) (6), (b) (7)(C) Detention Service Manager (DSM) ICE
- (b) (6), (b) (7)(C) Assistant Program Manager/PREA Auditor, Creative Corrections, LLC.
- (b) (6), (b) (7)(C) Supervisory Detention and Deportation Officer (SDDO) ICE
- (b) (6), (b) (7)(C) Sergeant – Prevention of Sexual Assault (PSA) Compliance Manager, ECCF
- (b) (6), (b) (7)(C) Director of Corrections, ECCF
- (b) (6), (b) (7)(C) Correctional Officer, ECCF
- (b) (6), (b) (7)(C) Correctional Officer, ECCF
- (b) (6), (b) (7)(C) Administrative Assistant, ECCF

Brief introductions were made, and the Auditor covered a detailed schedule for the audit visit. The Auditor provided an overview of the CAP reaudit on-site visit process and audit methodology used by the Auditor to demonstrate PREA compliance for those standards that were found deficient during the initial audit. The Auditor explained that the audit process is designed to assess compliance through the review of written policies and procedures and determine whether such policies and procedures are reflected in staff knowledge and day-to-day practices at all levels. The Auditor further explained compliance with the PREA standards would be determined based on the review of policy and procedures, observations made during the facility on-site inspection, additional documentation review and conducting both staff and detainee interviews.

A facility site inspection was conducted by the Auditor accompanied by personnel from the facility and ICE. All four housing units were visited where detainees are confirmed and programming areas, service areas, control center, admissions/intake, and medical areas. The Auditor observed all areas of the facility where detainees are allowed to go or provided services. During the site inspection, the Auditor made visual observations of program/service areas, housing units including bathrooms, showering stalls, officers post lines of sight throughout the dayroom, security mirrors, and video camera locations. The Auditor closely examined lines of sight and potential cross-gender viewing areas identified as a deficiency during the initial audit for compliance. The Auditor spoke to random staff and detainees regarding PREA education/reporting mechanisms and facility practices during the site inspection. The Auditor reviewed the housing unit logbooks to verify staff rounds for security staff and supervisors. While on-site, the Auditor conducted interviews with 8 detainees and 13 staff. Key facility staff interviewed during the audit included the Director of Corrections, PSA Compliance Manager, Health Service Administrator (HSA), Grievance Coordinator, intake staff, Classification Supervisor, Investigator, Administrative/Human Resource, SDDO/ICE, and four facility correctional officers.

There were five sexual abuse allegations reported during the CAP period. All five cases were detainee-on-detainee. Upon reviewing the investigative files, two incidents reported to ECCF occurred while the detainees were confined at another facility. The Auditor reviewed the investigative files for all five cases and determined the two incidents reported to have occurred at other facilities; ECCF handled them per the requirements of PREA standard 115.63 (Reporting to other confinement facilities). One of three incidents of sexual abuse reported to have occurred at ECCF was determined to be substantiated, and the other two cases were determined to be unfounded. Additionally, while on-site, the Auditor reviewed six staff background check files, three staff who received promotions, and three new hires. The Auditor also reviewed detention files for the eight detainees the Auditor interviewed, to include their PREA information provided at intake and PREA Risk Screening Information. Throughout the on-site visit, the Auditor requested and received additional supporting documentation for review to verify compliance with standards initially found deficient.

An exit briefing was conducted by the Team Lead and Auditor at the completion of the on-site audit. The following participants were in attendance:

- (b) (6), (b) (7)(C) Inspections and Compliance Specialist, ICE/OPR/ERAU
- (b) (6), (b) (7)(C) DSM/ICE
- (b) (6), (b) (7)(C) Assistant Program Manager/PREA Auditor, Creative Corrections, LLC.
- (b) (6), (b) (7)(C) SDDO/ICE
- (b) (6), (b) (7)(C) Sergeant – PSA Compliance Manager, ECCF
- (b) (6), (b) (7)(C) Director of Corrections, ECCF
- (b) (6), (b) (7)(C) Correctional Officer, ECCF
- (b) (6), (b) (7)(C) Correctional Officer, ECCF
- (b) (6), (b) (7)(C) Administrative Assistant, ECCF
- Guy Cirillo Warden, ECCF
- (b) (6), (b) (7)(C) Associate Warden, ECCF
- (b) (6), (b) (7)(C) Assistant Warden, ECCF
- (b) (6), (b) (7)(C) Chief of Staff, ECCF
- (b) (6), (b) (7)(C) Lieutenant, ECCF
- (b) (6), (b) (7)(C) Lieutenant, ECCF
- (b) (6), (b) (7)(C) Captain, ECCF

While the Auditor could not provide the facility with a final audit finding at that time, the Auditor did provide those in attendance with preliminary assessment of some of his findings during the CAP period Audit.

The Auditor shared with those in attendance the appreciation of the hospitality received, and the professionalism provided by all staff during the visit. The Auditor observed interactions between staff and detainees positively throughout the on-site audit reaudit. The Auditor shared with the Director of Corrections and the facility's leadership the feedback received from the detainee population regarding the facility's operations, the positive interviews with staff, and the professionalism demonstrated by staff encountered during the audit. The Auditor thanked all in attendance for their hard work and commitment to the DHS Prison Rape Elimination Act.

The facility has met substantial compliance with all outstanding standards.

PROVISIONS

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

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

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

Notes:

(d) Although the position of Agency PREA Coordinator exists, per the facility PSA Compliance Manager, he does not report to anyone. A review of the organization chart shows his position as Special Assistant to the Director. The policy PS CUS 051 does not provide confirmation of the reporting hierarchy. The facility PSA Compliance Manager is responsible for collecting and analyzing PREA data and preparing required reports. In addition, the PSA Compliance Manager is responsible for ensuring facility compliance including policies and procedures relative to PREA. The PSA Compliance Manager stated most of his time is related to PREA including making housing recommendations, communication with staff regarding detainees, logging and tracking all allegations, and incident review team duties. During the interview with the PSA Compliance Manager, he appeared to lack knowledge regarding his responsibilities for coordinating the facility's efforts to comply with the PREA standards. He indicated he coordinates the facility's efforts by reviewing cases and keeping track of grievances and PREA allegations.

Does Not Meet: The PSA Compliance Manager indicated that he did not report to anyone at the facility or the agency. After some confusion, the facility indicated that the position of Assistant to the Director noted on the organizational chart was the position designated as the PSA Compliance Manager. This position reports directly to the Facility Director. The standard requires that the PSA Compliance Manager serve as the point of contact for the agency's PSA Coordinator. The interview with the PSA Compliance Manager confirmed a relationship has not been established with an agency representative, as he noted he does not report to the agency. The facility needs to establish the PSA Compliance Manager as the point of contact with the appropriate agency staff who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures.

Corrective Action Taken: ECCF submitted a memorandum of understanding (MOU), dated April 1, 2020, titled "PREA Coordinator Duty and Responsibilities," delineating that the facility employs and has designated a Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager). The PSA Compliance Manager shall serve as the facility point of contact for the agency's PSA Coordinator and who must have sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. While on-site during the CAP reaudit the Auditor conducted interviews with the PSA Compliance Manager and Director of Corrections and determined the PSA Compliance Manager has sufficient time and authority to oversee the facility's efforts to comply with facility sexual abuse prevention and intervention policies and procedures and serves as the point of contact for the agency's PSA Coordinator. The facility has met substantial compliance.

§115.13 - Detainee supervision and monitoring

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

Notes:

(a) Although the facility presented a staffing plan, it could not be determined how the facility staffing plan was developed. The Warden, being new to the facility, indicated that he was unsure, and therefore, could not offer insight into its development. Documentation presented to the Auditor was dated 1/1/2019 and was titled "2018 Staffing Recap." It was authored by a Captain and forwarded directly to the Facility Director. It could not be determined through interviewing the Warden or PSA Compliance Manager, or documentation, when the last review occurred. The 2019 Staffing Analysis indicated 614 positions and showed 604 filled. It could not be determined through interviews, or by the document presented, what bottom line staffing needs were used to develop the plan. The review did indicate the required staff needed for correctional officers was 540 and for sergeants 49. The document presented did not take into consideration the need for video in the development of the plan. A review of the PAQ indicated the facility's staffing level is 745 staff that may have recurring contact with detainees. The facility's security staff is comprised of 619 ECCF staff; 401 males and 218 females. Security staff work t(b) (7)(E) [redacted] Sufficient supervision of detainees was observed through on-site observations of security, program, and medical staff supervising and interacting with detainees. The Auditor reviewed daily security shift rosters/assignments for all shifts and determined the facility is ensuring staffing levels are being maintained in accordance with the standard. (b) (7)(E) [redacted] In contrast, all reviewed incident reviews, and the 2018 Annual PREA Review Meeting minutes state, "There was sufficient video coverage of detainee housing and work areas. Through the review of the sexual abuse incident reviews, the incident review team reviewed staffing levels and were found adequate in all reviews."

(c) Although the facility had developed a staffing plan, it could not be determined that the development of the plan was based on the seven criteria of the standard to include generally accepted detention and correctional practices, any judicial finding of inadequacy, the physical layout, 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 facility custody. The staffing plan was developed by the Captain, with no input from the Administration or the PSA Compliance Manager; and forwarded to the Director. There is no documentation of a collaborative effort, review, or approval of the plan. The Warden indicated in his interview that the staffing plan is reviewed on a daily basis to ensure the safety and security of staff and detainees is maintained. All posts are filled daily. If there is a staff shortage, coverage is provided through overtime (mandatory or

volunteer call-in). The last Annual PREA Facility Assessment was completed July 3, 2019. It should be noted that the initial minutes provided to the Auditor prior to the on-site audit were not in compliance with the standard. Upon request for documentation to confirm compliance with the seven required aspects of the standard, the minutes were resubmitted during the on-site audit noting the seven criteria verbatim. The interview with the Warden could not verify the meeting minute's accuracy. The facility has no judicial findings of inadequacy. The review indicated the staffing plan was completed; stating no changes were needed and there were no staff deviations. This was the facility's first Annual PREA Assessment. The investigations files and incident reviews were reviewed by the Auditor; all stated there was no need for any additional staff and video monitoring. It was determined by the facility the need for additional video monitoring outside the realm of the incident reviews.

Does Not Meet: The staffing plan lacks review of the required standard criteria in its development. In addition, the staffing plan is developed solely by the Captain with no apparent input from administrative staff or the PSA Compliance Manager. The Annual PREA Assessment Meeting minutes were resubmitted verbatim and could not be verified as accurate by the Warden during his interview. Based on the review of the staffing plan, interviews with staff, and the Annual PREA Review Meeting minutes, dated July 3, 2019, it is clear that the staffing plan, while being developed, does not take into account appropriate staffing to protect detainees against sexual abuse and the need for additional video monitoring as required by the standard. (b) (7)(E) The staffing plan provided by the facility lacks a clear coordination between protecting detainees from sexual abuse and its development. Further, the Warden's interview could not confirm how the staffing plan was developed, approved, or reviewed. With the staffing plan development, the facility must take into consideration the criteria in the standard; and determine sufficient staffing levels for the protection of detainees against sexual abuse.

Corrective Action Taken: ECCF submitted the Facility Staffing Plan, signed and dated May 1, 2020, by the Facility Director. The facility also provided supporting documentation to include, but not limited to, an ECCF directive, submitted by the Facility Director, which defines the facility processes for completing a staffing plan; facility staffing schedules, including the number of staffing at specific times and shifts; staff job descriptions and examples of duties performed; memorandum - Staffing Levels (2019 staffing analysis) meet the criteria requirements of the standards and was considered by the facility when creating the staffing plan. In the review of the facility staffing analysis, the Auditor determined the facility is now evaluating adequate levels of detainee supervision and determining the need for video monitoring. Each element of the standard is taken into consideration and outlined within the staffing plan. During the CAP reaudit, the Auditor conducted interviews with the PSA Compliance Manager and Director of Corrections and determined, based on their interviews and submitted compliance documentation, the facility considers adequate levels of detainee supervision and the need for video monitoring. The facility has met substantial compliance.

§115.15 - Limits to cross-gender viewing and searches

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

Notes:

(g) The facility's policy PS CUS 051 states, "Staff members may not visually observe inmates/ICE detainees while they change clothing perform bodily functions or shower." Detainees interviewed indicated they felt they had enough privacy to change their clothes, shower, and perform bodily functions. They were not observed by staff of the opposite gender. Staff also confirmed the detainees have privacy for these functions. In the multi-detainee housing units, there are shower curtains in front of all showers and toilets are located in the cells with closed door with access upon request. The toilets in the medical housing cells and the intake holding cells were observed during the tour and provide privacy. In six of the seven dorms there are two urinals that did not provide privacy. The facility has started the process to make each urinal an individual stall. Policy PS CUS 051 also requires staff of the opposite gender announce their presence when entering detainee housing areas; this was observed during the audit. Detainees interviewed stated that staff of the opposite gender announce when entering the housing unit by loudly stating "female on the unit". Staff indicated that announcements are made upon entering the housing units.

Does Not Meet: In six of the seven dorms there are two urinals that did not provide privacy. The facility must complete the urinal stall installations on dorms 1-6 to afford privacy to the detainee from cross-gender viewing.

Corrective Action Taken: ECCF submitted photographic evidence for all six dorm bathrooms found to be deficient, relating to cross-gender viewing and privacy concerns. The facility placed privacy partitions between each urinal and frosted a glass window that looked directly into where the urinals are positioned. The photos demonstrate adequate levels for preventing cross-gender viewing and privacy concerns, and still allow the facility to maintain appropriate security. It should be also be noted that the Auditor visually inspected these areas of corrections during the CAP reaudit. The facility has met substantial compliance.

(i) The detainee handbook and policy PS CUS 046 states, "The ECCF shall not search or physically examine an inmate/ICE detainee for the sole purpose of determining the inmate's/detainees genital characteristics." However, policy PS CUS 051 states, "Medical practitioners conduct examinations of transgender individuals to determine genital status only in private settings and only when an individual's genital status is unknown" and "Examinations of detainees to determine genital status shall be conducted in private and by medical practitioners." The review of the training lesson plans, PREA ICE Facilities and Pre-Service Prison Rape Elimination Act ICE 2017, documented these policies are covered in annual training. During interviews with staff, they were aware of the policy and indicated only medical could conduct such search. No searches have occurred in the audit period per documentation memo and interview with PSA Compliance Manager. There were no transgender or intersex detainees housed during the audit to interview.

Does Not Meet: Policy PS CUS 051 states, "Medical practitioners conduct examinations of transgender individuals to determine genital status only in private settings and only when an individual's genital status is unknown" and "Examinations of detainees to determine genital status shall be conducted in private and by medical practitioners", thus allowing for the examination of transgender/intersex detainees to

determine genital status by facility policy. The facility's policy and practice needs to be updated to address the standard language; if the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning the information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence. The policy outlines, if a detainee's gender is unknown, is it determined through means other than a search, such as during conversations with the detainee, by reviewing medical records (if available), or, if necessary, learning such information as part of a broader medical examination conducted in private, by a medical practitioner. The Auditor interviewed the facility's HSA, four front-line correctional officers, including a first-line supervisor, and determined the facility is adhering to their amended policy and the standards requirement; staff refrains from searching or physically examining detainees for the sole purpose of determining the detainee's gender. Interviews with staff further indicated, if a detainee's gender is unknown, it will be determined through other means than a physical search, such as during conversations with the detainee, by reviewing medical records or, if necessary, learning such information as part of a broader medical examination conducted in private, by a medical practitioner. There were no transgender or intersex detainees on-site for the Auditor to interview. During the CAP period, the facility reported and was further corroborated by the Auditor through interviews with the PSA Compliance Manager and Director of Corrections; there have been no searches or physical examinations of transgender or intersex detainees, as they currently do not confine them. Therefore, there were no logs or other documentation related to searches or physical examinations for the Auditor to review. Additional documentation submitted as supporting evidence is a memorandum from the Warden dated April 1, 2020, which states, "Please be advised at this time we have an agreement with ICE ERO that we do not house transgender ICE detainees nor will they send said detainees to the Essex County Correctional Facility." The Auditor conducted interviews with the Director of Corrections, intake staff, HSA, and the PSA Compliance Manager. They all advised the Auditor that ECCF has an agreement with ICE and does not accept transgender detainees. However, if this agreement were ever to change, the facility would conform to the standards requirement. The facility has met substantial compliance.

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

(a) The facility's policy PS CUS 051 states, "Inmate/ICE detainee notification, orientation, and instruction must be in a language or manner that the inmate understands," and, "Inmates'/ICE detainees' education is available in accessible formats for all inmates/ICE detainees including those who are; limited English proficient (LEP), deaf, visually impaired, otherwise disabled and limited in their reading skills." Policy PS CUS 051 outlines that oral interpretation or assistance shall be provided to any inmate/ICE detainee who speaks another language in which written material has not been translated or who is illiterate and dictates that ECCF is in compliance with Federal Law and DHS policy to take reasonable steps to provide meaningful access to the facility's Sexual Abuse and Assault Prevention and Intervention Program for inmate/ICE detainees with LEP. Policy PS CUS 051 further dictates that ECCF make available competent foreign language and sign language interpreters to ensure effective communication with inmates/ICE detainees with LEP and disabilities. Policy PS CUS 023 Deaf, Hard of Hearing, Visually Impaired and Disabled Inmates/ICE Detainees states that videotapes will be shown with a closed-captioned feature during any program, service, or activity at the facility. The lack of close-captioned features on the housing unit TVs designated to play a reoccurring PREA video and the TV in Intake designated to play the PREA orientation video for new arrivals was viewed during the on-site tour. Addendums for the hard of hearing from policy PS CUS 023 only mention inmates and were not observed or presented in Spanish or any other language. Interviews with intake staff confirm there is no viable orientation for the disabled, including those who are blind and those with low vision as the pre-booking PREA video had significant sound issues that interviews with staff and detainees confirmed has been on-going for two years. According to an email from the facility post audit the sound issue has been fixed. Detainees who are deaf or hard of hearing would be provided the ICE National Detainee Handbook and access to interpreters who can interpret effectively, accurately, and impartially. ECCF reported the use of three certified sign language interpreters on staff, however this Auditor has not been provided with documentation of their certification as requested, prior to, and post on-site visit to verify the resource the facility states are utilized for interpretation. Staff during interviews had some difficulty explaining the steps that would be taken to effectively communicate with disabled detainees when necessary. They were unsure how detainees who have limited reading skills or blind would be provided this information. Intake staff indicated they would also be able to listen to the PREA video, however, as indicated above, the intake PREA video had significant sound issues. Most staff indicated being able to utilize social service and mental health staff to deliver explanations to detainees with intellectual disabilities and mental health staff to ensure that the detainee comprehends the information. Intake staff indicated that the orientation video is available in Spanish and English. The Auditors only viewed an English orientation video with significant sound issues. The ICE Detainee National Handbook is readily available in seven different languages English, Spanish, Portuguese, Haitian/Creole, French, Arabic, and Vietnamese at the facility. Copies of the Chinese, Hindu, Punjabi, and Russian are available upon request off the ICE website. The facility has a contract with Language Line Services Inc. for interpretation services. A copy of the contract was provided for documentation. The facility also has bilingual staff on all three shifts. There were two detainees identified that had disabilities during the on-site audit to interview. One detainee presented with a mental health issue and indicated he had no difficulty communicating with staff. The second detainee was hard of hearing and LEP. Through a staff interpreter he indicated that he had no problem communicating with staff and was housed in the infirmary due to being hard of hearing. The Auditors identified detainees with disabilities during the on-site tour even though the facility indicated there were no detainees with disabilities during the on-site audit and during the tour. It should be noted that policy PS CUS 023 does not reference ICE detainees, it only references inmates in the body of the policy.

Does Not Meet: The PREA video presentation that plays at intake, although the facility reported it has been fixed, had significant sound issues for two years as documented through detainee and staff interviews. Although the facility indicated by email that the significant sound issues have been repaired, there is no documentation that repairs have been completed. The facility needs to provide

documentation that the detainees are provided information in a manner they understand, and documentation that the video presentation sound has been repaired.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence. The policy indicated the appropriate steps are taken to ensure that detainees with 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. The policy delineates all the required elements of subpart 115.16(a). Additional documentation submitted was an email communication from the PSA Compliance Manager discussing the video audio issues and confirming they have since been corrected. Also provided was a completed detainee intake form acknowledging viewing of the PREA educational video dated 6/6/2019. Interview with the facility's PSA Compliance Manager and Director of Corrections indicated to the Auditor detainees who are deaf or hard of hearing are provided 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. Although ECCF was no longer accepting detainees at the time of the on-site visit reaudit, the Auditor was given a demonstration of the intake process for detainees to include observing the PREA educational video. Intake staff plays the video on a flat screen TV mounted on the wall. Directly in front of the TV are several benches where detainees must sit and receive the PREA educational video information. The Auditor was able to see and hear the video playing without issue. As noted earlier, while on-site the Auditor reviewed detention files for the eight detainees interviewed including documentation of their orientation PREA information provided at intake, which indicated the viewing of the PREA video. The facility has met substantial compliance.

§115.17 - Hiring and promotion decisions

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

Notes:

(a/b/d) Through review of policy PS CUS 051, it was determined that the facility has established a system of conducting criminal background checks for new employees and contractors who have contact with detainees to ensure they do not hire or promote anyone who engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The policy does not include volunteers, however, interviews with the human resource staff, and record review does confirm that the facility does background checks that include volunteers. The job application form requires the employee to answer questions of: have not engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution and have not been civilly or administratively adjudicated or convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to refuse. However, these questions need only be answered if the employee answers affirmative as an adult having ever been arrested, indicted, convicted for any violation of the criminal law, which are the questions relating to sexual abuse. Therefore, any incidents of sexual abuse as a juvenile, or incidents of sexual abuse which did not lead to an arrest would not be captured. This form is utilized for new hires. In the case of promotions, the facility utilizes the Essex County Department of Corrections form, that includes questions that ask the promotion applicant if he/she ever engaged in sexual abuse in a prison or other confinement settings; been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, coercion, or if the victim did not consent or was unable to consent to refuse; or had civilly or administratively adjudicated to have engaged in sexual in such activity. The form further asks if the promotion applicant has ever engaged or attempted to engage in any sexual advances or harassment incidents including unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. The background investigation questionnaire states the candidate will undergo a thorough background investigation including but not limited to the FBI, State Police, Local Police, Schools, Credit Bureaus, employment, family, etc. Policy PS CUS 051 indicates "that before hiring, consistent with Federal, State, and local law, makes its best effort to contact all prior institutional employees for information on substantiated cases of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse." The facility will contact prior institutional employers to obtain information on substantiated allegations of sexual abuse or any resignation during an investigation. All staff receive a copy of the Law and Regulations and sign that they received a copy. The Auditors attempted to select random employee files to review for the administrative adjudication check on the application form or as part of the hiring process paperwork and the background check prior to hiring. The facility was very reluctant to share employee personnel files. Finally, immediately prior to the exit close-out, the Warden personally went to Human Resources and pulled two random files for the Auditors to review. The two files were in compliance.

Background checks are also conducted through ICE prior to an ICE employee or ICE contractor being approved for hire. During a training session on September 25, 2018, and the training documentation available on the ERAU SharePoint site; the OPR Personnel Security Unit (PSU) Unit Chief explained that all ICE staff and any ICE contract employees must clear a background investigation through PSU before hiring or promoting any staff or contractor who may have contact with detainees. The contractor or staff complete an Electronic Questionnaires for Investigations Processing (e-QIP) and fingerprints to start the investigation process. The process takes an average of 45-60 days to determine suitability for hiring. If the prospective employee does not clear the background investigation, the individual will not be hired to work for ICE; if it is a contract employee, the office informs the contractor that the employee cannot perform work on behalf of ICE. The Unit Chief explained the sexual misconduct questions are asked of the potential employee as part of the e-QIP. Employees also have a continuing affirmative duty to report. The requirement is to report immediately to a supervisor and is outlined in Knowledge of Law and Regulations. For this facility, ICE PSU conducts background checks on ICE employees. The Auditor submitted five ICE employee names to PSU to verify the background check process. All were compliant.

Does Not Meet: Standard requires that the facility shall ask all applicants who may have contact with detainees directly about previous misconduct in written applications or interviews for hiring or promotions. Although the facility has established a questionnaire that is presented to all promotional candidates, it does not utilize the form for new staff hires; the facility depends solely on the on-line application results which allows the applicant to skip the PREA questions if they have never been arrested, indicted, and convicted of a crime. Per

Human Resource staff, and the provided promotional questionnaire, the facility includes all volunteers in their background checks, therefore policy PS CUS 051 should be updated to include volunteers. The facility must develop a process to ensure all new hires who may have contact with detainees are directly asked about previous misconduct in written applications or interviews for hiring or promotions. The facility must demonstrate the new process and provide documentation for review.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence. The policy now contains "volunteers" within the scope of the facility's hire and promotion decisions. The facility has developed a new process to ensure new hires, including volunteers who may have contact with detainees, are directly asked about previous misconduct in written applications or interviews for hiring or promotions per the standard's requirement. Potential candidates for employment and new hires, including volunteers, are now required to answer the newly developed PREA Acknowledgment Questionnaire Form, which is now part of the facility employment packet. The PREA Acknowledgment Questionnaire Form covers all elements outlined within standard 115.17. The Auditor interviewed the PSA Compliance Manager, Director of Corrections, and the facility lead investigator, who monitors the background check process for all new hires and promotions. All three indicated they are aware that staff, contractors, and volunteers who may have contact with detainees must be asked directly about previous misconduct either in written applications or interviews for hiring or promotions as per the standards requirement. The Auditor reviewed six employee background check files, three for new hires and three for promotions, and inspected the required PREA Acknowledgment Questionnaire Form in each. Due to the COVID national pandemic, the facility has not utilized the services of volunteers. Therefore, there were no files available for the Auditor to review that would contain the new background check questionnaire form. The facility has met substantial compliance.

§115.21 - Evidence protocols and forensic medical examinations

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

Notes:

(a) Agency policy 11062.2 outlines the agency's evidence and investigation protocols. The facility's policy PS CUS 051 states "The facility shall establish a protocol to ensure that each allegation of sexual abuse is investigated by the facility, or referred to an appropriate investigative authority", and "The facility is responsible for investigating allegations of sexual abuse involving a uniform evidence protocol that maximizes the potential for obtaining useable physical evidence for administrative proceeding and criminal prosecutions." The Auditor had requested a protocol be presented prior to, during the on-site audit, and post-audit for review. The facility did not present a protocol but referred the Auditor to Policy Statement Administration (PS ADM) 038 Processing & Control of Evidence policy which does not include sexual assault. The facility utilizes a PREA allegation checklist that is not covered by policy or procedure. The facility does not house juvenile detainees

Does Not Meet: Although, PS CUS 051 states verbatim the standard requirements, the facility does not have an actual uniform protocol to follow that maximizes the potential for obtaining useable physical evidence for administrative and criminal prosecutions. When requested by the Auditor, the facility referred the Auditor to another policy PS ADM 038 that did not include sexual assault evidence collection either. The facility must establish a uniformed evidence protocol for investigating allegations of sexual abuse. The facility investigators must be trained on the process and protocol.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence. The policy now indicates to the extent that the agency or facility is responsible for investigating allegations of sexual abuse involving detainees, it shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. As such, the facility processes all crime scenes, including sexual assault allegations, pursuant to policy PS.ADM.038 Processing and Control of Evidence in accordance with and as required by the New Jersey Attorney General's Guidelines. The Auditor interviewed the facility's PSA Compliance Manager, primary investigator and reviewed the facility's uniform evidence protocol, delineated within policy and determined that it requires the collection of physical evidence protocols for sexual assault allegations, processing & control of evidence and found it to be compliant with the standard in all material ways. In reviewing three completed investigations during the CAP period, the Auditor determined the facility utilized the required uniformed evidence protocols. The facility has met substantial compliance.

(b/d) Policy PS CUS 051 states, "A contractual agreement may be developed with a rape crisis center or other available community medical service to enhance facility medical services." The facility has no memorandum of understanding (MOU) agreement with Essex County Rape Crisis Center (ECRCC), nor is there documentation that the facility attempted to establish an MOU. Efforts to contact ECRCC revealed that ECRCC had blocked the facility's phone number. Through a phone call to ECRCC, they confirmed they have blocked the facility's calls. The facility does utilize Rape Abuse Incest National Network (RAINN); however, RAINN does not provide on-site services. The facility indicated that the hospital would contact victim advocacy services if a detainee was taken to the outside hospital. The one investigation file reviewed where a detainee was taken for outside medical services was determined that an assault did not occur, and victim advocacy services were not noted in the file. The facility has mental health staff on-site that detainees are referred to after a reported allegation, however, the Auditor was not provided documentation that mental health was appropriately trained to provide victim advocate services.

Does Not Meet: Policy PS CUS 051 indicated that the ECRCC will provide outside victim services after an incident of sexual abuse. Attempts to call the rape crisis hotline revealed that the center has blocked the facility's calls. There is no MOU in place or attempt for victim advocacy services. There is no documentation to verify victim advocacy services being provided by the local hospital or through another method as a result of an incident of sexual abuse. The facility must establish procedures to ensure that victim advocate services are available following incidents of sexual abuse and forensic exam through outside community resources or through a qualified community-based organization and/or facility staff member. The facility needs to provide documentation that victim advocacy services are available in the areas of crisis intervention and counseling during a forensic exam and as needed. If the mental health staff are to provide victim

advocacy services, they must have received education concerning sexual assault and forensic examinations in general. The facility needs to provide documentation of the training.

Corrective Action Taken: ECCF submitted an email communication between the Warden and the Sexual Assault Nurse Examiner (SANE) Supervisor, at the Essex County Prosecutors Office (ECPO), as evidence for compliance. The correspondence describes the process for all allegations of sexual abuse, including for inmates and detainees. When a detainee discloses sexual assault, they are entitled to a forensic medical exam by the forensic nurse from the ECPO Forensic Nurse Examiner (FNE) /Sexual Assault Response Team (SART) program. The allegation of sexual assault must be within a five-day window to receive a forensic medical exam, which includes evidence collection, forensic medical exam, any medications necessary for sexually transmitted infections, and "access to a confidential advocate from the rape crisis center." The on-call forensic nurse places that call to the advocate via the rape crisis number to activate them as part of the SART in accordance with the Attorney General (AG) guidelines. The Auditor interviewed the facility's PSA Compliance Manager. He stated the facility's evidence protocol procedures are utilized and considered how best to use available community resources and services to provide valuable expertise and support in crisis intervention and counseling. A review of the facility's uniform evidence protocols for sexual assault allegations ensures the facility has established procedures to make outside victim services available following incidents of sexual abuse, to the fullest extent possible per the standard's requirement. There were no detainees on-site for the Auditor to interview who had reported sexual abuse. The Auditor randomly selected ten staff and reviewed their All Staff PREA Training forms completed during the CAP period which includes a section on the facility's uniform evidence protocols for sexual assault allegations, ensuring the facility has established procedures to make outside victim services available following incidents of sexual abuse. The Auditor's review of three sexual abuse investigations completed during the CAP period indicated all three detainee victims were offered victim advocacy services but declined. The facility has met substantial compliance.

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

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

Notes:

(a) Policy PS CUS 051 states, "all staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault and the facility administrator shall promptly report the incident to the appropriate ICE Authority and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation." Policy PS CUS 051 dictates that the facility shall report all allegations immediately and effectively to the appropriate ICE authority who will report the allegation as a significant incident and refer the allegation for investigation. The facility will complete the investigation by a specially trained investigator. Staff indicated that all the PREA allegations are investigated through SID, Essex County Department of Corrections (ECDO investigative staff members assigned to the facility. SID will conduct all investigations including criminal. In practice, all allegations are reported to the facility's SID who investigates all allegations of sexual abuse and assault. All nine allegations were investigated by SID. Following the investigation, should criminal charges be warranted, the case is referred to the Essex County Prosecutor's Office for prosecution. Attorney General Law Enforcement Directive No. 2018-5, Directive Implementing Procedures and Protocols for Sexual Response and Referrals outlines the Prosecutor's role in cases of sexual abuse. The agency policy 11062.2 outlines the agency's evidence and investigation protocols. Once the investigation allegation is reviewed and accepted by the agency OPR investigator, the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If the investigation is not conducted by the ICE, the facility will complete the investigation by a specialized trained investigator. The Auditor had requested an investigation protocol be presented prior to, during the on-site audit, and post-audit. The facility did not present a protocol but referred the Auditor to policy PS ADM 038 Processing & Control of Evidence which does not include sexual assault. The facility utilizes a PREA allegation checklist that is not covered by policy or procedure. Per policy PS CUS 051, a staff member must immediately report an allegation through the chain of command (first line supervisor), or to the PREA Coordinator, Internal Affairs Bureau (IAB), PREA Hotline, or to any facility PREA Liaison. The policy further indicates that the facility administrator shall promptly report the incident to the appropriate ICE authority; and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. As previously stated, facility SID staff are responsible for conducting all administrative and criminal investigations of incidents that occur at ECCF. Policy PS CUS 051 dictates that the facility will document all investigation referrals. The allegations are referred to ICE. The investigator stated that OPR will review all cases to determine if an investigation is required by the agency. All allegations involving staff are investigated by trained facility SID staff. Staff indicated that all of the PREA allegations are investigated through SID. There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit. No allegations were reported to the Essex County Prosecutor. The three closed cases were also investigated by ICE staff and found unsubstantiated. Upon review of the investigation files, notifications were made to ICE, however, not all case numbers were assigned. All nine allegations were referred for facility investigation. A review of the PREA Allegation Spreadsheet provided to the Auditor confirmed three cases were investigated by ICE. The spreadsheet did not note the other six allegations that were reported to ICE by the facility. The notifications to the appropriate ICE authority were documented through emails in the facility allegation/investigation files. The Auditor asked for information on the six allegations to clarify why they were not on the spreadsheet. This issue was being addressed during the on-site audit. The Auditor did not receive any clarification on the inconsistency between the allegations reported to ICE and listed on the spreadsheet of ICE investigations completed. The Auditor received further documentation of a detainee grievance that alleged sexual abuse. The grievance was investigated by the facility and the allegation was reported to the ICE field office. The JIC was not notified by the ICE field office for agency review of the allegation and investigation process. This allegation was not listed on the spreadsheet.

The Auditor asked for information on the six allegations to clarify why they were not on the spreadsheet. This issue was being addressed during the on-site audit. The Auditor did not receive any clarification on the inconsistency between the allegations reported to ICE and listed on the spreadsheet of ICE investigations completed.

Does Not Meet: The facility does not have a written investigation protocol to ensure that each allegation of sexual abuse is investigated by the facility or agency. Policy PS CUS 051 dictates that the facility administrator shall refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. Interviews with security staff confirm that practice is to refer all cases to SID for investigation, who in turn, if criminal charges seem warranted, will refer the investigation to the Essex County Prosecutor. The facility does not utilize an outside law enforcement agency to complete investigations, other than ICE; SID conducts all investigations including criminal. Documentation is needed to provide the investigation action taken by ICE after an allegation is reported by the facility to ensure the investigation process of each allegation. The facility must develop a written investigation protocol to ensure that each allegation of sexual abuse is investigated administratively and/or criminally. The facility staff need to be trained on the written protocol.

Corrective Action Taken: Subpart (a) of the standard was noted as deficient in the initial audit report and in the provisional CAP audit report. However, subpart (a) deficiency was omitted from the CAP. Submitted as evidence by the facility was amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), which now includes the facility's investigation protocol to ensure that each allegation of sexual abuse is investigated administratively and/or criminally. The protocol consists of a description of the responsibilities of ICE Headquarters, the facility, and other investigative entities. Interviews conducted with ECCF's Primary Investigator, Director of Corrections, PSA Compliance Manger, and the SDDO concluded that both the facility and agency work collaboratively on all allegations of sexual abuse in accordance to the standards requirement. The Auditor reviewed three completed sexual abuse investigations and determined the facility protocol was utilized promptly and referred for investigation to an appropriate law enforcement agency, with the legal authority to conduct criminal investigations unless the allegation did not involve potentially criminal behavior, to include reported promptly to the agency as described in subparts (e) and (f) of the standard. ECCF has the legal authority to conduct criminal investigations. All three cases were reviewed for criminality and subsequently handled administratively. The facility has met substantial compliance.

(b/d) Policy PS CUS 051 states, "The facility is responsible for investigating allegations of sexual abuse involving detainees and shall follow a uniform evidence protocol that maximizes the potential for obtaining useable physical evidence for administrative proceedings and criminal prosecutions", and "ECCF shall ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for investigation by SID, and shall document such referrals." In addition, PS CUS 051 does not clearly outline the agency's responsibilities other than the facility administrator will coordinate as necessary with the ICE OPR. Policy PS CUS 051 dictates that investigations of sexual abuse and sexual harassment involving staff are referred to the Essex County Prosecutor's Office. According to interviews with Investigative staff, PSA Compliance Manager, and Warden, only incidents of sexual abuse or assault that are found to be criminal in nature by SID are referred for prosecution. Policy PS CUS 051 also states that the agency shall retain copies of all administrative and criminal reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, and that the facility shall maintain sexual abuse data collected for at least ten years after the date of initial collection, unless federal, state, or local law requires otherwise. The PSA Compliance Manager indicated that all investigations are maintained in accordance with policy covering retention of records.

Does Not Meet: The facility does not have a written protocol to outline the facility's responsibilities for sexual abuse investigations and reports other than the facility administrator will coordinate as necessary with the ICE OPR.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence, which now includes the facility's investigation protocol to ensure that each allegation of sexual abuse is investigated administratively and/or criminally. The protocol includes a description of the responsibilities of the facility, and other investigative entities as required by the standard. Interviews conducted with ECCF's Primary Investigator, Director of Corrections, PSA Compliance Manager, and the SDDO concluded that both the facility and agency work collaboratively on all allegations of sexual abuse. The Auditor reviewed three completed sexual abuse investigations and determined the facility's written protocol was utilized and that the facility coordinated their actions taken with ICE OPR and in accordance with the standards requirement. The facility has met substantial compliance.

(c) The ICE website, www.ice.gov/prea includes information on the agency's PREA overview, PREA policies, reporting methods with addresses and phone numbers, SAAPI standards, ICE Detainee National Handbook, ICE PREA poster, and ICE PREA Sexual Assault Awareness Information pamphlet. On the Essex County Corrections website, essexcountynj.org, is a webpage dedicated to PREA. The webpage contains the zero-tolerance policy and how to report sexual abuse or sexual harassment. There is a sentence that explains that all allegations will be referred for investigation, and, that ECCF will impose discipline for sexual misconduct, up to and including termination and criminal prosecution for staff, as well as, discipline for offenders who victimize other offenders. The website does not include detainees and refers strictly to offenders. There are no sexual abuse investigation protocols posted.

Does Not Meet: The facility's website does not include detainees. The facility's website does not make the sexual abuse investigative protocol available to the public through the website or another method. The facility must make the sexual abuse investigative protocol for detainee investigations available to the public through the facility's website or another method.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence, which now includes the facility's investigation protocol to ensure that each allegation of sexual abuse is investigated administratively and/or criminally. Additional documentation provided, "Essex County Department of Corrections Memorandum," outlined the facility's updates to their website, which now includes "detainees." The County's website now displays the facility's sexual abuse investigative protocol and that it is made available to the public. The Auditor reviewed the County's website and found it to be compliant with the standard in all material ways. The facility has met substantial compliance.

(e/f) Policy PS CUS 051 requires that all allegations are immediately and effectively reported to the appropriate ICE Authority. Interviews with the Warden and PSA Compliance Manager and provided documentation confirms the reporting is done via the ICE email distribution. The SID Investigative staff is also notified. The facility does utilize a checklist, however, there is no procedure available to staff on how to utilize the checklist. A review of the checklist by the Auditor confirmed that it is being utilized and does include the requirement to contact ICE when an allegation is made. Following an investigation by SID staff, any potential criminal case will be forwarded to the Essex County Prosecutor for prosecution. A review of the three closed investigation cases confirmed that notifications are made to the appropriate ICE authority and SID staff. ICE investigators completed investigations on three of the nine allegations reported. Upon review of the investigation files, notifications were made to OPR, however, not all allegations reported were documented on the PREA Allegation Spreadsheet verifying the investigation assignment or process or case numbers assigned. Of the three closed cases, one allegation was not reported promptly. The allegation was reported at the facility on August 24, 2019 and the facility reported to ICE on August 27, 2019.

Does Not Meet: The facility must promptly report to the JIC, the ICE OPR, or the DHS OIG, as well as, to the appropriate ICE FOD an incident of sexual abuse.

Corrective Action Taken: ECCF submitted a memorandum from the Warden titled, PREA Coordinator Duty and Responsibilities, as evidence. The memo indicated the PSA Compliance Manager serves as the facility's primary advocate and liaison with the DHS, ICE, US Marshal's Service (USMS), Center for Family Guidance (CFG) Health Systems LLC, and external rape crisis services as needed and will ensure proper and timely notifications are made to ICE FOD who will notify Joint Intake Center (JIC), the ICE OPR, or the DHS OIG. The above mentioned was corroborated through interviews with the Director of Corrections, facility primary Investigator, and PSA Compliance Manager. The Auditor reviewed three completed sexual abuse investigations conducted during the CAP period and determined the facility's written protocol was utilized. Proper and timely notifications are made to ICE FOD who will notify Joint Intake Center (JIC), the ICE OPR, or the DHS OIG. The facility has met substantial compliance.

§115.34 - Specialized training: Investigations

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

(a/b) The facility's policy PS CUS 051 reflects that investigators are to be trained in conducting sexual abuse investigations in confinement settings. The specialized training lesson plan, National Institute of Corrections (NIC) PREA: Investigating Sexual Abuse in a Confinement Setting includes sections on techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The facility has five specialized trained investigators who have completed the general PREA training and the required specialized training for investigators. The specialized training is provided electronically through the NIC website. The training was conducted in January 2015. The specialty training was verified through the interviews with investigative staff and review of five specialized training records, including training certificates and training attendance record forms with signatures. A review of investigative files indicated that they were completed by trained facility investigators. The three ICE staff that completed the investigations on the three closed cases had not completed specialized investigation training.

Does Not Meet: All ICE staff completing investigations must receive specialized investigation training.

Corrective Action Taken: Subparts (a)(b) of the standard were noted as deficient in the initial audit report and in the provisional CAP audit report. However, subpart's (a)(b) deficiency was omitted from the CAP. The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the ICE OPR Investigations Incidents of Sexual Abuse and Assault, that covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the ICE SharePoint to document compliance with the standard. In reviewing the training records on the ICE SharePoint, the Auditor confirmed agency investigators assigned to conduct investigations during the CAP period had completed the required training. The agency has met substantial compliance.

§115.41 - Assessment or risk of victimization and abusiveness

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

(e) Per policy PS CUS 051, the Essex County Department of Corrections (ECDOC) requires the facility to reassess each inmate's/ICE detainee's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the inmate/ICE detainee's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The policy further states that an inmate's/ICE detainee's risk level is reassessed again, only if it is warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that impacts the inmate's/ICE detainee's risk of sexual victimization or abusiveness. The standard requires that each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon receipt of additional, relevant information or following an incident of abuse or victimization. Based on the wording of

the standard that requires all ICE detainees be reassessed, the policy PS CUS 051 that requires reassessment not to exceed 30 days based upon any additional, relevant information received by the facility since the intake screening, falls short of compliance. Interviews with detainees indicated that a sergeant met with a majority of them approximately one month prior to the on-site audit for reassessment. Interviews with staff indicated that the process had just begun, and that the facility was reassessing all detainees at once. A review of five random detainee files confirmed that the reassessments had just begun with a large amount of assessments in a pile for filing.

Does Not Meet: Although the reassessment timing noted in policy PS CUS 051 of requiring reassessment no later than 30 days from intake, it does not require all detainees be reassessed. There is no clear procedure in place delegating the reassessment to any particular staff person. In addition, the procedure had just begun with a sergeant interviewing all detainees at once to come into compliance. The reassessments that had been completed were done utilizing the questions asked at intake. According to the PAQ the average time in custody is 24 days, however, the majority of the detainees interviewed had been detained for six months or more. The facility needs to update the policy to include reassessments for detainees within the 60-90-day period from the date of the initial assessment and develop a process to ensure the reassessments are completed. Staff need to be trained on the updated policy and process.

Corrective Action Taken: ECCF submitted a memorandum from the facility PSA Compliance Manager, titled, "On the Job Training for 60-90-day PREA Reassessments," as evidence. The document describes that the facility has identified an employee, correctional officer who has received training and is responsible for completing all detainee reassessments within the 60-90-day timeframe per the standards requirement. The training document also contains the signatures of the staff person who received the training and the staff person (PSA Compliance Manager) who conducted the training. Interviews conducted with intake staff, PSA Compliance Manager, confirmed that 60-90-day reassessments are completed per the standards requirement. While on-site, the Auditor was advised by the PSA Compliance Manager that he also assists in the completion of detainee risk assessments, which was indicted in the review of completed reassessment documentation. The Auditor interviewed eight detainees and reviewed their PREA risk assessment documentation to include the 60-90-day reassessments and determined six of the eight were completed timely. Two of the eight detainees had not been at the facility long enough to receive a reassessment. The Auditor also confirmed the facility has updated the policy which indicates reassessments for detainees shall be completed between 60-90 days from the date of the initial assessment per the standard requirement and the memorandum from the facility's PSA Compliance Manager, which reflects the new process put into practice by the facility. The facility has met substantial compliance.

§115.42 - Use of assessment information

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

(a) The facility's policy PS CUS 051 addresses the assessment process and the use of the screening information to determine housing, recreation, voluntary work, and other activities to ensure the safety of the detainee. If the detainee is identified at high risk of sexual victimization or a potential sexual abuse victim, the detainee is referred by the intake officer through the PREA email to the PSA Compliance Manager, medical, and mental health for further screening. The PSA Compliance Manager with input from medical and mental health will determine housing. During the site visit, the auditor observed the classification officer completing the risk assessment process with a detainee, the detainee score did not identify the detainee at risk and general housing was assigned. The interviews with the Intake Supervisor and PSA Compliance Manager indicated that housing assignments are made on a case by case basis with consideration of custody level and PREA risk factors. In review of five recently completed risk assessments in the detainee files, the Auditor determined the facility is utilizing collected data, such as the detainee's physical characteristics (build and appearance), age, whether the detainee has mental, physical or development disability, previous assignment in specialized housing, alleged offense and criminal history, whether the detainee is perceived to be Lesbian/Gay/Bi-Sexual/Transgender/Intersex (LGBTI) or is gender non-conforming to determine housing, recreation, work, and other activity decisions. Through staff interviews and observing a classification, it was determined that the facility addresses the needs of the detainee consistent with the security and safety of the individual detainee when it pertains to housing. Based on interviews with intake staff and the PSA Compliance Manager, the risk screening is not utilized regarding recreation, voluntary work, and other activities.

Does Not Meet: Although policy PS CUS 051 requires the facility to utilize the risk screening form to determine housing, recreation, volunteer work, and other activities. Interviews with intake staff and the PSA Compliance Manager indicated that they utilize the risk screening only to determine housing which falls short of the requirements of the standard. The facility must utilize the information from the risk screening to make informed individualized determinations to ensure the safety of each detainee including recreation, volunteer work, and other activities per the facility's policy and PREA standard.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence, which now states the facility shall use the information from the risk assessment under § 115.41 of this part to inform assignment of detainees to housing, recreation, and other activities, and voluntary work. Additional documentation submitted as evidence for compliance was a memorandum issued to the PSA Compliance Manager, titled "115.42 - Use of Assessment Information" dated March 20, 2020, indicating the facility must utilize the information from the risk screening to make informed, individualized determinations to ensure the safety of each detainee including "recreation, volunteer work, and other activities per the facility's policy and PREA standard." Interviews with intake staff, including the PSA Compliance Manager, confirmed the facility uses risk assessment documentation to inform housing, recreation, work, and other activity decisions and to make individualized determinations. A review of completed detainee risk assessment documentation completed during the CAP period demonstrated the facility uses this information to inform housing, recreation, work, and other activity decisions and make individualized determinations. The facility has met substantial compliance.

(b) The facility's policy PS CUS 051 indicates that ECCF staff when making assessment and housing decisions for a transgender or intersex inmate/ICE detainee shall consider the detainee's gender self-identification and make housing assignments for a transgender and/or intersex detainee on a case-by-case basis based on the detainee's health and safety. In addition, the policy dictates that placement of a transgender or intersex inmate/ICE detainee shall be consistent with the safety and security considerations of the facility. When a detainee self-identifies as a transgender/intersex during the intake process the facility shall consult a medical or mental health professional as soon as practicable on this assessment. The policy does not define "as soon as practicable" and does not indicate where the transgender or intersex detainee will be housed during the assessment. According to interview with the PSA Compliance Manager, he, with input from medical and mental health, is responsible for housing determinations for all detainees. He did not provide information as to what information is considered when making transgender or intersex detainee housing determinations. The policy dictates that all housing and programming assignments shall be reassessed at least twice each year to review any threats to safety experienced by the inmate/ICE detainee. At the time of the on-site audit, there were no transgender or intersex detainees housed.

Does Not Meet: The Auditor interviewed the PSA Compliance Manager to ascertain compliance with the standard and determined that the PSA Compliance Manager, whose responsibility it is to determine housing for all detainees, was unfamiliar with the intent of the standard, and therefore, the Auditor finds the facility does not meet the standard. The Auditor recommends that policy PS CUS 051 be updated to include the procedure used, what criteria needs to be followed, and how reassessments will be completed, in determining housing and programming needs for transgender and intersex detainees on a case by case basis and consideration of the detainee's gender self-identification.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence, which now incorporates all the elements outlined within standard 115.42(b). Additional documentation submitted as supporting evidence is a memorandum from the Warden dated April 1, 2020, which states, "Please be advised at this time we have an agreement with ICE ERO that we do not house transgender ICE detainees nor will they send said detainees to the Essex County Correctional Facility." The Auditor conducted interviews with the Director of Corrections, intake staff, HSA, and the PSA Compliance Manager. They all advised the Auditor that ECCF has an agreement with ICE and does not accept transgender detainees. However, if this agreement were ever to change, the facility would conform to the standards requirement. While on-site during the reaudit, there were no transgender detainees. The facility has met substantial compliance.

§115.43 - Protective custody

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

(a/b) Policies PS CUS 051 and PS CUS 038 Special Housing Unit (SHU) outlines the written procedures for protecting a detainee that is vulnerable to sexual abuse or assault. The policies were approved by the Wardens and ICE FOD during the on-site audit. Policy PS CUS 051 states that ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there is no available alternative means of separation from likely abusers. Policy PS CUS 038 states any inmate/ICE detainee who is found to be vulnerable to sexual abuse or assault will be immediately controlled by staff and, for cause and with supervisory approval, placed in the Close Custody SHU with documented detailed reason(s) for placement. The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Policy PS CUS 038 states in (a/b) Policies PS CUS 051 and PS CUS 038 Special Housing Unit (SHU) outlines the written procedures for protecting a detainee that is vulnerable to sexual abuse or assault. The policies were approved by the Wardens and ICE FOD during the on-site audit. Policy PS CUS 051 states that ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there is no available alternative means of separation from likely abusers. Policy PS CUS 038 states any inmate/ICE detainee who is found to be vulnerable to sexual abuse or assault will be immediately controlled by staff and, for cause and with supervisory approval, placed in the Close Custody SHU with documented detailed reason(s) for placement. The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Policy PS CUS 038 states in another section that an inmate/ICE detainee shall be placed in protective custody status in the Close Custody SHU only when there is documentation that is warranted and that no reasonable alternatives are available. The two policies, PS CUS 051 and PS CUS 038, are in direct conflict of reviewing for alternative placements and the type of custody housing; with policy PS CUS 038 in direct conflict with itself. A review of the investigative files indicates that all detainees who alleged sexual abuse, or sexual assault were immediately placed in closed custody. One detainee was moved to another cell in the evening and moved to closed custody in the morning even though there was no indication that the current cell move would not suffice. All such placements were documented.

Does Not Meet: The standard requires that the use of administrative segregation to protect detainees vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing. The facility needs to review and update the policies to be compliant with the standard and provide consistency among the facilities polices. The facility needs to develop a process and practice that reviews all alternative means of separation instead of just placing all detainees who are vulnerable to sexual abuse or assault in administrative segregation/protective custody/close custody SHU.

Corrective Action Taken: ECCF submitted amended policy PS.CUS.022 Protective Custody, as evidence, which now states, all post-allegation protective custody regarding PREA incidents shall abide by all of the tenets set forth in policy PS.CUS.051 Sexual Abuse & Assault

Prevention & Intervention; "ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there are no available alternative means of separation from likely abusers. In lieu of involuntary protective custody, inmates/ICE detainees may be housed in the infirmary." Interviews with the Director of Corrections, Segregation Supervisor, and PSA Compliance Manager confirmed ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there are no available alternative means of separation from likely abusers. They further indicated detainees usually are moved to another housing unit. Still, if this were not an option, the detainee would be placed in medical for the least amount of time required. While on-site and during the CAP period, the facility has not placed any detainees in administrative segregation due to a vulnerability to sexual abuse. The facility has met substantial compliance.

(d) Policy PS CUS 038 states that the SHU Supervisor shall conduct a review within 72 hours of the detainee's placement into administrative segregation to determine whether segregation is still warranted. The review includes an interview with the detainee. The review will be documented on the Special Housing Unit Review Form indicating the decision made and the justification. A supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in administrative segregation, and seven days thereafter for the first two months and every ten days thereafter. This policy was put into effect just prior to the on-site audit. However, the previous section of the policy still indicates inmates/ICE detainees shall have a review at least every thirty days thereafter and not seven. Also, PS CUS 051 states, "If an involuntary protective custody housing assignment is made, ECCF affords each such inmate/ICE detainee a review every 30-days." In cases of involuntary protection, the Special Housing Review Form will be reviewed and signed by the Warden upon completion. As no detainees remained in administrative segregation or protected custody for seven days or more, there was no documentation to review to determine compliance.

Does Not Meet: The standard requires written policy and procedures, although the facility has written policy and procedures, the policy language conflicts with the standard language. The standard calls for 10-day reviews after the first 30-days. Policies PS CUS 051 and PS CUS 038 indicate a review every 30-days and include conflicting direction for reviews. The practice could not be determined during the on-site audit. The facility needs to update the policies to address the proper time frames per standard and ensure all conflicting procedures are removed from policies. The facility staff need to be trained on policy and procedure changes.

Corrective Action Taken: ECCF submitted amended policy PS.CUS.038 Special Housing Unit (SHU), as evidence, which now incorporates all the required elements of standard 115.43(d). The policy now outlines the requirement of subpart (d) as required per the standard. The Segregation Supervisor indicated he is aware of the policy revision and recalled receiving this information during the facility's annual in-service All Staff PREA Training. This was also confirmed through interviews with the facility's Director of Corrections and PSA Compliance Manager. During the CAP period and while the Auditor was on-site, no detainees had been placed in segregated housing for risk of sexual victimization or following a sexual abuse allegation. The facility has met substantial compliance.

§115.52 - Grievances

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

Notes:

(c) The facility's policy PS CUS 017 and Detainee Handbook provides written procedures and timeframes for handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. If staff identify the grievance involves an immediate threat to an inmate's/ICE detainee's health, safety, and welfare the grievance is to be handled as a time-sensitive emergency grievance. Policy PS CUS 017 does not reference incidents of substantial risk of imminent sexual abuse to the detainee under "Emergency Grievances." PS CUS 017 further states that the emergency grievance may be brought by an inmate/ICE detainee to a designated staff or social worker, Penal Counselor, Inmate Advocate, or designee, and directly to the Office of the Warden or designee. In the absence of these personnel, the inmate/detainee may inform a shift supervisor. Policy PS CUS 017 does not mention the tablet as a way to report an emergency grievance even though through staff interviews, it was determined that this was the current procedure. The grievance is forwarded to the Warden or designee for immediate corrective action to protect the alleged victim. Per policy PS CUS 017, all requests designated as "General" must be answered within 5 business days from the date the request is forwarded, and requests designated as "Medical" must be received by the Medical Department within 24 hours from the date the request is forwarded or the next business day, with a response from medical staff within 5 working days, where practicable. The policy does not provide timeframes for time sensitive grievances. There was one grievance regarding an allegation of sexual abuse. This grievance was received on 1/9/19 and referred for investigation on the same day. The grievance was against a staff member and involved an improper pat-down search by a staff member. Although reported to the appropriate ICE authority, the allegation is not included on ICE OPR list of PREA and Sexual Abuse/Assault Allegations provided by the Team Lead. The facility provided the Auditor an email that was sent to ICE to document the reporting process as reviewed during the investigation file review. The grievance was investigated by the facility with an outcome of unfounded. Although the allegation was reported to the ICE field office, the ICE field office did not notify the JIC for agency review of the allegation and investigation process; therefore, this allegation was not listed on the spreadsheet. Furthermore, The agency did not provide an outcome since an investigation was not conducted by the agency. The Auditor attempted to interview the detainee; however, he refused an interview. The Grievance Coordinator indicated that she receives immediate notification by email of an allegation of sexual abuse/assault grievance and it is handled immediately. If it is a non-workday, she would begin the process by reporting the allegation to the facility.

Does Not Meet: The standard requires that the facility implement written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. Policy PS CUS 017 does not

include reference to incidents of substantial risk of imminent sexual abuse to the detainee under "Emergency Grievances." Policy PS CUS 017 is outdated on how to report an emergency grievance by not including use of the detainee tablet, which as determined by staff interviews, is the current procedure to report.

Corrective Action Taken: Policy PS CUS 051 indicates the facility has implemented written procedures for identifying and handling time-sensitive grievances associated explicitly with "sexual abuse" as required by standard 115.52(c). The detainee tablet is listed in the amended Policy PS CUS 017 as a method to report an emergency grievance which was indicated to the Auditor through staff interviews as the primary avenue for reporting. The Auditor interviewed the Grievance Coordinator and was advised the facility has implemented written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse. During the CAP period, there were no sexual abuse allegations reported through the grievances process. The facility has met substantial compliance.

§115.53 - Detainee access to outside confidential support services

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

Notes:

(a/b) The facility's policy, PS CUS 051 states the facility shall have representatives from outside entities that provide relevant services, expertise and actions to be coordinated but not be limited to having a victim advocate available to the inmate/ICE detainee victim during the forensic medical exam, providing crisis intervention counseling for the victim before and after the forensic medical exam. Policy PS CUS 051 also states that, ECCF shall provide victims with community-based victim support services based on contractual or other arrangements (i.e. MOU) with local organizations and a contractual arrangement may be developed with a rape crisis center or other available community to enhance facility medical needs. Based on an interview with the PSA Compliance Manager, no MOU exists with an outside community-based support service, nor is there documentation that the facility attempted to develop an MOU. The PSA Compliance Manager did state that Essex County Rape Crisis Center was contacted and refused to enter an MOU due to the requirement of background checks. There was not any written documentation to verify that this attempt was made. An interview with the Health Services Administrator indicated that she was unfamiliar with the availability of outside resources offered at the hospital. A review of investigative reports does not document that an outside local support service was offered. An attempt to contact the Essex County Rape Crisis Center via the PREA Hotline was unsuccessful. Further investigation revealed that the Center blocked the facility's telephone number. The facility provides hotline services through RAINN; an American nonprofit anti-sexual assault organization, the largest in the United States. RAINN operates the National Sexual Assault Hotline, as well as the Department of Defense Safe Helpline, and carries out programs to prevent sexual assault, help survivors, and ensure that perpetrators are brought to justice through victim services, public education, public policy, and consulting services. However, there is no MOU in place, or is there a documented attempt to enter an MOU to outline services to be provided. An attempt to call the RAINN hotline was also unsuccessful due to issues with the dialing instructions. This issue was resolved during the on-site audit, and information regarding dialing instructions were posted on all housing units post on-site audit. Picture of the postings were provided to the Auditor via email. Interviews with two detainees who reported sexual abuse revealed that neither were provided with information on how to contact someone from the community to provide emotional support, counseling, or legal advice. Of the 26 random detainees interviewed 11 detainees knew of the PREA hotline having seen the poster on the bulletin board in the housing unit. The other 15 detainees were not aware of information about organizations that can provide support services for sexual abuse victims.

Does Not Meet: The facility does not have a MOU in place or documentation of an attempt to obtain a MOU for community resources and services. In the investigative reports reviewed, there is no documentation of crisis intervention being offered to victims while at the outside hospital emergency room. The facility must establish procedures to make emotional support services available following incidents of sexual abuse through an outside community resources or through a qualified community-based organization and/or facility staff member to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation, and the prosecution of sexual abuse perpetrators to most appropriately address victims' needs. The facility needs to provide documentation of obtaining emotional support services or attempts of an MOU/agreement with community service providers.

Corrective Action Taken: ECCF submitted revised policy PS CUS 051 which states, "ECCF has established procedures which include outside agencies in the facility's sexual abuse prevention and intervention protocols. Inmates/ICE Detainees have access to outside victim advocates for emotional support services related to sexual abuse (i.e. Essex County Rape Crisis Center). This information is provided in our Inmate/ICE Detainee Handbook, as well as on informational posters." The Auditor further confirmed, as mentioned above, observing this information in detainee handbooks, and posted in the housing units. Also submitted as evidence is an email communication between the Warden and the SANE Supervisor with the Essex County Prosecutors office. Information in the email confirms that the ECCF is covered under the County's MOU provided through the Essex County Prosecutors Office. The correspondence describes the process for all allegations of sexual abuse, including for inmates and detainees. When a detainee discloses sexual assault, they are entitled to a forensic medical exam by the forensic nurse from the ECPO FNE/SART program. The allegation of sexual assault must be within a five-day window to receive a forensic medical exam, which includes evidence collection, forensic medical exam, any medications necessary for sexually transmitted infections, and "access to a confidential advocate from the rape crisis center." The on-call forensic nurse places that call to the advocate via the rape crisis number to activate them as part of the SART in accordance with the AG guidelines. There were three completed sexual abuse investigations during the CAP period. In reviewing the investigative files, all three detainee victims were offered and denied victim advocacy services. The facility has met substantial compliance.

(d) There is a posting in the housing units that states all telephone calls at the facility are subject to being recorded, except legal calls. According to the Warden, via a post on-site audit email received by the Auditor, there is no posting regarding to what extent communications are monitored for the hotline calls to RAINN, however, they are not recorded. He further stated, as there is no recording

prior to the call going through, this indicates to the detainee the call is not being recorded. A review of the PREA Sexual Assault Awareness Information pamphlet, ICE National Detainee Handbook, PREA posters, and policy PS CUS 051 addendum does not provide information to the detainee of the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The DHS poster provides ways to make anonymous phone calls by entering 415 852 753 as their alien number. Also, the detainee handbook and PREA pamphlets inform detainees that staff members are required to keep the reported information confidential and only discuss it with the appropriate officials on a need-to-know basis. The Warden indicated, via email, that the RAINN Hotline number is not monitored. The Auditors suggested that a notice be posted that informs the detainees to the extent the phones are monitored including that hotline numbers for sexual abuse reporting are not monitored.

Does Not Meet: The standard requires that the detainees are informed, prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. A review of available documentation, including the ICE detainee handbook, PREA poster, and policy PS CUS 051 indicates that although the detainee is informed that the information he reports can be done anonymously and will be only be discussed with those on a need-to-know basis, the information does not inform the detainee the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The facility needs to develop a method to inform detainees prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Corrective Action Taken: Subparts (d) of the standard was noted as deficient in the initial audit report and in the provisional CAP audit report. However, the subpart (d) deficiency was omitted from the CAP, and therefore the facility was unaware of the found deficiency. However, while on-site the Auditor determined PS CUS 051 revised policy states detainees are informed prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The Auditor further corroborated, through an interview with PSA Compliance Manager and observing, the above-mentioned information is provided to detainees in their facility handbooks and posted on bulletin boards in the housing units. The facility has met substantial compliance.

§115.61 - Staff reporting duties

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

Notes:

(a/b) Policy PS CUS 051 states all staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault through, or outside, the ECCF's chain of command, and, 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. Employees are required to report any information to the PSA Compliance Manager, SID, PREA Hotline, or any facility PREA liaison. The facility administration shall promptly report the incident to the appropriate ICE Authority and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency, SID, having jurisdiction for the investigation. The policy was approved by the Wardens and the ICE FOD during the on-site audit. Reporting requirements are covered in the annual in-service training, pre-service training, and shift briefings for all staff. Specialized and random staff interviews confirm that staff are knowledgeable in their reporting duties, the process of reporting, and to whom to report. Random staff interviewed indicated they would report immediately to their supervisor and the PSA Compliance Manager and then write an incident report. This reporting information is also provided on the staff's PREA Staff's Responsibility Card. Per policy PS CUS 051, staff shall be allowed to privately report sexual abuse to the PSA Compliance Manager, IAB, 24/7 Employee Hotline, through the website, or to any facility PREA liaison. During the interviews, most staff indicated they would report privately through the hotline. The Auditor received further documentation of a detainee grievance that alleged sexual abuse. The staff member that was informed of the allegation initially did not report the incident immediately. The staff member left the facility for the day and did not report the allegation until days later.

Does Not Meet: The staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault to the PSA Compliance Manager, SID, PREA Hotline, or any facility PREA liaison. The facility must provide updated training with staff to ensure staff are aware of the reporting requirements.

Corrective Action Required: ECCF submitted revised policy PS CUS 051, as evidence to demonstrate compliance with subpart 115.61(a)(b), which states, "All staff must immediately report any known or suspected incidents or allegations of sexual abuse or assault through or outside of ECCF's chain of command. All Employees may report any information to the PREA Coordinator, IAB, PREA HOTLINE or to any Facility PREA Liaison. " Note: "IAB" is an acronym for "Internal affairs Bureau. "Additional supporting documentation provided was a document titled "PREA Response Checklist." This document is to be completed and attached to all incident reports involving sexual misconduct. The Auditor interviewed the PSA Compliance Manager and four correctional officers and was advised they are aware that all sexual abuse allegations shall immediately be reported per agency and facility's written policies and procedures. Staff further indicated they receive PREA refresher information during the PREA All Staff Training conducted during in-service. The All Staff PREA Training contains a segment advising staff that they must immediately report any known or suspected incidents or allegations of sexual abuse or assault and ways that can be reported outside the reporters' chain of command and timeliness, as outlined in policy and per the standards requirement. The Auditor reviewed ten randomly selected staff training files to verify training received and acknowledged. A review of the three completed investigations showed that they were reported timely and handled properly per the policy requirements. The facility has met substantial compliance.

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

(a/b) Policy PS CUS 051 dictates that staff members must use a coordinated, multidisciplinary team approach responding to sexual abuse, such as a Sexual Assault Response Team (SART). Although policy PS CUS 051 dictates a plan be developed, the facility has not presented a written institutional plan to coordinate actions taken by the multidisciplinary team including first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The facility does utilize a PREA Response Checklist for Incidents of Sexual Abuse to document the activities of staff, but it is not incorporated in a plan that could guide users on how and when the checklist should be utilized. A review of the checklist indicated it does not include the use of outside community support organizations for those ICE detainees taken to an outside hospital for emergency treatment or forensic examination.

Does Not Meet: Policy PS CUS 051, updated during the on-site audit, dictates that staff members must use a coordinated, multidisciplinary team approach when responding to sexual abuse, such as a Sexual Assault Response Team (SART). Although policy PS CUS 051 dictates a plan be developed, the facility has not presented a written institutional plan to coordinate actions taken by the multidisciplinary team including first responders, medical and mental health practitioners, and facility leadership in response to an incident of sexual abuse. The facility must develop a written institutional plan to coordinate actions taken by first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. With the policy being updated during the on-site audit, there was no demonstrated practice or documentation provided to determine compliance with the standard and policy.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence to demonstrate compliance with subpart 115.65(a)(b), which outlines the facility's written institutional plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. Additional information provided is a document titled "PREA Response Checklist." The checklist outlines the actions that are to be taken by first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The checklist is required to be completed and attached to all incidents related to sexual abuse. The Auditor conducted interviews with the Director of Corrections and PSA Compliance Manager. They both indicated the facility has a written institutional plan to coordinate actions taken by first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. They also affirmed the facility uses a coordinated, multidisciplinary team approach to responding to sexual abuse. In reviewing three completed sexual abuse investigations, and the PREA Response Checklist, the Auditor determined the facility complies with the facility policy and standard requirement in all material ways. The facility has met substantial compliance.

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

(a) The facility's policy PS CUS 051 states that all detainees and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations are protected from retaliation from the other inmates/ICE detainees or staff. The policy does not include contractors or volunteers. The policy designates the SID Unit to monitor retaliation. The Warden did not know who was actually designated to monitor retaliation. The PSA Compliance Manager indicated he is responsible for monitoring detainees. When questioned about staff, he further indicated he does monitor staff also. Staff is informed of protection from retaliation through training in pre-service and in-service. Of the three closed cases this audit period, no monitoring was conducted. Two detainees who reported sexual abuse were interviewed. Neither indicated that they were being monitored for retaliation.

Does Not Meet: Policy PS CUS 051 dictates that the SID staff conduct retaliation monitoring. Interviews with staff indicated clearly that staff was unaware of the procedure for monitoring retaliation and who is responsible for monitoring of detainees and staff for retaliation. A review of the investigative files revealed no monitoring was being conducted for those who reported sexual abuse. Interviews with detainees that reported sexual abuse stated they were not being monitored. The policy does not include contractors or volunteers. The facility needs to update the policy to include contractors and volunteers. Also, the policy needs to be updated to indicate what designated staff member is responsible for monitoring if SID is not conducting the monitoring as policy states. The facility needs to establish a process for monitoring for retaliation and the staff responsible for monitoring detainees and staff for retaliation.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence to demonstrate compliance with subpart 115.67(a), which outlines, if any "individual" who cooperates with an investigation expresses a fear of retaliation, appropriate measures will be taken to protect that individual against retaliation. Additional information provided was an Essex County Department of Corrections memorandum titled, PREA Coordinator Duty and Responsibilities from the Warden. The memo indicates the PSA Compliance Manager will "ensure there isn't any retaliation against victims who have reported a PREA violation." Monitoring for retaliation will include 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. In reviewing three completed investigations during the CAP period, the Auditor observed monitoring for retaliation documentation that occurred for 90 days. The PSA Compliance Manager conducts the monitoring for retaliation and advised he meets with the detainee several times throughout the monitoring period, which the Auditor observed through completed monitoring for retaliation forms signed by the detainee. The facility has met substantial compliance.

(c) Policy PS CUS 051 outlines the monitoring timeframes. During the interview with the Warden and PSA Compliance Manager both were unsure of the procedure to monitor staff and/or detainees who fear retaliation for reporting sexual abuse of sexual harassment or for cooperating with investigations. Although PS CUS 051 dictates that SID is responsible for this task, neither knew what the policy required. During the interview with the PSA Compliance Manager he first stated that he "did not know" when asked who was responsible for monitoring staff. He further stated that he monitors detainees by making phone calls to the housing unit security staff to "see how the detainee is doing." He did not indicate that he would meet with the detainee at any time during the monitoring. He stated he would request input from housing unit staff, monitor disciplinary reports, and housing unit and program changes, however, he did not state that he would monitor other possible suggestions of retaliation such as grievances, hotline calls, change in detainee behavior, and monitoring of phone calls and mail. The Warden indicated that the PSA Compliance Manager would monitor, and that staff would interview the detainee. The Warden did not know the required timeframe for the monitoring to take place. The PSA Compliance Manager indicated that the monitoring just started prior to the on-site audit and that there was no log or other documentation to verify monitoring takes place. Of the three closed cases reviewed there was no indication of monitoring implemented for either the staff or the detainee involved in the allegation. Of the two detainees who reported sexual abuse, they stated they were not monitored or knew what staff member would monitor. The PSA Compliance Manager was less than knowledgeable of the monitoring responsibilities.

Does Not Meet: The staff member assigned for monitoring for retaliation should meet with the individual and review documentation to determine if retaliation is occurring, and not rely on phone calls to the housing unit security staff, who could be the one retaliating. The facility must create a process for monitoring retaliation of staff, contractors, volunteers, or detainees that report, complains about, or participates in an investigation of sexual abuse. This process must include time frames for monitoring and documentation.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051), as evidence to demonstrate compliance with subpart 115.67(a), which outlines, if any "individual" who cooperates with an investigation expresses a fear of retaliation, appropriate measures will be taken to protect that individual against retaliation. Additional information provided was an Essex County Department of Corrections memorandum titled, PREA Coordinator Duty and Responsibilities from the Warden. The memo indicates the PSA Compliance Manager will "ensure there isn't any retaliation against victims who have reported a PREA violation." In reviewing three completed investigations during the CAP period, the Auditor observed monitoring for retaliation documentation that occurred for 90 days. The PSA Compliance Manager conducts the monitoring for retaliation and advised he meets with the detainee several times throughout the monitoring period, which the Auditor observed through completed monitoring for retaliation forms signed by the detainee. The facility has met substantial compliance.

§115.68 - Post-allegation protective custody

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

Notes:

(a) Policy PS CUS 038 Special Housing Unit (SHU) states "The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged", and "An inmate/ICE detainee shall be placed in Protective Custody status in the Close Custody SHU only when there is documentation that it is warranted and that no reasonable alternatives are available." The policy also indicates that Protective Custody is also referred to as Administrative Segregation. The two sections of the standard, as noted above, appear to be in direct conflict with unclear direction to staff. Policy PS CUS 051 states that ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there is no available alternative means of separation from likely abusers. The direction of policy PS CUS 051 is in direct conflict with sections of policy PS CUS 038. A review of the three closed investigative files indicates that the detainee is placed immediately into Administrative Segregation/Protective Custody as procedure. One file reviewed showed the detainee made an allegation against his cell mate during the overnight shift. He was moved into a separate cell during the overnight and immediately placed into Administrative Segregation/Protective Custody the following morning when the day shift staff arrived. Staff interviewed indicated he was moved during the day shift due to the fact that it became clear that the detainee made a sexual abuse allegation against his cell mate. Policy PS CUS 038 is compliant with the requirements of 115.43. The PSA Compliance Manager stated the facility tries to avoid protective custody. This was not confirmed with the review of the closed investigation files. In fact, the review indicated that immediately placing the detainee in administrative segregation/protective custody is ECCF procedure. A review of the three closed cases note that the facility had immediately placed all alleged detainee victims in administrative segregation/protective custody following the allegation. There were no detainees identified to interview.

Does Not Meet: Although Policy PS CUS 051 states that ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made; and a determination has been made that there is no available alternative means of separation from likely abusers, policy PS CUS 038 states the facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abuses can be arranged. The PSA Compliance Manager indicated that the facility tries to avoid protective custody. This was not however, verified by a review of the three closed investigations that showed that the reporting victim was immediately placed in administrative segregation/protective custody. The facility needs to review and update the policies to be complaint with the standard and provide consistency among the facility's polices. The facility needs to develop a process and practice that reviews all alternative means of separation instead of just placing all detainees who alleged sexual abuse in closed custody.

Corrective Action Taken: ECCF submitted amended policy PS.CUS.022 Protective Custody, as evidence to substantiate compliance with standard 115.68(a), which now states, all post-allegation protective custody regarding PREA incidents shall abide by all of the tenets set

forth in policy PS.CUS.051 Sexual Abuse & Assault Prevention & Intervention; ECCF prohibits the placement of inmates/ICE detainees who allege to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there are no available alternative means of separation from likely abusers. "In lieu of involuntary protective custody, inmates/ICE detainees may be housed in the infirmary." The Auditor interviewed the PSA Compliance Manager and Director of Corrections, and both stated ECCF will not place a detainee who alleges to have suffered sexual abuse in involuntary protective custody housing unless an assessment of all available alternatives has been made and a determination has been made that there are no available alternative means of separation from likely abusers. They further indicated detainees usually are moved to another housing unit. Still, if this were not an option, the detainee would be placed in medical for the least amount of time required. There have been no detainees placed in involuntary segregation during the CAP period. A review of three completed sexual abuse investigations determined the facility housed the victim in the least restrictive housing option possible, which was in the detainee general population. The facility has met substantial compliance.

(c) Policy PS CUS 038 states that the facility should assign detainees vulnerable to sexual abuse or assault to Administrative Segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such assignment shall not ordinarily exceed a period of 30 days. Policy PS CUS 051 states that if an involuntary protective custody housing assignment is made, ECCF affords each such inmate/ICE detainee a review every thirty (30) days to determine whether there is a need for separation from the general population. Neither policy addressed a reassessment, taking into consideration any increased vulnerability of the detainee as a result of sexual abuse before returning to general population. The PSA Compliance Manager stated there would be a reassessment, however, could not offer any additional information. There was no written documentation to review to determine compliance in the three reviewed closed investigations. There were no identified detainees to interview that were housed in administrative segregation/protective custody.

Does Not Meet: Policies PS CUS 038 and PS CUS 051 do not require a reassessment of the detainee who is being released to general population. The facility must establish a process for completing reassessments of detainees prior to returning to general population. Staff must be trained on the process.

Corrective Action Taken: ECCF submitted policy PS.CUS.051 and the Essex County Department of Corrections - Close Custody SHU Review Form as evidence to substantiate compliance with standard 115.68(c). Initially, the Auditor did not accept ECCF's provided documentation for partial compliance. Neither policy nor the Close Custody SHU Review Form, addressed if a detainee victim who is in protective custody after being subjected to sexual abuse is not returned to the general population until a proper reassessment has been completed. While on-site during the reaudit, the Auditor reviewed the updated policy and the ECCF Protective Custody Review form. Both require a detainee victim who is in protective custody after being subjected to sexual abuse is not to be returned to the general population until a reassessment has been completed. Interviews with the Director of Corrections, PSA Compliance Manager, and Segregation Supervisor indicated to the Auditor that a detainee in protective custody would be reassessed per policy and the standard requirement before being released. The segregation supervisor is responsible for conducting the reviews of all detainees in protective custody for whatever reason. During the CAP period, the facility has not placed a detainee in protective custody/administrative segregation. The facility has met substantial compliance.

§115.71 - Criminal and administrative investigations

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

Notes:

(a) Although the facility has the responsibility for investigating allegations of sexual abuse, a review of policies provided to the Auditor indicates that the facility does not have a written policy that requires that all investigations must be prompt and thorough. Policy PS CUS 051 does dictate that investigations shall be conducted by trained investigators. Policy PS CUS 051 further states that the facility administration shall promptly report the incident to the appropriate ICE Authority and refer all cases that appear potentially to support criminal prosecution to the appropriate law enforcement agency having jurisdiction for investigation. The policy was approved by the Wardens and the ICE FOD during the on-site audit. The facility's practice however, requires all allegations be referred to the facility's SID for investigation. The allegations are referred to the appropriate ICE authority and SID staff for investigation. There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit. No allegations were reported to the Essex County Prosecutor. The three closed cases were also investigated by ICE staff and found unsubstantiated. A review of training records confirms all SID staff are trained investigators. The facility has five specialized trained SID staff members. The three ICE staff which completed the closed investigations had not completed specialized training. The Investigator stated that investigations are started immediately, as soon as reported and are objective based on evidence. The review of the investigations showed that investigations are started promptly.

Does Not Meet: All investigations must be completed by specialized trained investigators. All ICE staff conducting investigations must complete specialized investigation training.

Corrective Action Taken: The agency policy 11062.2 states OPR shall provide specialized training to OPR investigators who conduct investigations into allegations of sexual abuse and assault, as well as, Office of Detention Oversight staff, and other OPR staff, as appropriate. The lesson plan is the "ICE OPR Investigations Incidents of Sexual Abuse and Assault," that covers in depth investigative techniques, evidence collections, and covers all aspects to conducting an investigation of sexual abuse in a confinement setting. The agency offers another level of training, the Fact Finders Training which provides information needed to conduct the initial investigation at the facility to determine if an incident has taken place or to complete the administrative investigation. This training includes topics related to

interacting with traumatized victims; best practices for interacting with LEP; Lesbian, Gay, Bi-sexual, Transgender, Intersex (LGBTI), and disabled detainees; and an overall view of the investigative process. The agency has provided training records for agency investigators on the ICE SharePoint to document compliance with the standard. In reviewing the training records on the ICE SharePoint, the Auditor confirmed agency investigators assigned to conduct investigations during the CAP period had completed the required training. The agency has met substantial compliance.

(b) The Warden and PSA Compliance Manager stated in cases, where upon conclusion of a criminal investigation that was found to be unsubstantiated, the facility would conduct an administrative investigation. The PSA Compliance Manager stated in cases where upon conclusion of a criminal investigation that was found to be substantiated, an administrative investigation would be conducted. Section XVIII of policy PS CUS 051 states that upon a conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted, and, upon conclusion of a criminal investigation where the allegation was unsubstantiated the facility shall review any criminal investigation reports to determine whether an administrative investigation is necessary, or appropriate. This verbiage was added during the on-site audit. There is no SAAPI Coordinated Response Plan, or policy, that directs staff to begin an investigation, when to conduct the investigation, or in what timeframe the investigation is to begin or be completed. Also, added to policy PS CUS 051 during the on-site audit; the administrative investigations shall be conducted after consultation with the appropriate investigation office within DHS or DOJ and the assigned criminal investigative entity. Of the three closed allegations, all investigations were completed by facility SID staff and ICE. The PSA Compliance Manager indicated that the SID consults with the Essex County Prosecutor's Office. According to the PAQ and PSA Compliance Manager there were no allegations of sexual abuse referred for prosecution during the audit year.

Does Not Meet: The updated SAAPI Coordinated Response Plan does not include procedural direction of when, how, and in what timeframe the administrative investigation should be conducted. Interviews with the Warden and PSA Compliance Manager could not determine implemented practice. The facility needs to demonstrate compliance with the updated policies and the process developed to ensure the practice of referring investigations for administrative investigation as necessary or appropriate. The facility must also provide training to staff on the policy changes and the process developed.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.71(b), which states, "upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports determining whether an administrative investigation is necessary or appropriate. After consultation with the appropriate investigative office within the DHS and the Essex County Prosecutor's Office, administrative investigations shall be conducted." Additional information provided was an Essex County Department of Corrections memorandum from the Warden titled PREA Coordinator Duty and Responsibilities. The memo indicates the PSA Compliance Manager "will monitor all PREA cases, via the PREA Event Log, to ensure the investigation is completed in a timely manner. Interviews with the Director of Corrections, PSA Compliance Manager, and the primary facility investigator indicated that an administrative investigation would be conducted upon the conclusion of a criminal investigation where the allegation was substantiated. The primary investigator and PSA compliance Manager stated an administrative investigation is completed for all cases, whether substantiated or unsubstantiated. As noted earlier, the primary investigator and SDDO indicated the facility and agency work collaboratively during the investigative process. The Auditor reviewed three completed sexual abuse investigations during the CAP period and observed documentation that the facility consulted with DHS and the criminal investigative entity. The facility has met substantial compliance.

(c) Policy PS CUS 051 states the facility shall develop written procedures for administrative investigations, including all items required for investigations as listed in the standard. There is no written protocol that provides procedural direction to staff. It also states an investigation report shall be written for all investigations of sexual abuse utilizing the investigative report template, PREA Investigation Report. The PSA Compliance Manager and Investigator shared that the following information and evidence would be collected: statements, interviews, evidence, logbooks, video footage, and forensic evidence from the hospital, telephone calls, and review of detainee history. Of the three completed allegations, all investigations were completed by the facility SID and ICE. The facility does not have in policy or plan, information on how to coordinate and sequence the two types of investigations in accordance with paragraph (b) as dictated by the standard.

Does Not Meet: Policy PS CUS 051 states the facility shall develop written procedures for administrative investigations, including all items required for investigations as listed in the standard. There is no written protocol that provides procedural direction to staff. The facility does not have in policy or plan information on how to coordinate and sequence the two types of investigations in accordance with paragraph (b) as dictated by the standard. The facility must develop written procedures for administrative investigations which includes the provisions of the standard.

Corrective Action Taken: ECCF submitted, amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.71(c), which delineates all the elements within subpart 115.71(c). Policy further states "upon the conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports determining whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS and the Essex County Prosecutor's Office." Additional information provided was an Essex County Department of Corrections memorandum from the Warden titled, PREA Coordinator Duty and Responsibilities. The memo indicates the PSA Compliance Manager "will monitor all PREA cases, via the PREA Event Log, to ensure the investigation is completed in a timely manner. Interviews with the facility Director of Corrections and PSA Compliance Manager indicated the facility uses written procedures for administrative investigations that include each provision's element. Upon concluding a criminal

investigation where the allegation was unsubstantiated, the facility reviews any available completed criminal investigation reports determining whether an administrative investigation is necessary or appropriate. The facility process was further corroborated through a review of the facility's PREA Events Log and completed investigations during the CAP period. The facility has met substantial compliance.

(f) Interviews with Investigative staff indicate that all investigations are completed by the facility SID. The Investigator indicated in his interview that ICE does not investigate nor is information provided in regards to allegations that ICE may complete.

Does Not Meet: According to facility investigative staff (SID) they are responsible for all investigations at Essex. The facility needs to cooperate with outside investigators, including ICE, and shall endeavor to remain informed about the progress of the investigation.

Corrective Action Taken: ECCF submitted, amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.71(f), which states "investigations of sexual abuse and sexual harassment involving inmate/ICE detainee, or staff is referred to the Essex County Prosecutors Office. The facility administrator shall coordinate as necessary with the ICE Office of Professional Responsibility (OPR) and/or criminal investigative entities responsible for the investigation of the incident." Additional information provided was an Essex County Department of Corrections memorandum from the Warden titled, PREA Coordinator Duty and Responsibilities. The memo indicates the PSA Compliance Manager "will monitor all PREA cases, via the PREA Event Log, to ensure the investigation is completed in a timely manner." Interview with the Director of Corrections, PSA Compliance Manager, and primary investigator stated when outside agencies investigate sexual abuse, the facility cooperates with outside investigators and remains informed about the progress of the investigation. The Auditor reviewed three completed investigations completed during the CAP period and determined the facility cooperated with outside investigators and stayed informed about the progress of the investigation. The facility has met substantial compliance.

§115.76 - Disciplinary sanctions for staff

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

(a/b) Policy PS CUS 051 requirement for the discipline of staff for incidents of substantiated cases of sexual abuse is located in two sections. Section XXX does not include termination from Federal service; section XVIV, was added during the on-site audit, and does include termination from Federal Service. The Warden stated in the interview that a staff member suspected of sexual abuse would be moved to a non-contact detainee post until the investigation is completed. If the case was substantiated, the staff member would be terminated. Policy PS CUS 051 was reviewed and approved by the Wardens and ICE FOD during the on-site audit. Of the three closed cases reviewed, there were no allegations of sexual misconduct by a staff member. There were no staff terminations, resignations, other sanctions this audit period per the Warden, memo to file, and PAQ.

Does Not Meet: The policy PS CUS 051 sections XXX and XVIV are contradicting. The policy does not include that removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse. The facility policy must be updated to address the provisions of the standard and ensure that the sections are not contradictory.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.76(a)(b), which states "staff shall be subject to disciplinary or adverse action up to and including removal from their position and their Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies." Interviews with the Director of Corrections, PSA Compliance Manager, stated staff would be removed from their position and Federal service who have engaged in or attempted, or threatened to engage in sexual abuse. During the CAP period, the facility did not have any staff-on-detainee sexual abuse reports and investigations. Therefore, there were no sanctions applied to staff for the Auditor to review. The facility has met substantial compliance.

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

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

(b) Per PS CUS 051, when a referral for medical follow-up is initiated, the detainee receives a health evaluation no later than two working days from the date of assessment. The HSA stated the detainees from a referral would be seen within 72 hours and noted in the medical progress notes in the detainee's medical file. A referral would also be made to mental health if one was not made previously. During the audit period, a pre on-site memo to file indicated that a detainee was referred for medical follow-up during the assessment process, however, review of the medical file indicated that the detainee had a PREA score of zero and that the referral was not part of the intake process. The Auditor did not note any referrals to medical from the intake assessments while reviewing the detainee files.

Does Not Meet: The standard requires that the detainee will receive a health evaluation, no later than two working days from the date of assessment. Although the standard is supported by policy PS CUS 051, interviews with medical staff reveal that the practice is to see the detainee for evaluation within 72 hours. The facility must develop a process to ensure that detainees referred for follow-up will receive a health evaluation no later than two working days from the date of the assessment. The facility policy should be updated to reflect the new process and the required time frame per standard.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.81(b), which now states "when a referral for medical follow-up is initiated, the inmate/ICE

detainee shall receive a health evaluation no later than two (2) working days from the date of assessment." The Auditor interviewed the facility's HSA. She stated that when a referral for medical follow-up is initiated, the detainee will receive a health evaluation no later than two working days from the assessment date. She further indicated that it would mostly likely happen the same day. The PSA Compliance Manager stated that no detainees during the CAP period reported during their intake assessment to have experienced prior sexual victimization or perpetrated sexual abuse. The facility has met substantial compliance.

§115.86 - Sexual abuse incident reviews

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

Notes:

(a) Policy PS CUS 051 outlines the requirement, procedures, and timeframes for sexual abuse incident reviews. The standard further requires that the facility shall implement the recommendations for improvement. Designated staff are required to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including unfounded. The inclusion of reviewing unfounded allegations was added during the on-site audit. Although policy PS CUS 051 states that the PSA Compliance Manager shall together with upper-level management officials, conduct a sexual abuse incident review, the Warden indicated during his interview, he has never seen a conducted review. The PSA Compliance Manager indicated that he conducts reviews of every case within three to six weeks of completion. He did not indicate that the report is to be shared with facility administration or the Agency PREA Coordinator. The PSA Compliance Manager indicated that he completes the incident reviews and files them. The PSA Compliance Manager utilizes an Incident Review Form to complete and document the review. The PSA Compliance Manager is responsible for implementing any recommendation for improvement or document its reasons for not doing so. The Auditor reviewed the sexual abuse incident reviews of the three closed investigative cases. There were nine allegations reported during the audit period. Of the nine allegations, only three cases were closed investigations which involved three detainee-on-detainee sexual abuse. All three cases were determined to be unsubstantiated through investigations conducted by the facility's SID Unit and ICE. In one closed file, the incident review was completed by the facility on 10/2/18 prior to the case being officially closed by ICE OPR on 3/21/19. There were no further reviews that took into consideration information regarding the ICE investigation. The facility is completing incident reviews upon completion of the facility investigation. In another case, the entire file was not afforded to the Auditor. Interview with a SID investigator revealed that the PSA Compliance Manager dictated to them what to include in the file presented for the Auditor review. All reviews indicated that the reviews occurred within 30 days and there were no deficiencies or need of improvement.

Does Not Meet: The standard requires that the facility shall conduct an incident review at the conclusion of every investigation of sexual abuse, and where the allegation is not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation. The requirement of all reviews, including cases determined to be unfounded, was added during the on-site audit. The facility must develop a review team consisting of upper level management officials that completes incident reviews and utilizes the review form to document the incident reviews within 30 days. The facility must also develop an incident review process that addresses the 30-day review timeframe and providing the report and response to the agency PSA Coordinator.

Corrective Action Taken: ECCF submitted amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.86(a), which now incorporates all the elements required of subpart (a). Policy further states, "The ECCF Sexual Abuse and Assault Prevention and Intervention Program Coordinator shall, together with upper-level management officials, conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation. The sexual abuse incident review team shall include upper-level management officials, the PREA Compliance Manager and allows for input from line supervisors, investigators, and medical or mental health practitioners. Where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation." Also submitted was a memo from the Warden outlining the PSA Compliance Manager's responsibilities. The PSA Compliance Manager is responsible for conducting briefings and PREA after-action reviews of PREA cases with administrative personnel, the medical department, and the mental health department. Interviews with the Director of Corrections and PSA Compliance Manager, stated allegations not determined to be unfounded; the facility prepares a written report recommending whether the allegation or investigation indicates that there may be a need to update policies or practices that could better prevent, detect, or respond to sexual abuse. The Auditor reviewed three completed investigations during the CAP period and reviewed completed after incident reviews for two cases determined not to be unfounded. Both reviews were conducted per policy and the standards requirement. The third case was determined to be unfounded. Although an after-incident review report was not completed or required per the standard, the Auditor reviewed the PREA Event Log and saw where it was reviewed by the PSA Compliance Manager per the standards requirement. The PSA Compliance Manager further stated although a written report is not required for cases determined to be unfounded, since he has taken over the position as the PSA Compliance Manger he has made it a best practice to ensure the review is documented. Interview with SDDO confirmed he receives either hard copies of the completed after incident reviews while on-site or via email and shares with his supervisor, ensuring they are forwarded to the agency PREA Coordinator. The facility has met substantial compliance.

(b) An Incident Review Form is utilized to complete and document the review. All elements of the standard are addressed on the form. The PSA Compliance Manager confirmed all the elements are reviewed and documented on the form. The standard is supported through policy PS CUS 051, however, the interview with the PSA Compliance Manager indicates that he files the form upon completion. Interview with the Warden indicates he has never seen an incident review form.

Does Not Meet: The facility through interviews with the Warden and PSA Compliance Manager does not have a review team as required by standard and as outlined in PS CUS 051. The facility must develop a review team that completes incident reviews by utilizing the Incident Review form to review the incident in order to identify issues and develop recommendations to assist in reducing incidents of sexual abuse and/or sexual assault in the facility.

Corrective Action Taken: ECCF submitted as evidence amended policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.86(a), which now incorporates all the elements required of subpart (a). Policy further states, "The ECCF Sexual Abuse and Assault Prevention and Intervention Program Coordinator shall, together with upper-level management officials, conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation. The sexual abuse incident review team shall include upper-level management officials, the PREA Coordinator and allows for input from line supervisors, investigators, and medical or mental health practitioners. Where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation." Also submitted was a memo from the Warden outlining the PSA Compliance Manager's responsibilities. The PSA Compliance Manager is responsible for conducting briefings and PREA after-action reviews of PREA cases with administrative personnel, the medical department, and the mental health department. Interviews with the Director of Corrections, and PSA Compliance Manager, stated allegations not determined to be unfounded; the facility prepares a written report recommending whether the allegation or investigation indicates that there may be a need to update policies or practices that could better prevent, detect, or respond to sexual abuse. The Auditor reviewed three completed investigations during the CAP period and reviewed completed after incident reviews for two cases determined not to be unfounded. Both reviews were conducted per policy and the standards requirement. The third case was determined to be unfounded. Although an after-incident review report was not completed or required per the standard, the Auditor reviewed the PREA Event Log and saw where it was reviewed by the PSA Compliance Manager per the standards requirement. The facility has met substantial compliance.

(c) Policy PS CUS 051 outlines the procedures for conducting an annual review of all sexual abuse investigations and resulting incident reviews. The 2018 Annual Review of Sexual Abuse Investigations was completed on July 3, 2019. The PSA Compliance Manager indicated that the annual report would be conducted in the first quarter. The document is in the form of meeting minutes dated July 3, 2019. The minutes included statistical data from 2018. The PSA Compliance Manager indicated that no improvements were needed, even though based on facility determination cameras were needed in two of the dorms. (b) (7)(E) (b) (7)(E) There was no comparison of data from 2017 and 2018 as the presented meeting minutes were the first time an Annual Review was conducted by the facility. The Warden was shown a copy of the meeting minutes for clarification; in his interview he stated he had not seen minutes and could not confirm their accuracy. The Warden had been at the facility for about four months. The 2018 Annual Review of Sexual Abuse Investigations was filed and not forwarded to the ICE FOD and the agency PSA Coordinator.

Does Not Meet: The facility must develop a process to conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. The results and findings of the annual review must be provided to the facility administrator, FOD or his or her designee, and the agency PSA Coordinator. The facility must provide documentation of the process.

Corrective Action Taken: ECCF submitted as evidence amended Policy Sexual Abuse & Assault Prevention & Intervention (PS CUS 051) as evidence to demonstrate compliance with subpart 115.86(c), which incorporates all the elements required of subpart(c). The policy states "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 facility administrator, Field Office Director or designee, and the agency PSA Coordinator." The Auditor conducted interviews with the Director of Corrections and PSA Compliance Manager. Both stated the facility performs an annual review of all sexual abuse investigations and incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts and would complete a negative report if the facility did not have any reports of sexual abuse during the reporting year. They further indicated that the results and findings of the annual review are distributed to the appropriate personnel at the facility, Field Office Director (FOD) or his or her designee, and the agency PSA Coordinator. Interview with SDDO confirmed he receives either hard copies of completed after incident reviews and the facility annual reports while on-site or via email. He further stated he shares this information with his supervisor, ensuring the reports are forwarded to the FOD and agency PREA Coordinator. During the on-site reaudit, the Auditor reviewed the facility's 2019 annual review of sexual abuse investigations results and findings and found that it was completed in accordance with policy and the standards requirement. The 2019 annual report contained the facility's completed Survey of Sexual Victimization, 2019 Local Jail Jurisdictions Summary Form. The facility has met substantial compliance.

AUDITOR CERTIFICATION:

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

Mark Stegemoller June 16, 2021
Auditor's Signature & Date

(b) (6), (b) (7)(C) June 16, 2021
PREA Program Manager's Signature & Date