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

Homeland Security

AUDITOR INFORMATION			
Name of auditor:	Jodi Upshaw	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866-(b) (6), (b)
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	(409) 866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Chicago		
Field Office Director:	Ladeon Francis		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	101 W. Ida B Wells Drive, Suite 4000 Chicago, IL 60605		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Finney County Jail		
Physical address:	304 N. 9Th Street, Garden City, Kansas 67846		
Telephone number:			
Facility type:	Intergovernmental Service Agreement		
PREA Incorporation Date:	7/21/2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	620-272(b) (6), (b) (
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	620-272-(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.

During the audit, the Auditor found the Finney County Jail (FCJ) met 11 standards, had 0 standards that exceeded, 1 standard that was non-applicable, and 29 non-compliant standards. As a result of the facility being out of compliance with 29 standards, the facility entered a 180-day corrective action period which began on August 30, 2023, through February 26, 2024. The purpose of the corrective action plan is for the facility to develop and implement a Corrective Action Plan (CAP) to being these standards into compliance.

On September 29, 2023, the Auditor received notification of the facility's first CAP via email from the Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) and reviewed the submission. Additional documentation and responses were provided by the facility and reviewed by the Auditor on September 27, 2023, October 5, 2023, October 30, 2023, November 2, 2023, November 7, 2023, December 13, 2023, January 17, 2024, January 29, 2024, February 16, 2024, and February 28, 2024. During the final review on February 28, 2024, the Auditor determined that the facility demonstrated compliance with 27 standards found non-compliant at the time of the site review and found 2 standards still non-compliant.

Number of Standards Initially Not Met: 29

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
- §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
- §115.31 - Staff Training
- §115.32 - Other Training
- §115.33 - Detainee Education
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.43 - Protective Custody
- §115.51 - Detainee Reporting
- §115.52 - Grievances
- §115.53 - Detainee access to outside confidential support services
- §115.61 - Staff and Agency Reporting Duties
- §115.64 - Responder 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
- §115.77 - Corrective action for contractors and volunteers
- §115.78 - Disciplinary sanctions for detainees
- §115.81 - Medical and mental health screening; history of sexual abuse
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers

- §115.86 - Sexual abuse incident review

Number of Standards Exceeded: 0

Number of Standards Met: 27

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
- §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
- §115.31 - Staff Training
- §115.32 - Other Training
- §115.33 - Detainee Education
- §115.35 - Specialized training: Medical and mental health care
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- §115.71 - Criminal and administrative investigations
- §115.76 - Disciplinary sanctions for staff
- §115.77 - Corrective action for contractors and volunteers
- §115.78 - Disciplinary sanctions for detainees
- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review

Number of Standards Not Met: 2

- §115.65 - Coordinated Response
- §115.81 - Medical and mental health screening; history of sexual abuse

PROVISIONS

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

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

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

Notes:

(c)(d): FCJ SAAPP mandates, "The Finney County Jail is committed to maintaining a "zero tolerance" toward sexual abuse and sexual harassment." Additionally, the "Finney County Jail will affirmatively act to prevent sexual abuse and assaults on detainees, provide prompt and effective intervention and treatment for victims of sexual abuse and assault, and control, discipline, and prosecute the perpetrators of sexual abuse and assault. The Finney County Jail will appoint an officer to serve as a PREA coordinator. This officer shall address each allegation and refer such allegation to the appropriate authority for investigation." During the onsite tour the Auditor observed the DHS-prescribed sexual assault awareness notice in the ICE processing room and the one open bay/dormitory housing unit in English and Spanish. The Auditor also observed the facility zero-tolerance policy in the facility's detainee handbook. The facility has appointed and employs a PSA Compliance Manger who serves as the facility point of contact for the agency PSA Coordinator. The Auditor reviewed the organizational chart and observed the PSA Compliance Manager reports to the JA and then to the Sheriff. Interview with the PSA Compliance Manager confirms that he is the point of contact for the facility and Agency PSA Coordinator. In addition, the PSA Compliance Manager confirmed he has sufficient time and the authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. Interviews with three random deputies confirmed they were aware of the facility and Agency zero-tolerance policy toward all forms of sexual abuse. The facility provided the Auditor with evidence that the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit dated June 6, 2023. This revision has not been reviewed or approved by the Agency; therefore, the facility is not in compliance with subsection (c) of the standard.

Recommendation: The Auditor recommends that FCJ review the current SAAPP policy for additional edits prior to forwarding to ICE for review and approval. Many areas of the policy do not align with the DHS PREA standards.

Corrective Action:

Does Not Meet (c): A review of FCJ SAAPP dated June 6, 2023, confirms it has not been submitted to the Agency for review and approval. To become compliant, the facility must provide documentation that confirms the facility has submitted FCJ SAAPP dated June 6, 2023, to the Agency for review and approval as required by subsection (c) of the standard.

Corrective Action Taken:

On January 17, 2024, the facility provided an updated FCJ SAAPP that was submitted to the Agency for approval. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates. The Auditor finds that the facility has demonstrated compliance with provision (c) and is now compliant with this standard.

§115.13 - Detainee supervision and monitoring

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

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The facility will provide sufficient staffing to ensure that detainee supervision is performed in a manner that will deter and prevent sexual abuse. The use of electronic monitoring devices will be in place to assist and document events. The Facility is equipped with (b) (7)(E) (b) (7)(E) . The video camera system will be updated on a routine basis." A review of the facility PAQ indicated FCJ has 36 security staff working two 12-hour shifts, 7:00 a.m. – 7:00 p.m. and 7:00 p.m. – 7:00 a.m. during the audit period. During the on-site tour the Auditor observed appropriate staffing levels in the booking area, but when walking throughout the facility noticed staff infrequently. There are a total of (b) (7)(E) located throughout the facility that have pan, zoom and tilt (PTZ) functionality. (b) (7)(E) Interview with the PSA Compliance Manager confirmed the facility does not utilize a staff to detainee ratio. A review of FCJ SAAPP policy confirmed it does not include the requirement that the facility develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs and shall review those guidelines at least annually. The facility does not utilize post orders and did not provide the Auditor with comprehensive detainee supervision guidelines which resulted in non-compliance with provision (b). Interviews with the JA and PSA Compliance Manager further confirmed that when determining adequate levels of detainee supervision and the need for video monitoring, the facility did not take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports and any other relevant factors, including but not limited to length of time detainees spend in agency custody. The facility did not provide documentation to the Auditor to confirm that when determining adequate levels of supervision, or when determining the need for video monitoring in 2022, all factors in subsection (c) of the standard were considered. As a result, the facility is non-compliant with provision (c).

(d): FCJ SAAPP mandates, "Assigned staff are to make security checks of all areas of responsibility on an irregular basis, and unannounced security inspections on all shifts with the goal of deterrence of detainee sexual abuse. Staff are prohibited from alerting others that unannounced security inspections are being conducted." The Auditor reviewed logs (b) (6) for several days. The logs appeared to be a unit log documenting cell checks and activities during the shift. There were no notations in the logs reviewed by the Auditor for any unannounced security inspections; therefore, the facility is non-compliant with provision (d).

Corrective Action:

Does Not Meet (b)(c): The facility did not submit comprehensive detainee supervision guidelines for the Auditor to review. The facility could not provide the Auditor with documentation to confirm the facility considered all elements required by subsection (c) of the standard when determining adequate staffing levels or the need for video monitoring when updated in 2022. To become compliant, the facility must develop and document a staffing plan which takes into consideration all elements required in subsection (c) of the standard. In addition, if applicable, the facility must provide documentation to confirm when determining the need for video monitoring in 2022 all elements required by subsection (c) of the standard were considered.

Does Not Meet (d): There were no notations in the logs reviewed by the Auditor for any unannounced security inspections. To become compliant the facility must implement a procedure of conducting unannounced security inspections for night as well as day shifts and provide the Auditor with documentation that these rounds are occurring as required.

Corrective Action Taken:

On October 30, 2023, the facility submitted a comprehensive detainee supervision guidelines/staffing plan and security logs. The comprehensive detainee supervision guidelines/staffing plan was accepted by the Auditor as demonstration of compliance with provisions (b) and (c). On January 17, 2024, January 29, 2024, February 16, 2024, and February 28, 2024, the facility submitted additional documented security inspection logs to indicate implementation of unannounced security inspections. The Auditor accepted these logs as sufficient evidence to demonstrate substantial compliance with provision (d). The facility is now compliant with this standard.

§115.15 - Limits to cross-gender viewing and searches

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

Notes:

(b)(c)(d): FCJ SAAPP mandates, "Cross-gender pat-down searches shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the search is required or in exigent circumstances. All cross-gender pat-down searches shall be documented." The facility reported that there have not been any cross-gender pat down searches of a detainee conducted during the audit period. The Auditor reviewed a video of a male detainee processed into the facility and observed the pat-down search was not completed until a male staff member was available to conduct the search. Interviews with three deputies confirmed that cross gender pat down searches are not normally conducted due to an adequate ratio of male/female staff members on each shift. All staff confirmed that should a cross gender pat down be conducted it would be documented.

(e)(f): FCJ SAAPP mandates, "Cross-gender strip searches of cross-gender visual body cavity searches shall not be performed except in exigent circumstances, including consideration of officer safety or when performed by medical practitioners following authorization by the Jail Administrator. All cross-gender strip searches or cross-gender visual body cavity searches shall be documented." The Auditor reviewed a Finney County Jail Strip Search Form which requires staff to fill in the name of the detainee, sex, date/time, the name of the staff member, sex of staff member and the result of the search. Interviews with three deputies confirmed that they do not conduct cross-gender strip or visual body cavity searches. Staff further confirmed that should a strip search or visual body cavity search be conducted it would be documented. FCJ does not house juvenile detainees.

(g): FCJ SAAPP mandates, "The Finney County Jail shall ensure that detainees may shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks." During the onsite review the Auditor observed staff of the opposite gender announce their presence upon entry in the housing units. Interviews with three deputies confirmed they are aware of this policy, and all stated they do announce.

(h): FCJ is not designated as a Family Resident Center; therefore, provision (h) is not applicable.

(i): FCJ SAAPP mandates, "Finney County Jail personnel shall not search or physically examine a transgender or intersex detainee solely to determine their genital status or if the genital status is unknown. This may be determined during private conversations with the detainee, by reviewing medical records, or by learning the information as part of a standard medical examination that all detainees undergo as part of intake, or other processing procedure conducted in private by a medical practitioner." Interviews with three deputies confirmed that cross gender strip or body cavity searches or searches to determine the detainee's genital status are not allowed. Interviews with medical confirmed that they have not had an instance of a detainee's gender being unknown, but should this situation arise medical would review medical records or learn the information as part of the intake medical examination.

(j): FCJ SAAPP policy does not reference training requirements for staff. The Auditor reviewed a Pat Down Search Performance Objective form that provides a step-by-step guide in how to conduct a pat-down search. The performance objective does not include procedures for conducting cross-gender pat-down search or searches of transgender and intersex detainees. The performance objective also does not include that pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration for officer safety. Review of 13 staff files confirmed that staff had accomplished the pat-down search performance objective; however, the performance objective is not in compliance with this subsection. The Auditor reviewed an email dated May 25, 2023, that directed staff that "Pat downs and strip searches on Transgender, Intersex, and Cross gender detainees will be conducted in a professional manner and by a staff member with the same genitalia as the detainee." The facility did not provide confirmation that all staff had acknowledged the email. Interview with the TO confirmed that upon hire all new staff would be trained on the email directive.

Corrective Action:

Does Not Meet (j): The performance objective utilized by newly hired staff does not include procedures for conducting cross-gender pat-down search or searches of transgender and intersex detainees and information that pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration for officer safety. To become compliant, the facility must implement training for security staff in the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees and that the searches will be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. The training must be documented and provided to the Auditor for compliance evaluation.

Corrective Action Taken:

On October 30, 2023, the facility submitted a sign in sheet for Cross Gender/Transgender Pat downs and a memorandum from the Jail Administrator with a link to the PREA Resource Centers video on Cross-Gender and Transgender Pat Searches. The Auditor finds that the facility has demonstrated compliance with provision (j) and is now compliant with this standard.

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

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

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility will take appropriate steps 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 and sexual harassment. Such steps shall include providing access to interpreters who can communicate effectively, accurately, and impartially. The facility shall ensure that written materials are provided in formats or through methods that ensure effective communication with the following: Detainees who are deaf or hard of hearing, Those who are blind or have low vison, Those who have intellectual, psychiatric problems, Those with speech disabilities and Those with limited English proficiency." During the onsite audit the Auditor observed the DHS-prescribed sexual assault awareness notice, reporting numbers for the ICE DRIL and the OIG poster in the ICE processing room and the one open bay/dormitory housing unit in English and Spanish. The Auditor requested to review detainee files, but these files are kept electronically and could not be accessed. Interview with one DO confirmed that detainees are shown a PREA orientation video during ICE processing at the facility; however, the video is available in English and Spanish and has just been implemented recently. The DO further confirmed that ICE provides the ICE Detainee Handbook and DHS-prescribed ICE Sexual Abuse Awareness (SAA) information pamphlet to each detainee and detainees are required to sign for receipt of this information in English or Spanish. While onsite the Auditor did

not observe availability of the 14 required languages required for the DHS Handbook: English, Spanish, Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali. The Auditor observed the SAA information pamphlet in the required 15 languages: Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian. Interview with booking/classification staff confirmed that the facility handbook is provided to detainees in English and Spanish only and they were unaware of how to access the additional languages. Interviews further confirmed that staff were not aware of needed resources or how to access resources to accommodate a detainee with a sight, hearing, psychiatric, learning disability or interpretation or translation of a language other than English or Spanish when providing PREA related information. The Auditor observed the ERO Language Services poster in the booking area, although staff stated they had not utilized this resource. Interviews with three deputies confirmed that staff would not utilize another detainee to provide interpretation for another detainee pertaining to allegations of sexual abuse.

Corrective Action:

Does Not Meet (a)(b)(c): In an interview with a DO it was confirmed that the Agency (ERO) provides the detainees with the DHS-prescribed SAA Information pamphlet, and the ICE National Detainee Handbook only in English and in Spanish. Interviews with booking staff confirmed the facility provides the detainee with a facility handbook only in English and Spanish. Booking staff further confirmed that they have not used the language line to interpret PREA related information for any detainee. To become compliant the facility must develop a practice that provides all detainees access and equal opportunity to the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The facility must identify available resources to provide the information contained in the facility handbook to detainees who are blind or have limited sight, are deaf or hard of hearing, and for those who have an intellectual, psychiatric, or speech disability, or limited English proficient (LEP) can utilize. In addition, the facility must have available, either in printed copy or electronic for printing, the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) for distribution to detainees. The facility must also train staff on the use of a designated language interpretation service, have information readily accessible to booking and floor staff and provide documentation the procedure has been implemented and training of appropriate staff. In addition, the facility must submit to the Auditor documentation for 10 detainees received during the CAP period who speak languages other than English or Spanish to confirm the new procedure has been implemented. If applicable, the submitted files should include a sampling of detainees who are LEP, deaf or hard of hearing, blind or have limited sight, or may have intellectual, psychiatric, or a speech disability.

Corrective Action Taken:

On October 30, 2023, the facility submitted an email to staff with the following posters attached: ICE Cognitive Impairments and Effective Communication, I Speak Language Identification Guide, ICE Detainee Notice of Language Services and the ICE ERO Language Services resource flyer. The facility additionally submitted pictures of these posters within the booking area. On November 7, 2023, the Auditor reviewed policy language for compliance and found the proposed changes acceptable. On January 17, 2024, the facility submitted an updated FCJ SAAPP for Auditor review. On January 29, 2024, the facility submitted updated FCJ SAAPP with dates adjusted and a memorandum that stated FCJ has not received any detainees who speak a language other than English or Spanish. The Auditor accepted the proposed corrective action; however, the standard remained non-compliant through the remainder of the CAP period to allow the facility to demonstrate the new procedure has been implemented. On February 16, 2024, the facility submitted the FCJ Accommodating Detainees with Disabilities/Limited English Proficient Addendum. The facility additionally submitted an email sent to all jail staff with instructions to read several policies, the FCJ Addendum Policy memo and the FCJ SAAPP with corrected date. The email further instructed staff to sign, date and return the email to the PSA Compliance Manager after the policies were read. The Auditor was additionally provided with ICE review and approval of

the updated policies. On February 28, 2024, the facility submitted an email sent to all jail staff with FCJ SAAPP and PREA medical, volunteer and contractor training, a training sign-in sheet and a memorandum that FCJ has not had an incidents or reports of sexual abuse during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b) and (c) and is now compliant with this standard.

§115.17 - Hiring and promotion decisions

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

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent- or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." FCJ SAAPP mandates, "The Facility will not hire or promote anyone who may have contact with detainees, and will not enlist the services of any contractor who may have contact with detainees, Who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or; Who has been 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 consent or refuse; All new staff will be asked if there has ever been an allegation of PREA made against them. If a substantiated allegation is discovered or if the potential employee resigned during a pending investigation of alleged sexual abuse, prior institutional employers will be contacted to determine if the potential employee was either civilly or administratively adjudicated to have engaged in the activity described above; The facility will document the asking of PREA questions and include this fact in the personnel file of newly hired staff; Material omissions or materially false information will be grounds for termination or withdrawal of an offer of employment; Staff have a continuing affirmative duty to report any misconduct involving sexual abuse." A review of 13 FCJ staff files confirmed that initial background checks were conducted on all staff prior to hire. All staff files contained a continuing affirmative duty to report statement, but based on the dates signed and interviews, this procedure was implemented only a month prior to the onsite audit; additionally, there was no indicating the misconduct questions are being asked during interviews, prior to promotion, and during annual written reviews. A review of new applicant's personal history statement contains a statement that material omissions regarding such misconduct or the provision of materially false information would be grounds for termination or withdrawal of an employment offer. Interview with the HR representative confirmed background checks are completed on all applicants prior to hire. There was no evidence to indicate that the facility contacts prior institutional employers of an applicant for employment to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. The interview also indicated that should a facility contact FCJ for information regarding a former employee, the information would be given based on the current laws of Kansas which is by written request. There were no contractor or volunteer files available for the Auditor to review to confirm if proper screenings for prior criminal conduct were conducted. The PSO confirmed that background investigations for four ICE employees requested by the Auditor are current.

Corrective Action:

Does Not Meet (a)(b)(c)(d)(e): The facility does not have in place a requirement to ask applicants about prior misconduct outlined in provision (a). The facility has no documentation indicating that criminal history background checks are conducted on contractors prior to enlisting their services. The facility has no documentation indicating that proper screenings for volunteers are being conducted. The facility did not impose upon staff a continuing affirmative duty to disclose sexual misconduct during the audit period. To become compliant, the facility must provide the Auditor documentation for eight newly hired employees and two promoted employees that includes evidence of background checks; evidence that the misconduct questions have been asked; notification to employees of the continuing affirmative duty to report sexual misconduct; and evidence to confirm that the facility contacted prior institutional employers to obtain information regarding sexual misconduct or resignations during a sexual abuse investigation. The facility must provide the Auditor with documentation for two contractors indicating a background investigation has been conducted in accordance with provision (d). The facility must also provide documentation for two volunteers to provide evidence that the facility did not enlist the services of any volunteer who may have continuing contact with detainees who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997), who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity.

Corrective Action Taken:

On October 30, 2023, the facility submitted a PREA Employment Questionnaire that new hires must complete regarding prior misconduct outlined in provision (a). On January 17, 2024, the facility submitted an updated FCJ SAAPP for Auditor review. On January 29, 2024, the facility submitted a memorandum that stated FCJ has only had six new hires and no new contractors, volunteers, or promotions. The facility additionally submitted signed PREA Employment Questionnaires for six staff hired during the CAP period. The Auditor found partial compliance with the submitted documents; however, left the standard open for the remainder of the CAP period for the facility to submit documentation showing additional new hires or staff promoted have had completed background checks, evidence that the misconduct questions have been asked, notification to employees of the continuing affirmative duty to report sexual misconduct, and evidence to confirm that the facility contacted prior institutional employers to obtain information regarding sexual misconduct or resignations during a sexual abuse investigation. On February 28, 2024, the facility submitted a memorandum that FCJ has not had any contractors or volunteers hired or promoted during the CAP period or any additional new hires or staff promoted during the CAP period. The previous six new hire documentation is accepted as compliance that new hires or staff promoted have had completed background checks, evidence that the misconduct questions have been asked, notification to employees of the continuing affirmative duty to report sexual misconduct, and evidence to confirm that the facility contacted prior institutional employers to obtain information regarding sexual misconduct or resignations during a sexual abuse investigation. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b), (c), (d), and (e) and is now compliant with this standard.

§115.21 - Evidence protocols and forensic medical examinations

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

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per policy 11062.2, when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement

agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." FCJ SAAPP mandates, "The Facility is responsible for investigating allegations of sexual abuse and shall follow a uniform evidence protocol. All clothing and bedding will be collected. These items will be placed in a paper evidence bag and labeled according to procedure; All evidence will be turned over to the Investigator; Victim will be scheduled for an examination and/or treatment as necessary; The facility shall offer all detainees who experience sexual abuse access to forensic medical examinations with the victim's consent and without cost to the detainee and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Examinations shall be performed by a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forensic Examiner (SAFE) or a qualified medical practitioner if SANE or SAFE is not available; and The Facility shall develop a protocol, in conjunction with DHS on how best to utilize community resources and services to make available valuable expertise and support in the areas of a crisis intervention and victim advocacy." FCJ is utilizing the facility SAAPI policy for a uniform evidence protocol. A review of this policy confirms it has not been developed, reviewed, or approved in coordination with DHS. The Auditor reviewed an email between FCJ and Family Crisis Services, Inc, which stated in part that Family Crisis Services works with the FCSO to provide advocacy services to victims of sexual violence. Family Crisis Services additionally provides a 24-hour crisis line, referrals, and advocates. During the onsite the Auditor observed the Family Crisis Services telephone number and address posted in the open bay/dormitory housing unit. Interviews with the PSA Compliance Manager and medical staff confirmed that should a detainee require medical services they would be transported to St. Catherines Hospital for a SAFE/SANE examination where services would be provided at no cost to the detainee. The Auditor contacted Family Crisis Services and confirmed this organization would provide expertise and support in the areas of crisis intervention, counseling, information, and referrals as needed for a detainee. The Auditor additionally contacted an emergency room nurse at St. Catherines who confirmed that SANE/SAFE examinations would be conducted at the hospital. There were no allegations of sexual abuse reported at FCJ during the audit period. FCJ does not house juvenile detainees.

(e): FCJ SAAPP mandates, "Any outside investigating agency tasked with investigating allegations of sexual assault will follow all requirements of standard 115.21." Interview with the facility Investigator confirmed that he is an employee of FCSO and is responsible for conducting administrative sexual abuse investigations. Should the case be referred for criminal prosecution, the FCSO would investigation the case. He confirmed that both entities are part of the same agency; and therefore, are required to follow the requirements of subsection (a – d) of the standard.

Corrective Action:

Does Not Meet (a): A review of FCJ SAAPP confirms that the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit dated June 6, 2023, and has not submitted to the Agency for review and approval. Interview with the PSA Compliance Manager could not confirm FCJ SAAPP was developed in coordination with DHS. To become compliant, the facility must submit FCJ SAAPP dated June 6, 2023, to the Agency for review, coordination, and approval and submit documentation to the Auditor for compliance review.

Corrective Action Taken:

On January 17, 2024, the facility submitted an updated FCJ SAAPP that was submitted to the Agency for approval. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates. The Auditor finds that the facility has demonstrated compliance with provision (a) and is now compliant with this standard.

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

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

Notes:

(a)(b)(c)(d)(e)(f): The Agency provided policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary. b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." FCJ SAAPP states in part that the Facility shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Policy further mandates, "Retention of such reports will be for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. When a detainee(s) is alleged to be perpetrator, it is the facility administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to ICE. When an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the following shall be notified immediately: the Facility Administrator; the Finney County Sheriff; and the respective Field Office Director. The Field Office Director shall notify: The Deputy Assistant Director, Detention Management Division, The ICE office of Professional Responsibility (OPR). OPR will refer to the matter to the DHS Office of the Inspector General (OIG). The facility administrator or Field Office Director shall also refer the matter to the FBI (or other appropriate law enforcement agency)." The Auditor reviewed the facility website https://wwwfinneycounty.org and confirmed the FCJ SAAPP evidence protocol is not posted resulting in non-compliance with provision (c). The Auditor reviewed a memorandum that stated should the FCSO investigate the case and the investigation would fall into compliance with section 115.21 a-d of the SAAPI policy. Interviews with the JA, PSA Compliance Manager and Investigator confirmed the facility would investigate all allegations of sexual abuse and that FCJ would conduct an administrative investigation unless it was criminal or involved a staff member. Should a staff member be involved in an investigation the FCSO would investigate. The Auditor confirmed through interviews that appropriate notifications would be made to ICE and investigative authorities and ICE would make the appropriate notifications to the Joint Intake Center, the ICE Office of Professional responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director for an alleged detainee or staff perpetrator of detainee sexual abuse. Interview with the PSA Compliance Manager further confirmed sexual abuse records would be kept in his office in a locked cabinet, which the Auditor observed. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

Does Not Meet (c): The Auditor reviewed the facility website https://wwwfinneycounty.org and confirmed facility protocol is not posted on its website or otherwise made available to the public as required by subsection (c) of the standard. To become compliant the facility must post facility protocols to its website or otherwise make the protocol available to the public. To become compliant, the facility must ensure that facility protocols are made available to the public and provide documentation to the Auditor.

Corrective Action Taken:

On November 2, 2023, the facility submitted a link to the Finney County Jail PREA website. The website provides the public with the protocols required of provision (c) of this standard. The Auditor finds that the facility has demonstrated compliance with provision (c) and is now compliant with this standard.

§115.31 - Staff Training

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

Notes:

(a)(b)(c): The Auditor reviewed FCJ SAAPP and it does not specifically address training requirements of staff who may have contact with detainees. The facility provided and the Auditor reviewed a New Jail Deputy Orientation checklist, one acknowledgement example that where a staff member had read the Finney County Jail/ICE Detainee Sexual Abuse and Assault Prevention Policy revised on April 11, 2023, and the ICE Prison Rape Elimination Act (PREA) Training for Contractors and Volunteers. Interview with the TO indicated that staff were trained just recently; however, sufficient documentation could not be provided. The interview with the TO further confirmed that new staff would be trained on the new FCJ SAAPP policy. Interviews with four staff confirmed that PREA training was completed within the last three months and had received no training prior. The Auditor reviewed 13 staff files and confirmed staff training was accomplished within three months of the onsite and consisted of a signed acknowledgement form of the FCJ SAAPP. However, the training curriculum submitted does not align with the information stated on the training records and the Auditor found this insufficient to confirm that staff had received training on the topics outlined in provisions (a). The facility has not demonstrated compliance with staff training requirements.

Corrective Action:

Does Not Meet (a)(b)(c): Training records reviewed indicated staff had recently been trained; however, the training records did not align with the curriculum provided and the Auditor was unable to confirm that all topics required of provision (a) were covered in the training. To become compliant, the facility must implement a training curriculum that includes all elements required of this standard and provided to the Auditor for compliance review. After implementation, documentation must be provided that all staff have received this training. Additionally, the facility must implement procedures to ensure that all newly hired staff receive this training and that all existing staff receive refresher training at least every two years.

Corrective Action Taken:

On October 30, 2023, the facility submitted the ICE Prison Rape Elimination Act (PREA) training slides for Contractors and Volunteers and annual PREA training slides which complies with provision (a) of the standard. On January 17, 2024, the facility submitted updated FCJ SAAPP for review. On February 16, 2024, the facility submitted an email sent to all jail staff with instructions to read several policies, the FCJ Addendum Policy memo and the FCJ SAAPP with corrected date. The email further instructed staff to sign, date and return the email to the PSA Compliance Manager after the policies were read. On February 28, 2024, the facility submitted an email sent to all jail staff with instructions to review all attachments provided and a link to the training. The facility submitted a training roster, PREA training for medical, PREA training for contractors and volunteers, the FCJ policy addendum, and FCJ SAAPP confirming through signature that jail staff has completed the identified training. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b) and (c) and is now compliant with this standard.

§115.32 - Other Training

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

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility shall ensure that all volunteers and contractors who have contact with detainees have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection and response policies and procedures, volunteers will have a background check to insure no sexual misconduct." Interview with the TO confirmed that all volunteers and contractors who have contact with detainees are not trained. Interview with the PSA Compliance Manager also confirmed that contractors may have contact with detainees have not been trained according to the requirements of this standard.

Corrective Action:

Does Not Meet (a)(b)(c): The facility has not demonstrated that volunteers and other contractors have been trained on their responsibilities under the agency's and facility's sexual abuse prevention, detection, intervention and response policies and procedures. To become compliant the facility must develop procedures to ensure all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the agency's and facility's sexual abuse prevention, detection, intervention and response policies and procedures. Once developed and implemented, the facility must provide documentation of these procedures and evidence for two other contractors and two volunteers to indicate they have received the required training.

Corrective Action Taken:

On October 30, 2023, facility submitted the ICE Prison Rape Elimination Act (PREA) training slides for Contractors and Volunteers. On January 17, 2024, the facility submitted the updated FCJ SAAPP for the Auditor to review. On January 29, 2024, the facility submitted an email to contractors and staff with the ICE PREA Contractor and Volunteer training attached, updated FCJ SAAPP with adjusted dates, confirmation emails from contractors and volunteers that the email was received and a PREA Employee training outline from the PREA Resource Center. The Auditor accepts the training as compliant; however, left the standard open for the reminder of the CAP period for the facility to submit additional training documentation of contractor and volunteer new hires through the CAP period. On February 28, 2024, the facility submitted a memorandum that stated FCJ has not had any additional contractors or volunteers hired during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b) and (c) through policy revision and training and is now compliant with this standard.

§115.33 - Detainee Education

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

Notes:

(a)(b)(c)(d)(e)(f): FCJ SAAPP mandates, "During the intake Transactions detainees shall receive information explaining the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse and sexual harassment. The detainee receives information regarding the "zero tolerance" during the detainee screening process in booking. In cases of limited English proficiency (LEP) or hearing impairment, information on SAAPI will be provided, when possible, in a language or manner understood by the detainee. PREA statements and posters are placed in detainees living area. Detainees will be educated on prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings. Detainees will be educated on the right to receive treatment and counseling if subjected to sexual abuse. Detainees will be educated about self-protection and indicators of sexual abuse and definitions and examples of detainee sexual abuse, staff on detainee sexual abuse and coercive sexual activity. Detainees will also be educated on the prevention and intervention strategies. Detainees will be educated on the methods of reporting sexual abuse, including any staff member, including a staff member other than an immediate point-of-contact line officer, the DHS Office of Inspector General, and the Joint Intact Center. All detainees must sign in and acknowledge they understand the policy prior to their assignment to be a cell/pod." The intake process at FCJ consists of detainee education in the form of a PREA video watched in the ICE processing room and ICE staff presenting the detainee with the ICE National

Detainee Handbook. The facility further provides the FCJ facility handbook to detainees. The materials are presented in English or Spanish only. FCJ provided and the Auditor reviewed five signed orientation acknowledgement forms indicating that the detainees had received the SAAPI pamphlet in English or Spanish. These forms were not dated; therefore, the Auditor was unable to confirm that this information was provided during the intake process. The Auditor also reviewed a Finney County Jail/ICE Detainee SAAPI Orientation form signed by the detainees indicating they had viewed the orientation video and received the PREA/SAPPI brochure. The Auditor requested documentation for additional detainees while onsite, but the PSA Compliance Manager advised the Auditor that these electronic documents could not be accessed. During the onsite the Auditor observed the DHS-prescribed sexual assault awareness notice, the name of facility PSA Compliance Manager and a poster for Family Crisis Services in the housing unit. Should a detainee have hearing, visual, limited reading skills, psychiatric or learning disabilities interviews with staff confirmed they would speak slower or louder, be patient or use google translate, but were unaware of the resources available to accommodate a detainee with a sight, hearing, psychiatric, learning disability or interpretation or translation of a language other than English or Spanish.

Corrective Action:

Does Not Meet (a)(b)(c)(d)(e)(f): FCJ does not provide an adequate orientation program to detainees. ICE presents the detainee with the ICE Detainee National Handbook, SAAPI information pamphlet and a PREA video. The facility only provides the detainee with a facility handbook which does not include: information about the agency's and facility's zero-tolerance policies for all forms of sexual abuse and provides instruction on: prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of-contact line officer(e.g., the compliance manager or a mental health specialist), the DHS Office of Inspector General, and the Joint Intake Center; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The facility does not provide the detainee notification, orientation, and instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The facility was not able to access electronic detainee records for the Auditor to review. In order to become compliant, the facility must provide an orientation program to the Auditor that notifies the detainee about the agency's and facility's zero-tolerance policies for all forms of sexual abuse and provides instruction on: prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of-contact line officer(e.g., the compliance manager or a mental health specialist), the DHS Office of Inspector General, and the Joint Intake Center; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. In order to become compliant with subsection (b) of this standard, documentation must be provided that the orientation program is in formats accessible to detainees that are deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills. The facility must also provide documentation that it has the capability to educate detainees in other languages besides English and Spanish. In order to become compliant with subsection (c) of this standard, the facility must provide documentation that detainees have participated in the orientation process and be able to access electronic documentation in the detainee file. In order to become compliant with subsections (e) and (f), the facility must have the DHS-prescribed Sexual Assault Awareness Notice and the DHS detainee handbook available in a language that easily understood to the detainee. The facility should provide additional documentation the DHS-

prescribed Sexual Assault Awareness Information pamphlet can be provided to detainees in all 14 languages and the DHS detainee handbook is provided and received by all detainees in all 15 of the required languages.

Corrective Action Taken:

On December 13, 2023, the facility submitted a Finney County Detention Facility Orientation and a blank detainee Certification of Receipt of PREA Orientation form in English and Spanish. On January 17, 2024, the facility submitted a FCJ Inmate Handbook in English with a revision date of 03/28/2023, a FCJ facility PREA orientation packet with acknowledgement pages in English and Spanish and an updated FCJ SAAPP. On January 29, 2024, the facility submitted an email to staff with instruction that the orientation and receipt form would be given with the detainee handbook at intake in a manner detainees understand which would then be signed by the detainee. The facility additionally provided read receipts for the email, a blank Finney County Jail Orientation packet, a detainee file showing the signed acknowledgement of PREA orientation, detainee acknowledgement of viewing the orientation video and receiving the PREA SAAPI brochure. The facility also provided evidence they have the DHS-prescribed SAAPI pamphlet in 15 languages and the 2023 ICE National Detainee Handbook in 14 languages available for distribution to detainees. On February 16, 2024, the facility submitted the FCJ Accommodating Detainees with Disabilities/Limited English Proficient Addendum. The facility additionally submitted an email sent to all jail staff with instructions to read several policies, the FCJ Addendum Policy memo and the FCJ SAAPP with the corrected date. The email further instructed staff to sign, date and return the email to the PSA Compliance Manager after the policies were read. The facility provided four Certification of Receipt of PREA Orientation Acknowledgement forms, of which three were for Spanish speaking detainees. On February 28, 2024, the facility submitted a training sign-in sheet of staff acknowledging training on PREA contractor, volunteer, and medical training, updated FCJ SAAPP and the FCJ policy addendum which included the Accommodating Detainees with Disabilities/LEP Addendum. Additionally, the facility provided a memorandum from the Jail Administrator attesting Finney County Jail has had no detainees that are deaf, visually impaired, or otherwise disabled during the CAP period; therefore, the facility has demonstrated compliance through policy updates, staff training, and file documentation for four detainees. The FCJ policy addendum has addressed a procedure implemented for detainee orientation for those that are deaf, visually impaired, or otherwise disabled as well as to detainees who have limited reading skills. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b), (c), (d), (e) and (f) and is now compliant with this standard.

§115.35 - Specialized training: Medical and mental health care

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

Notes:

(a): The facility does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners, and therefore, this element of the standard is not applicable.

(b)(c): FCJ SAAPP mandates, "The Facility shall ensure that all full and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and How and to who, to report allegations or suspicions of sexual abuse and sexual harassment." The Auditor reviewed completed ACH training courses for the medical nurse. The course is listed as "Annual Training PREA" and not listed as the specialized medical and mental health care training required of the standard. Interview with the medical nurse confirmed that annual training has been completed, but not the specialized training. Interview with the Mental Health Practitioner confirmed that they had only been hired two weeks ago and have not completed the required training. The Auditor was not provided with training records or curriculum or a lesson plan for the required medical and mental health specialized training for review to confirm medical and mental health have been trained on how to detect and assess signs of sexual abuse, how to respond effectively and professionally to victims of

sexual abuse, how and to whom to report allegations or suspicions of sexual abuse and how to preserve physical evidence of sexual abuse. Medical staff employed by FCJ do not conduct medical forensic examinations. A review of FCJ SAAPP dated June 6, 2023, confirmed it has not been submitted to the Agency for review and approval.

Corrective Action:

Does Not Meet (b)(c): The facility did not provide training records or curriculum for the medical and mental health specialized training to confirm the contract medical and mental health staff have been trained and that the training includes all required elements of subsection (b) of the standard. In addition, the facility did not provide medical and mental health staff training records or course completion certificates to confirm specialized training has been received. Additionally, the facility has not submitted their FCJ SAAPP policy dated June 6, 2023, to the Agency for review and approval. To become compliant the facility must submit a copy of the specialized training curriculum utilized for medical and mental health staff, documentation that all medical and mental health staff have received the required specialized training; and evidence that the FCJ SAAPP has been submitted to the Agency for review and approval.

Corrective Action Taken:

On October 30, 2023, the facility submitted PREA Specialized Training slides which complies with subsection (b) of the standard. The facility additionally submitted two medical staff training records. On January 17, 2024, the facility submitted an updated FCJ SAAPP that was submitted to the Agency for approval. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates. On February 16, 2024, the facility provided an email to mental health staff with instruction for staff to complete four provided YouTube training links, sign the email and return after completion. The facility provided documentation staff signed and returned the email on February 9, 2024. The facility additionally provided the specific links to the four National PREA Resource Center learning modules for the Auditor's review. The Auditor finds the facility has demonstrated compliance with provisions (b) and (c) and is now compliant with this standard.

§115.41 - Assessment for risk of victimization and abusiveness

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

Notes:

(a)(b)(c)(d)(e)(f)(g): FCJ SAAPP mandates, "All Detainees shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other detainees or sexually abusive toward other detainees. During intake the detainee shall be classified within 12 hours of the admission into the facility utilizing several factors including criminal history, perpetrator history, victimization history and special vulnerabilities including LGBTQI+. The facility will reassess the risk of sexual victimization or abusiveness of an at-risk detainee every 90 days." Interview with Booking/Classification staff confirm that detainees are held separately in the booking area until classified and this process is completed within 12 hours of entering the facility. The Auditor was provided a PREA Risk of Victimization Assessment tool the facility had recently started to utilize. Review of this form confirms the questions only apply to victimization and do not adequately assess a detainee for risk of abusiveness. Further interview with the Booking/Classification staff confirmed that reassessment is not completed at the 60-to-90-day requirement or at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. Additionally, interviews with staff confirmed there is no control over information contained in the detainee electronic file and any staff can access the information. The Auditor requested to observe electronic detainee files to review screening documents, but the PSA Compliance Manager advised the electronic files could not be accessed. There were no detainees housed at the facility during the onsite audit.

Corrective Action:

Does Not Meet (a)(c)(d)(e)(g): The facility just recently started to utilize the PREA Risk of Victimization Assessment and does not have a risk assessment tool to assess detainees for risk of abusiveness, therefore the facility is not compliant with all elements of this standard. To become compliant, the facility must implement a risk assessment tool that will assess detainees upon intake to identify those likely to be sexual aggressors or sexual abuse victims so they can be housed accordingly. This assessment tool must meet all elements of subsection (c) and (d) of this standard and be provided within twelve hours of admission to FCJ. The facility must provide the developed assessment to the Auditor with documentation that it is being utilized. Once the facility has developed the assessment tool, they must provide documentation that the assessment is being utilized for intake and reassessments at the 60-to-90-day initial assessment as needed. Documentation must be provided to the Auditor for 10 detainee intakes during the CAP period. The facility must train appropriate staff on the requirements under this subsection and provide documentation that training has been completed. The facility must provide documentation that appropriate controls on the dissemination of sensitive information is not exploited to the detainee's detriment by staff or other detainees of the developed assessment.

Corrective Action Taken:

On October 30, 2023, the facility submitted a Prison Rape Elimination Act (PREA) Screening for Risk of Sexual Victimization and Abusiveness form and a POST PREA Incident Reassessment for review. Both assessments comply with subsection (c) of this standard. On January 17, 2024, the facility submitted an updated FCJ SAAPP for review. On January 29, 2024, the facility submitted a PREA Risk of Victimization Assessment tool training roster with staff signatures, a memorandum that the facility is a 72 hour holding facility and 60 - 90-day reassessments have not occurred during the audit period and an email to staff with an assessment attached stating the assessment will be used at intake, 60 - 90 days after intake or anytime when warranted based on receipt of additional relevant information or following an incident of abuse or victimization. On February 16, 2024, the facility provided four detainee assessments, an email to all jail staff and staff read receipts for the email. On February 28, 2024, the facility submitted a memorandum that they have not had any detainees housed at FCJ for more than 60 days; therefore, there have been no 60 – 90-day reassessments conducted and had no instances of sexual abuse reported. Also on February 28, 2024, the facility submitted two additional detainee screenings for risk of sexual victimization and abusiveness. The facility also provided a memorandum stating detention files are maintained and secured electronically and that only the Jail Lieutenant and the Captain of the Sheriff's Office has access to detainee risk assessments. The Auditor finds that the facility has demonstrated compliance with provisions (a), (c), (d), (e) and (g) and is now compliant with this standard.

§115.42 - Use of assessment information

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

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility shall use information from the risk screening to inform housing, bed, education, and program assignments with the goal of keeping separate those detainees at high risk of being sexually victimized from those at high risk of being sexually abusive. Transgender and intersex detainees shall have an opportunity to shower separately from other detainees." The facility does not have a viable risk assessment tool required under standard 115.41 and subsequently will be not compliant with subsection (a) of this standard. In an interview with Booking/Classification staff it was confirmed that medical or mental health personnel are not consulted prior to making housing decisions for a transgender or intersex detainee. Interviews with booking/classification staff also confirmed that housing decisions would be made based on security and not a detainee's gender self-identification or an assessment of the effects of placement on the detainee's health and safety which is also not in compliance with this standard. Interviews with the JA, PSA Compliance Manager and three random staff confirm that a transgender or intersex detainee has not been housed at the facility during the audit period. Staff confirmed that a transgender or intersex detainee would be able to shower separately.

Corrective Action:

Does Not Meet (a)(b): The facility does not have a viable risk assessment required under standard 115.41 and subsequently will be not compliant with subsection (a) of this standard. To become compliant, the facility must provide documentation that a risk assessment developed under standard 115.41 is utilized to make individualized determinations about how to ensure the safety of each detainee. Once implemented the facility must train all booking, classification, medical and mental health staff on both new practices and provide training documentation to the Auditor. The facility must submit to the Auditor 10 detainee files to confirm that the new practice has been implemented. If applicable, the facility must submit to the Auditor any detainee files that include detainees who are transgender or intersex to confirm the facility considered the detainee's gender self-identification when making assessment and housing decisions for a transgender or intersex detainee and reassessed a transgender or intersex detainee's placement and programming at least twice each year to review any threats to safety experienced by the detainee.

Corrective Action Taken:

On January 17, 2024, the facility submitted the updated FCJ SAAPP, a blank screening for risk of sexual victimization and abusiveness form and a blank post PREA incident assessment for Auditor review. On January 29, 2024, the facility submitted a detainee risk assessment, memorandum that stated there has not been a transgender or intersex ICE detainee housed at FCJ, blank risk assessment and blank post assessment forms. On February 16, 2024, the facility submitted four detainee risk assessments. On February 28, 2024, the facility submitted two additional detainee screenings for risk of sexual victimization and abusiveness and a memorandum that stated FCJ has not had a transgender or intersex detainee housed at the facility during the CAP period. FCJ created a viable assessment required under standard 115.41 and has trained appropriate staff on how to use the assessment to determine housing, recreation, other activities and voluntary work. Review of the provided risk assessments confirm the facility has adequately assessed detainees for safety and has housed them accordingly. The Auditor finds that the facility has demonstrated substantial compliance with provisions (a) and (b) and is now compliant with this standard.

§115.43 - Protective Custody

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

Notes:

(a)(b)(c)(d)(e): FCJ SAAPP mandates, "Detainees at high risk for sexual victimization shall not automatically be place in involuntary segregated housing unless an assessment of all available alternatives had been made. Detainees at high risk for sexual victimization may be placed in involuntary segregated housing if an assessment of all available alternatives indicates there is no available alternatives means of separation from likely abusers. Any use of segregated housing to protect a detainee who has allegedly suffered from sexual abuse shall be subject to the requirements listed herein." A review of FCJ SAAPP confirms it does not require a supervisory staff member to conduct a review after a detainee has spent seven days in administrative segregation and every week thereafter, for the first 30 days, and every 10 days thereafter, or the requirement to notify the appropriate ICE FOD no later than 72 hours after the initial placement into segregation whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Review of FCJ SAAPP also confirms there is no provision to provide detainees access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable. In addition, a review of FCJ SAAPP confirmed it has not been developed in consultation with the ICE ERO FOD having jurisdiction for the facility. The facility provided an ICE Administrative Segregation Order for the Auditor to review. This form has areas for the reason for placement and a brief outline of circumstances for the placement. The Auditor also reviewed a Protective Custody Request form in which a detainee could request protective custody. This form gives notification to the detainee they would be placed on a 23/1 lockdown status and their placement would not be completed until after 10 days even if they requested removal prior to the 10-day requirement. Interview with

the JA and PSA Compliance Manager confirms that the facility previously had not utilized the ICE Administrative Segregation Order. As a result, the facility is non-compliant with the requirements of (a)(d)(e). There were no allegations of sexual abuse at FCJ during the audit period.

Corrective Action:

Does Not Meet (a)(b)(c)(d)(e): A review of FCJ SAAPP confirms it does not require a supervisory staff member to a review after the detainee has spent seven days in administrative segregation and every week thereafter, for the first 30 days, and every 10 days thereafter, or the requirement to notify the appropriate ICE FOD no later than 72 hours after the initial placement into segregation whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Additionally, the policy does not require that an assignment to administrative segregation for this purpose should not ordinarily exceed 30 days. The FJC SAAPP included no provision to provide detainees access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable. To become compliant the facility must update their written procedures (FCJ SAAPP) to include all elements of the standard and these procedures must be developed in consultation with the ICE ERO FOD having jurisdiction of the facility. The revised written procedures must be provided to the Auditor for compliance review along with evidence that these procedures were developed in consultation with the ICE ERO FOD. Once updated, the facility must submit documented training for all applicable staff on the updated policy. If applicable, the facility must submit to the Auditor documentation for any detainee who is placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault during the CAP period for compliance review.

Corrective Action Taken:

On November 8, 2023, the facility submitted proposed FCJ SAAPP policy language for inclusion in the facility SAAPP policy. On January 17, 2024, the facility submitted the updated FCJ SAAPP submitted to the Agency for approval. On January 29, 2024, the facility submitted an updated FCJ SAAPP with dates adjusted, an email to staff with the updated SAAPP attached and read receipts from staff. On February 28, 2024, the facility submitted memorandums which stated there has not been any incident of sexual abuse or assault or any detainees placed in protective custody due to vulnerability to a sexual abuse or assault. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b), (c), (d) and (e) through policy updates and staff training and is now compliant with this standard.

§115.51 - Detainee Reporting

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

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility shall provide multiple internal ways for detainees to privately report sexual abuse and sexual harassment or violation of those responsible for such incidents. Detainees may report sexual abuse and sexual harassment by using the Inmate Communications Form (ICF) to report to the Administration staff or externally mailing to family member who can contact the Jail Administrator. Detainees can report sexual abuse and sexual harassment directly to detention and/or medical staff. Detainees have access to phone and any contact a family member to have them report the allegation to the Jail Administration. The facility shall provide detainees with access to outside victim advocates for emotional support services related to sexual abuse. Detainees shall be provided multiple ways to privately report retaliation for reporting sexual abuse, staff neglect or violations of responsibilities that may have contributed to an incident of sexual abuse. Facility staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document verbal reports. The facility has established a method to receive third-party reports of sexual abuse in its facility and makes it available to the public on how to report sexual abuse on behalf of a detainee." During the onsite audit the Auditor observed the DHS-prescribed sexual assault awareness notice, the DHS OIG poster and DRIL poster displayed in the open bay/dormitory housing unit. The Auditor also observed posters within the

housing unit for Family Crisis Services. During the onsite the Auditor attempted to make a telephone call to the DHS OIG through a detainee telephone in the housing unit. The telephone number dialed would not connect and the Auditor was not able to complete the call. Interviews with three random staff confirmed that they would accept verbal reports, it would be reported to supervision, and they would be documented immediately.

Corrective Action:

Does Not meet (b): The facility provides information of one way to report a sexual abuse to a public or private entity that is not part of the agency and allows the detainee to remain anonymous if requested via the DHS OIG. These informational posters were observed in the detainee housing unit; however, during the audit, a call could not be completed through this method from the detainee phones. To become compliant, the facility must provide the Auditor with documentation of at least one method detainees can report sexual abuse to a public or private entity or office that is not part of the agency, and that they are able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous upon request. Evidence of a successful test call completion must be submitted for compliance review.

Corrective Action Taken:

On December 13, 2023, the facility submitted an email from ICE staff that confirmed a telephone call to the OIG was successfully made utilizing the jail call system from a detention cell. The Auditor finds that the facility has demonstrated compliance with provision (b) and is now compliant with the standard.

§115.52 - Grievances

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

Notes:

(a)(b)(c)(d)(e)(f): FCJ 606 Inmate Grievances mandates, "All inmates shall be provided with a grievance process for resolving complaints arising from facility matters with at least one level of appeal. Inmates will receive information concerning the grievance procedure in the Inmate Handbook issued to them. Inmates may appeal the finding of a grievance to the Jail Administrator as the final level of appeal within five days of receiving the findings of the original grievance. The Jail Administrator will review the grievance and either confirm or deny it. If the Jail Administrator confirms the grievance, he/ she will initiate corrective actions. In either case, the inmate shall receive a written response to the appeal. Appeals related to sexual abuse allegations shall be confirmed or denied by the Jail Administrator within 10 calendar days. Inmates cannot file a grievance on behalf of another inmate, but an inmate may assist another inmate in the preparation of a grievance." Review of FCJ SAAPP, FCJ 606 Inmate Grievance, and the facility Inmate Handbook confirmed there was no information included for: allowing a detainee to file a formal grievance relating to sexual abuse at any time or in lieu of lodging an informal grievance or compliant, not imposing a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse, written procedures for identifying and handling time sensitive grievances that involve an immediate threat to detainee health, safety or welfare related to sexual abuse and directive that facility staff to bring medical emergencies to the immediate attention of proper medical personnel for further assessment. FCJ 606 Inmate Grievance states in part that the JA will confirm or deny a grievance related to sexual abuse allegations within 10 calendar days, which does not meet the 5-day requirement of subsection (e) of the standard. FCJ Inmate Handbook further states, "Initial grievances must be submitted no later than 10 calendar days after the incident the inmate is grieving about. Jail Staff will then have 10 business days to respond to the grievance." This information does not meet the requirement of subsections (a) or (b) of the standard. The Auditor reviewed the facility Inmate Handbook and could not confirm the grievance section notifies detainees of how PREA grievances are to be submitted, the appeal process, and time limits. Interview with the GO confirms that the FCJ has not had any allegations of sexual abuse during the audit period and has not received any grievances regarding an allegation of sexual abuse. The GO further indicated detainees are permitted to file a formal grievance related to sexual abuse at any time with no time limit imposed and that there are written

procedures for handling time-sensitive grievances, but he would have to look them up. In addition, the GO confirmed that medical emergencies are brought to the immediate attention of medical staff and FCJ would allow a detainee's request for assistance from another person. The Auditor determined this policy was newly established by the facility prior to the onsite audit and the process had not been utilized for a PREA grievance.

Corrective Action:

Does Not Meet (a)(b)(d)(e): A review of FCJ SAAPP, FCJ 606 and the Inmate Handbook confirms it does not include information for: allowing a detainee to file a formal grievance relating to sexual abuse at any time or in lieu of lodging an informal grievance or compliant, not imposing a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse, written procedures for identifying and handling time sensitive grievances that involve an immediate threat to detainee health, safety or welfare related to sexual abuse and directive that facility staff to bring medical emergencies to the immediate attention of proper medical personnel for further assessment. Written directive also does not include appropriate timelines for issuing a decision on the grievance with 5 days of receipt and a response to an appeal of the grievance decision within 30 days. Written directive only includes the requirement that a detainee can use assistance from another detainee to prepare a grievance, but do not include staff, family members or legal representative or that staff shall take reasonable steps to expedite requests from these other parties. To become compliant, FCJ 606 Inmate Grievances must be updated to include all elements of the standard. FCJ Inmate Handbook must also be updated to include the written process for filing a grievance at any time, emergency grievance, appeal timelines and requests for assistance by others. Once updated the facility must provide documentation to the Auditor confirming the update was completed. The facility must train all appropriate staff in the updated process and once completed submit to the Auditor documentation that the training was received. If applicable, the facility must submit to the Auditor any detainee grievances alleging sexual abuse that occur during the CAP to confirm the updated practice has been implemented.

Corrective Action Taken:

On November 8, 2023, the Auditor reviewed proposed policy language and made recommendations for compliance. On January 17, 2024, the facility submitted the updated FCJ SAAPP, FCJ facility orientation information in English and Spanish, an email sent to all staff with an inmate handbook attached and instruction for staff to become familiar with the new grievance procedures, an FCJ inmate handbook in English and a memorandum stating that there have not been any reports or grievances submitted within the audit period. On January 29, 2024, the facility submitted a PREA ICE Detainee Grievances training roster, memorandum stating there has not been any detainee grievances alleging sexual abuse during the CAP period and an updated FCJ SAAPP with dates adjusted. On February 16, 2024, the Auditor accepted the updated handbook as partial compliance; however, left this standard open for the facility to submit any detainee grievances alleging sexual abuse through the end of the CAP to confirm the updated practice has been implemented. On February 28, 2024, the facility submitted a memorandum that stated there have not been any instances of a detainee filing a grievance related to sexual abuse during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b), (d) and (e) through policy revisions and staff training and is now compliant with this standard.

§115.53 - Detainee access to outside confidential support services

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

Notes:

(a)(b)(c)(d): FCJ SAAPP mandates, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse and assault perpetrators to address victims' needs most appropriately." The facility provided an email from Family Crisis Services acknowledging this organization will provide services to detainees of

FCJ. The Auditor observed a poster for the Family Crisis Services in the open bay/dormitory housing unit with a telephone number and mailing address. Detainees are notified that all calls from the facility are subject to monitoring and recording under the "Telephones" section of the FCJ Inmate Handbook. Further review of the handbook confirms the facility does not provide information to the detainee about the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Interview with the PSA Compliance Manager confirmed that Family Crisis Services would be utilized for detainee support services as needed and all telephone calls are monitored and recorded.

Corrective Action:

Does Not Meet (a)(d): A review of the facility handbook confirms the facility informs detainees of the extent to which communication with outside resources will be monitored, but it does not inform detainees the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws or does it include the contact information for Family Crisis Services. During the onsite audit the Auditor confirmed that the signage related to Family Crisis Services was only available in English. The facility additionally must notify detainees the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws. The facility must document that the requirements have been implemented and provide said documentation to the Auditor for compliance.

Corrective Action Taken:

On January 17, 2024, the facility provided an updated FCJ SAAPP that was submitted to the Agency for approval. The facility additionally provided a FCJ facility orientation packet in English and Spanish and an FCJ facility handbook with a revised date of 03/28/2023. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates, photographs of the Family Crisis Services brochure and notification posted in the housing units that reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The brochure and notification were both posted in English and Spanish. The Auditor finds that the facility has demonstrated compliance with provisions (a) and (d) and is now compliant with this standard.

§115.61 - Staff and Agency Reporting Duties

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

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." FCJ SAAPP mandates, "Staff must report allegations or knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in the facility; retaliation against detainees or staff who report or participate in an investigation into such an incident; and any staff neglect or violation of responsibility that may have contributed to an incident of retaliation and staff shall be permitted to report an incident outside the chain of command." Review of FCJ SAAPP confirms that staff shall be permitted to report an incident outside the chain of command; however, policy does not specify a method staff may use and the Auditor did not observe informational signage during the onsite for staff to utilize. Further review of FCJ SAAPP confirmed the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit effective June 6, 2023, and has not submitted to the Agency for review and approval. Interviews with three deputies confirmed they

were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse and retaliation or staff neglect. Staff could not confirm information on how to make a report of sexual abuse outside the chain of command. Interviews with staff also confirmed they would not reveal any information regarding an allegation of sexual abuse to anyone other than to the extent necessary. Interview was the Investigator confirmed that if a victim is under 18 or considered a vulnerable adult under state law, the allegation would be reported to the designated State or local services agency. The facility has not had any sexual abuse reports during the audit period for review. The facility does not house juveniles.

Corrective Action:

Does Not Meet (a)(d): A review of FCJ SAAPP confirms staff will be trained on a method by which they can report outside of their chain of command; however, the policy does not specify the method staff would use and there is no informational signage posted at the facility. A review of FCJ SAAPI further confirmed the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit. The facility provided FCJ SAAPP dated June 6, 2023, for Auditor review. To become compliant, the facility must update FCJ SAAPP to include a method for staff to report an allegation of sexual abuse outside the chain of command, include this information in staff training or otherwise post informational signage for staff to utilize. All staff must be trained on this requirement and documentation provided to the Auditor of completed training. Appropriate staff must additionally be trained on the mandatory Agency reporting requirement if the victim is under the age of 18 or considered a vulnerable adult. The facility must provide the Auditor with documentation of this completed training. The facility must also submit the revised FCJ SAAPP to the Agency for review and approval and submit documentation to the Auditor that this has been completed.

Corrective Action Taken:

On January 17, 2024, the facility provided an updated FCJ SAAPP that was submitted to the Agency for approval. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates, an email to staff stating staff can report outside the chain of command either by calling the facility PREA coordinator or emailing or calling the second or third level supervisor directly and read receipts for the email. On February 16, 2024, the facility submitted an Addendum that includes instruction for staff to report allegations of sexual abuse or sexual harassment anonymously by calling the DHS OIG or the Kansas OIG. The facility also submitted an email sent to all jail staff with instructions to read several policies, the FCJ Addendum Policy memo, and the FCJ SAAPP with corrected date. The email further instructed staff to sign, date and return the email to the PSA Compliance Manager after the policies were read. The Auditor was additionally provided with ICE review and approval of the updated policies. The Auditor finds that the facility has demonstrated compliance with provisions (a) and (d) is now compliant with this standard.

§115.64 - Responder Duties

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

Notes:

(a)(b): FCJ SAAPP mandates, "Staff shall take immediate action to separate any detainee who alleges that he/she has been sexually abused or assaulted from the alleged assailant and shall refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms. The first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a period that still allows for the collection of physical evidence, the first responder shall: Request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and Ensure the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating defecating, smoking, drinking, or eating." Interviews with three DOs

confirmed that staff would separate the alleged victim from the abuser and protect the scene, but staff could not articulate first responder duties to request the detainee victim not take any action that could destroy physical evidence and ensure the alleged abuser does not take action that could destroy evidence. The facility did not have any reported sexual abuse allegations during the audit period to review.

(b): FCJ SAAPP mandates, "If the first staff responder is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." During the onsite audit FCJ did not have any volunteers or other contractors available for interview; however, the facility's policy requires and an interview with the PSA Compliance Manager confirmed that non-security staff who becomes aware of a sexual abuse allegation are required to follow the FCJ SAAPP.

Corrective Action:

Does Not Meet (a)(b): Interviews with staff confirmed that the alleged victim and abuser would be separated, and scene protected, but staff could not articulate first responder duties to request the detainee victim not take any action that could destroy physical evidence and ensure the alleged abuser does not take action that could destroy evidence. To become compliant the facility must train/retrain all security and non-security staff on their first responder responsibilities. Once completed the facility must submit to the Auditor documentation that the training was received.

Corrective Action Taken:

On January 17, 2024, the facility provided an updated FCJ SAAPP that was submitted to the Agency for approval. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates, an email to staff stating security and non-security first responder responsibilities and read receipts for the email. The Auditor finds that the facility has demonstrated compliance with provisions (a) and (b) and is now compliant with this standard.

§115.65 - Coordinated Response

Outcome: Does not Meet Standard

Notes:

(a)(b)(c)(d): FCJ SAAPP mandates, "The facility uses a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a security staff member, and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise. If a victim of sexual abuse is transferred between facilities the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The facility utilizes FCJ SAAPP as their coordinated, multidisciplinary team approach to responding to sexual abuse. A review of this policy confirms the plan does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. Further review of the policy confirms that the facility would not provide a DHS or non-DHS facility information pertaining to an incident or the detainee victim's potential need for services if the victim requests the information not to be shared. This statement contradicts subsection (c), in which the facility shall, as permitted by law, inform a receiving DHS facility of the detainee victim's need for potential services. Interview with the JA confirmed the facility would utilize FCJ SAAPP as a guide should an incident occur. Additionally, should a victim be transferred to any other facility information pertaining to the incident and victim's potential need for medical or social services would be provided. FCJ did not have any allegations of sexual abuse during the audit period.

Corrective Action:

Does Not Meet (a)(b)(c)(d): The Auditor's review of FCJ SAAPP confirms it does not include the coordinated actions to be taken by staff first responders, medical and mental health practitioners, investigators, and facility

leadership in responding to an incident of sexual abuse. The facility would use FCJ SAAPP as a guide should an incident occur, but this policy does not specify actions of each team member. An interview confirmed that information would be given to a transferring facility of a detainee victim's need for potential services with no distinction between a DHS or non-DHS facility or the requirements of subsection (c) and (d). To become compliant, the facility must develop a 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. In addition, the facility must update policy to reflect the verbiage of subsection (c) and (d) and provide to the Auditor for compliance review. The facility must train affected staff of the newly developed and implemented institutional plan and provide documentation to the Auditor this training was completed.

Corrective Action Taken:

On January 17, 2024, the facility submitted an updated FCJ SAAPP for review. On January 29, 2024, the facility submitted a PREA Investigator Protocol training roster, an email to staff about specialized response and victim services requirements, read receipts for the email and updated FCJ SAAPP with adjusted date. On February 16, 2024, the facility submitted an email sent to all jail staff with instructions to read several policies, the FCJ Addendum Policy memo and the FCJ SAAPP with revised date. The email further instructed staff to sign, date and return the email to the PSA Compliance Manager after the policies were read. The Auditor was additionally provided with ICE review and approval of the updated policies. On February 28, 2024, the facility submitted FCJ SAAPP, FCJ policy addendum, a staff training sign-in sheet and a memorandum stating there have been no incidents of sexual abuse reported during the CAP period. Although the facility has updated policy and training, the Auditor finds that the facility did not develop a 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. Based on policy revisions the facility has demonstrated compliance with (b), (c), (d). The facility remains non-compliant with provision (a); therefore, this standard is not compliant.

§115.67 - Agency protection against retaliation

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

Notes:

(a)(b)(c): Agency policy 11062.2 mandates, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." FCJ SAAPP mandates, "The facility shall take necessary measures to protect all detainees and staff that report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other detainees and staff." The facility did not have any sexual abuse allegations reported during the audit period and subsequently did not have any sexual abuse grievances filed. Review of FCJ SAAPP further confirms that 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 investigators has not been considered. FCJ SAAPP additionally does not provide for monitoring for at 90 days following a report or the should the need arise over 90 days if there is a continuing need. Interview with the PSA Compliance Manager confirmed that the facility would monitor disciplinary only and this monitoring would be documented on an observation form. Interview with the JA confirmed that should staff retaliation occur, the staff member would immediately be counseled on the behavior.

Corrective Action:

Does Not Meet (b)(c): The facility does not consider 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 investigators. Although

documenting retaliation monitoring on an observation form is acceptable, the PSA Compliance Manager could not articulate the need for monitoring for at least 90 days or longer if there is a demonstrated continuing need. To become compliant, the facility must implement a procedure to ensure retaliation monitoring is conducted for 90 days or longer if needed and it employs 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 investigators in addition to disciplinary report monitoring. Evidence of this procedure must be provided to the Auditor for compliance review, along with any documented retaliation monitoring resulting from allegations of sexual abuse that occurs during the CAP period, if applicable.

Corrective Action Taken:

On January 17, 2024, the facility submitted the updated FCJ SAAPI for review. On January 29, 2024, the facility submitted updated FCJ SAAPI with dates adjusted. On February 16, 2024, the facility submitted an email sent to all jail staff with instruction to read several policies, the FCJ Addendum Policy memo and the FCJ SAAPP with revised date. The email further instructed staff to sign, date and return the email to the PSA Compliance Manager after the policies were read. The Auditor was additionally provided with ICE review and approval of the updated policies. On February 28, 2024, the facility submitted the FCJ policy addendum, staff sign-in sheets for training on FCJ SAAPP and a memorandum that stated the facility has not had any sexual abuse or assault incidents during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (b) and (c) through policy revisions and staff training and is now compliant with this standard.

§115.68 - Post-allegation protective custody

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

Notes:

(a)(b)(c)(d): FCJ SAAPP policy does not reference post-allegation protective custody. The facility provided a segregation order for Auditor review but an interview with the PSA Compliance Manager could not articulate to the Auditor how and under what circumstances this form would be utilized. The form does not include areas to document that detainee placement represents the least restrictive housing option possible subject to the requirements of 115.43 or areas for the required placement reviews also required of standard 115.43. An interview with Booking/Classification staff confirmed that a reassessment is not completed following an incident of abuse or victimization. Interview with the JA indicated that should protective custody be needed the detainee victim would be housed in the least restrictive manner as possible and notification would be made to ICE when a detainee is held in administrative segregation over 72 hours. The JA further confirmed that a detainee would not be held for longer than five days in administrative segregation unless the detainee requested this placement. The facility did not have any reported allegations during the audit cycle.

Corrective Action:

Does Not Meet (c)The facility does not reassess detainees prior to their return to general population after an incident of sexual abuse. To become compliant the facility must implement a practice that requires detainee victims who are in protective custody after having been subjected to sexual abuse not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. Once established the facility must document that the practice has been implemented and that all applicable staff have been trained on the new practice. If applicable, the facility must submit to the Auditor a reassessment prior to the detainee return to general population when a detainee was placed into administrative segregation due to an allegation of sexual abuse.

Corrective Action Taken:

On January 17, 2024, the facility submitted updated FCJ SAAPP for review. On January 29, 2024, the facility submitted updated FCJ SAAPP with dates adjusted. On February 16, 2024, the facility submitted an email sent to all jail staff with instructions to read several policies, the FCJ Addendum Policy memo and the FCJ SAAPP with revised date. The facility submitted an Addendum with information that a detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee because of the sexual abuse. On February 28, 2024, the facility submitted the FCJ policy addendum, training sign-in sheet and a memorandum that stated FCJ has not had any sexual abuse or assault incidents during the CAP period. The Auditor finds that the facility has demonstrated compliance with provision (c) through policy revisions and staff training and is now compliant with this standard.

§115.71 - Criminal and administrative investigations

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

Notes:

(a)(b)(c)(e)(f): FCJ SAAPP mandates, "When the Facility conducts its own investigations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third party and anonymous reports. The Facility shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The facility shall develop written procedures for administrative investigations, including provisions requiring: Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation. The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse and assault, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." Review of FCJ SAAPP confirms that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Review of policy does not direct FCJ to consult with the appropriate investigative office within DHS prior to conducting an administrative investigation and interview with the PSA Compliance Manager confirms DHS is not consulted resulting in non-compliance with provision (b). FCJ has not developed written procedures for administrative investigations, including provisions requiring: Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and Retention of such reports for as long as the alleged abuser is detained or employed by the agency or

facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation. As a result, the facility does not meet provision (c). Review of completed training records confirmed the facility investigator has completed the required specialized training required of subsection (a) of this standard. Interview with the JA confirmed that any investigations would be completed and not terminated due to the departure of an alleged abuser or victim from the employment or control of the facility. The JA further confirmed that if FCSO completed the investigation, he would remain informed by speaking with the investigator daily. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

Does Not Meet (c): FCJ has not developed written procedures for administrative investigations, including provisions requiring: Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. To become compliant, the facility must develop written procedures for administrative investigations to include all requirements of subsection (c). Once completed the facility must provide the procedures to the Auditor and train all affected staff of the new procedures. The facility must provide the Auditor with documentation of the completed training.

Corrective Action Taken:

On December 13, 2023, the facility submitted a FCJ PREA Investigations Protocol which confirms that FCJ has developed written investigative procedures. On January 17, 2024, the facility provided an updated FCJ SAAPP that was submitted to the Agency for approval and an email to all staff with the FCJ investigations protocol attached and instructions to read the new protocol. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates and a PREA Investigations Protocol training roster. The Auditor finds that the facility has demonstrated compliance with provision (c) and is now compliant with this standard.

§115.76 - Disciplinary sanctions for staff

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

Notes:

(a)(b)(c)(d): FCJ SAAPP mandates, “Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies to the disciplinary provisions set forth in the county's personnel policies and procedures.” A review of FCJ SAAPP confirms it does not contain the verbiage, “including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies” or “removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer.” However, as termination is greater than removal from Federal Service, the Auditor finds FCJ SAAPP wording in substantial compliance with the wording required by subsection (b) of the standard. Review of FCJ SAAPP confirms there is no provision for the facility to report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies unless the activity was clearly not criminal. Additionally, there is no

provision for the facility to make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known. The Auditor was provided with a blank termination letter and blank letter for notification to law enforcement agencies that was implemented just prior to the onsite audit. The Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the dated June 6, 2023, and this revision has not been submitted for review or approval by the Agency. FCJ has not had any sexual abuse allegations during the audit period. Interview with the JA confirmed that staff are subject to disciplinary action to include termination for substantiated allegations of sexual abuse or violations of agency or facility sexual abuse policies.

Corrective Action:

Does Not Meet (b)(c)(d): FCJ SAAPP dated June 6, 2023, has not been submitted for review or approval by the Agency. The facility recently implemented the written termination notice and the notice to a law enforcement agency of termination; however, had not developed procedures on how the facility would 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. To become compliant, the facility must submit the FCJ SAAPP with a revision date of June 6, 2023, for agency review and approval and provide evidence to the Auditor for compliance review. The facility must provide the Auditor evidence of their procedure for notifying law enforcement agencies and reasonable efforts to report to any relevant licensing bodies for completed sexual abuse allegations that may occur during the CAP period, if applicable.

Corrective Action Taken:

On November 8, 2023, the facility and the Auditor reviewed and approved proposed FCJ SAAPP language. On January 17, 2024, the facility provided an updated FCJ SAAPP that was submitted to the Agency for approval. On January 29, 2024, the facility submitted an email to staff containing information about staff discipline and notification of relevant licensing bodies, read receipts for the email and updated FCJ SAAPP with revised dates. On February 28, 2024, the facility submitted a memorandum that stated there has not been any sexual abuse or assault incidents reported at FCJ during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (b), (c) and (d) through policy revision and is now compliant with this standard.

§115.77 - Corrective action for contractors and volunteers

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

Notes:

(a)(b)(c): FCJ SAAPP mandates, "Contractors suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility takes appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility reports such incidents to the ICE/ERO regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known. All allegations or suspicions of sexual abuse will be investigated and reported in a timely manner." Interview with the JA confirmed that criminal incidents involving contractors would be reported to FCSO immediately for investigation. The contractor would be removed from any duties that involved detainee contact pending the outcome of an investigation. The incident would be reviewed to consider if other policies were violated prior to allowing reentry into the facility. Interview with the JA could not confirm that FCJ would notify, if appropriate, relevant licensing bodies as required of the standard for contractors and volunteers. The JA confirmed that if an incident involved a medical contractor (ACH), they would be notified.

Recommendation: FCJ SAAPP should be updated to include the terms contractor or volunteer. Current policy only addresses contractors, but the standard contains verbiage for contractors and volunteers.

Corrective Action:

Does Not Meet (a): The facility indicated they would notify ACH should an incident occur but could not articulate that relevant licensing bodies would be notified. To become compliant, the facility should implement a procedure to ensure that reasonable efforts are made to report contractor or volunteer misconduct to relevant licensing bodies. Once implemented the facility must provide the Auditor with the new procedure for review.

Corrective Action Taken:

On November 8, 2023, the Auditor reviewed and approved the submitted proposed policy language. On January 17, 2024, the facility submitted an updated FCJ SAAPP containing the procedure for ensuring that reasonable efforts are made to report contractor or volunteer misconduct to relevant licensing bodies for review. On January 29, 2024, the facility submitted the FCJ SAAPP with revised dates, an email to staff with a training link to the ICE PREA Contractor and Volunteer training, an email with updated FCJ SAAPP to staff and read receipts for the emails. The Auditor finds that the facility has demonstrated compliance with provision (a) and is now compliant with this standard.

§115.78 - Disciplinary sanctions for detainees

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

Notes:

(a)(b)(c)(d)(e)(f): FCJ SAAPP mandates, "Detainees shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the detainee engaged in detainee on-detainee sexual abuse following criminal finding of guilt for detainee-on-detainee sexual abuse. Such discipline shall be administered according to the guidelines set forth. Reports 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 allegation is not substantiated." Review of FCJ SAAPP policy confirms that there is not a documented procedure implemented for detainee discipline, the facility does not consider whether the detainee's mental disability contributed to the behavior or that the detainee will not be disciplined for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. A review of the FCJ Handbook confirms there are major or minor violations but does not list prohibited actions. The handbook further details progressive penalties for a minor or major violation and appeals process. Interview with the JA confirmed that detainees would be subjected to progressive disciplinary sanctions following a finding of guilty in a disciplinary proceeding. The interview further confirmed that detainees would not be disciplined for sexual contact with a staff member unless staff did not consent to the contact or disciplined for making a good faith report. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

Does Not Meet (c)(d): The facility does not document the detainee disciplinary procedure either in FCJ SAAPP policy or within the facility handbook. FCJ does not consider during the disciplinary process if the detainee's mental disability contributed to the behavior. To become compliant, the facility must implement a disciplinary procedure and document this procedure in FCJ SAAPP policy or the facility handbook. The facility must also implement procedure to evaluate if a detainee's mental disability or mental illness contributed to the behavior when determining what type of sanction, if any, should be imposed. The facility must provide the Auditor with documentation of the newly implemented procedures and train applicable staff of these new procedures. The facility must also provide the Auditor, as applicable, with any detainee disciplinary taken as a result of a substantiated sexual abuse allegation during the CAP period so the Auditor may assess compliance with the newly implemented procedure.

Corrective Action Taken:

On November 8, 2023, the facility and the Auditor reviewed proposed policy language changes. On January 17, 2024, the facility submitted updated FCJ SAAPP, FCJ inmate handbook and a blank FCJ facility orientation packet in English and Spanish containing the required language and procedures to be compliant with this standard. On January 29, 2024, the facility submitted a blank FCJ Major Violation Notice, email to staff concerning detainee discipline requirements with the FCJ handbook, FCJ detainee orientation packet in English and Spanish, read receipts for the email and a memorandum stating there has not been any disciplinary sanctions for a detainee found to have engaged in sexual abuse or any incidents of sexual abuse or sexual harassment. The facility also submitted updated FCJ SAAPP with revised dates. The Auditor found that the facility has trained applicable staff on the new procedures. On February 28, 2024, the facility submitted a memorandum that there has not been any incidents of sexual abuse or assault at FCJ during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (c) and (d) through policy revision and applicable staff training and is now compliant with this standard.

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

Outcome: Does not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "If the screening process indicates that a detainee has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall contact the Facility's medical or mental health practitioner within 14 days of the detainee screening." The facility just recently started to utilize the PREA Risk of Victimization Assessment, which was determined in 115.41, does not include an assessment of detainees for risk of abusiveness. Interview with booking/classification staff confirmed that there is no procedure in place that requires detainees be referred to medical or mental health staff should the detainee disclose prior sexual victimization or records indicate a perpetration of sexual abuse. Review of the FCJ SAAPP confirms that it mandates that staff contact medical or mental health within 14 days of the detainee screening which is in conflict with the two-working day for medical and 72 hours for mental health requirement of the standard. Interview with the mental health practitioner confirmed the staff member had recently been hired two weeks prior to the onsite.

Corrective Action:

Does Not Meet (a)(b)(c): The facility does not utilize a risk assessment tool that is compliant with standard 115.41. To become compliant, the facility must develop a risk assessment pursuant to standard 115.41 that will adequately assess detainee risk for victimization or abusiveness. In addition, the facility must also implement procedures to include the requirement to refer the detainee to a qualified medical or mental health practitioner for medical or mental health follow-up as appropriate. The procedure must also include the requirement that once the referral is made the medical follow-up must be initiated and the detainee must receive a medical evaluation no later than two working days from the date of assessment and if the referral is to mental health the detainee must receive a mental health evaluation within 72 hours after the referral. Once implemented the facility must train all booking, medical, and mental health staff on the implemented procedure and provide the Auditor with documentation that that the training was received. If applicable, the facility must provide documentation of referrals and subsequent evaluations for qualifying detainees during the CAP period.

Corrective Action Taken:

On January 17, 2024, the facility submitted updated FCJ SAAPP, a blank screening for risk of sexual victimization and abusiveness and a blank post PREA incident assessment. On February 16, 2024, the facility provided an email to all jail staff with a detainee screening for risk of victimization and a post PREA incident reassessment along with email read receipts. The Auditor accepts this as partial compliance; however, the Auditor left the standard open for the facility to provide documentation of referrals and subsequent evaluations for qualifying detainees during the CAP period. On February 28, 2024, the facility submitted FCJ policy

addendum, staff sign-in sheets for PREA medical, contractor and volunteer training and a memorandum that FCJ has not had any detainee referred with a prior history of sexual victimization during the CAP period. The facility, however, did not submit referrals to mental health for two detainees that completed intake on 02/16/2024 and 02/22/2024. Both detainees were identified on the risk assessment as "having a prior or current conviction for a sexual offense." The facility has not demonstrated compliance with (a), (b) and (c) and this standard remains non-compliant.

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

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

Notes:

(a)(b)(c)(d)(e)(f)(g): FCJ SAAPP mandates, "The Facility shall offer ongoing medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility. The facility shall provide victims of sexually abusive vaginal penetration by a male abuser access to pregnancy test and timely access to all lawful pregnancy related medical services. All victims shall have access to sexually transmitted tests as medically appropriate. Such services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperated with any investigation arising out of the incident." Interview with the medical nurse confirms that should a detainee receive treatment at St. Catherines Hospital, the treatment plan would be continued at the facility and that FCJ would provide health services consistent with the community level of care. Additionally, treatment would be provided free of cost whether or not the detainee chose not to name the abuser or cooperate with any investigation. Interview with the mental health practitioner confirmed that they had recently started employment with FCJ and has not provided evaluations for detainee victims of abuse. Additionally, she was not aware of the requirement to provide an evaluation to victims of prior sexual abuse while in immigration detention or the requirement to attempt to conduct an evaluation of known detainee-on-detainee abusers. There were no allegations of sexual abuse reported during the audit period.

Corrective Action:

Does Not Meet (b)(g): Facility staff could not articulate the component requirements (b) and (g) of this standard. To become compliant, the facility must implement a procedure that ensures medical and mental health evaluations, as appropriate, and treatment is provided to detainee who have been victims of sexual abuse while in immigration detention. Documentation where detainee victims of sexual abuse are offered evaluations, treatment, and follow-up services, including treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody must be provided to the Auditor for compliance review, if applicable. Additionally, the facility should provide documentation to the Auditor that the facility has implemented a procedure for detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated to receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Additionally, the facility must implement a procedure that ensures a mental health evaluation is attempted of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Once implemented, documentation of an evaluation of this nature is to be provided to the Auditor for compliance review, as applicable.

Corrective Action Taken:

On January 17, 2024, the facility submitted updated FCJ SAAPP containing the required language and procedures, a blank screening for risk of sexual victimization and abusiveness and a blank post PREA incident assessment. On February 16, 2024, the facility provided an email to all jail staff with a detainee screening for risk of victimization and a post PREA incident reassessment along with email read receipts. On February 28, 2024, the facility submitted a memorandum that stated FCJ has not had any detainee medical referrals with a prior

history of sexual victimization during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (b) and (g) through policy revision and staff training and is now compliant with this standard.

§115.86 - Sexual abuse incident review

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

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The Facility shall collect accurate, uniform date for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The Jail Administrator/designee shall review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training." The facility reported it did not have any allegations of sexual abuse during the audit period. Review of FCJ SAAPP confirms that facility policy is in conflict with subsection (a) of the standard in that a sexual abuse incident review shall be completed at the conclusion of every allegation. The facility provided an email sent to the SDDO just prior to the onsite with an attachment entitled Negative Report Exhibit; however, the report was not provided for the Auditor to review. An interview with the PSA Compliance Manager confirmed the facility does not complete an annual negative report if the facility has not had a reported allegation of sexual abuse during the reporting period.

Corrective Action:

Does Not Meet (a)(b)(c): The facility procedures do not include an incident review of unfounded sexual abuse allegations. The facility must implement a procedure to ensure that all incidents of sexual abuse are reviewed at the conclusion of the investigation, and that a written report be prepared within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse for those that are substantiated or unsubstantiated. The facility must provide the Auditor evidence of implementation of these procedures for compliance review, and documentation of any reviews conducted, as applicable, for investigations closed within the CAP period. Additionally, the facility must provide evidence that notification is made to the FOD and PSA Coordinator for any new closed sexual abuse investigations that occur during the CAP period for compliance review. In addition, the facility must provide documentation that current year annual report, or negative report, was prepared and forwarded to the ICE FOD and Agency PSA Coordinator as required of this standard.

Corrective Action Taken:

On November 8, 2023, the facility submitted, and the Auditor reviewed proposed FCJ policy language outlining procedures to conduct an incident review on all allegations. On January 17, 2024, the facility submitted updated FCJ SAAPP, and an annual 2020 reporting year Sexual Abuse and Assault Report dated December 21, 2021. On January 29, 2024, the facility submitted updated FCJ SAAPP with revised dates, the 2023 Annual Sexual Abuse and Assault Report, confirmation the report was sent to the ICE FOD, ICE PSAC and ERO Sexual Assault email group. On February 28, 2024, the facility submitted a memorandum that stated FCJ has not had any incidents or reports of sexual abuse during the CAP period. The Auditor finds that the facility has demonstrated compliance with provisions (a), (b) and (c) through policy revision and is now compliant with this standard.

AUDITOR CERTIFICATION:

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

Jodi Upshaw 3/20/2024

Auditor's Signature & Date

(b) (6), (b) (7)(C) 3/27/2024

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 3/27/2024

Assistant Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

AUDIT DATES			
From:	6/27/2023	**To:**	6/29/2023
AUDITOR INFORMATION			
Name of auditor:	Jodi Upshaw	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-
PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	409-866-
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Chicago		
Field Office Director:	Michael Melendez		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	101 W. Ida B Wells Drive, Suite 4000 Chicago, IL 60605		
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Finney County Jail		
Physical address:	304 N. 9Th Street Garden City Kansas 67846		
Telephone number:	620-272-3756		
Facility type:	IGSA		
PREA Incorporation Date:	7/21/2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Facility Administrator
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	620-272-
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	PSA Compliance Manager
Email address:	(b) (6), (b) (7)(C)	**Telephone #:**	620-272-

NARRATIVE OF AUDIT PROCESS AND DESCRIPTION OF FACILITY CHARACTERISTICS

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

The U.S. Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) audit of the Finney County Jail (FCJ) was conducted on June 27, 2023 – June 29, 2023, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Jodi Upshaw, employed by Creative Corrections, LLC. The Auditor was provided guidance and review during the audit report writing and review process by the ICE PREA Program Manager (PM) (b) (6), (b) (7)(C) and Assistant Program Manager (APM), (b) (6), (b) (7)(C), both DOJ and DHS certified PREA Auditors. The PM's role is to provide oversight to the ICE PREA auditing process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA standards. FCJ is a county government facility governed by the Finney County Sheriff's Office (FCSO) and operates under contract with the DHS ICE, Office of Enforcement and Removal Operations (ERO). The audit period is from June 21, 2020, through June 29, 2023. This is the first DHS PREA audit for FCJ.

The facility houses County adult male and female detainees with low, medium, and high custody levels. The design capacity for the facility is 178 and includes detainees and local pre-trial County male and female arrestees. The average daily ICE population for the prior 12 months was 1. The facility reported there were 53 ICE detainees booked into the facility in the last 12 months with an average length of time in custody of 2 days. The current detainee population on the first day of the audit was zero. The facility is comprised of one building which includes one female multiple occupancy cell housing unit, two male multiple occupancy cell housing units and one open bay/dormitory housing unit that could be used for male or female detainees. Cells used for (b) (7)(E) are located just outside of the housing units or within the intake area depending on circumstances of placement. Previously detainees were comingled with county inmates in the multiple occupancy cell housing units, but according to the Jail Administrator (JA) detainees are now housed in the one open bay/dormitory housing unit. Depending on the detainee population females could be housed in the open bay/dormitory housing unit or within the Intake Area.

Approximately two weeks prior to the audit, the ERAU Team Lead (TL), (b) (6), (b) (7)(C), provided the Auditor with facility policies and other pertinent documents through the ICE SharePoint and ERAU AMRS site. The PAQ and supporting documentation was organized with the PREA Pre-Audit Policy and the Document Request DHS Immigration Detentions Facilities form and placed within folders for ease of auditing. The main policy that provides facility direction for FCJ is the Finney County Jail/ICE Detainee Sexual Abuse and Assault Prevention Policy (FCJ SAAPP). All documentation, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Auditor for interviews with staff and detainees. The Auditor also reviewed the facility's website, https://wwwfinneycounty.org and the Agency's website, www.ice.gov.

The entry briefing was held in the FCJ JA's conference room on June 27, 2023. The ICE ERAU TL opened the briefing. In attendance were:

(b) (6), (b) (7)(C), TL, Inspections and Compliance Specialist (ICS), ICE/OPR/ERAU
(b) (6), (b) (7)(C), Supervisory Detention and Deportation Officer (SDDO), ERO
(b) (6), (b) (7)(C), Detention and Deportation Officer (DO), ERO
(b) (6), (b) (7)(C), JA, FCJ
(b) (6), (b) (7)(C) Lieutenant, (LT), Prevention of Sexual Abuse (PSA) Compliance Manager, FCJ
(b) (6), (b) (7)(C), LT, FCJ
Jodi Upshaw, Auditor, Creative Corrections, LLC

The Auditor introduced herself and then provided an overview of the audit process and methodology to be used to determine PREA compliance with those present. The Auditor explained the audit process is designed to not only assess compliance through written policies and procedures but also to determine whether such policies and procedures are reflected in the knowledge of staff at all levels. She further explained compliance with the PREA standards will be determined based on review of policy and procedures, observations made during the facility tour, provided documentation for review, and conducting staff and detainee interviews. No correspondence was received from any detainee, outside individual, or staff member.

The audit commenced on June 27, 2023, and included the sallyport, booking area, medical unit, master control, and housing units. The booking area consists of a close watch cell and five holding cells that included a toilet and sink. There were two interview rooms that could be used as holding cells if needed. There was a change out room that included a toilet and shower area enclosed with a shower curtain. Outside of the holding cells is a desk area for staff and telephone area for detainee use. There is a medical office just off of the booking area. Located outside of the booking area is the ICE processing room that that ICE utilizes when bringing detainees into the facility. Located within this area was the DHS-prescribed Sexual Assault Awareness Notice with facility contact name and number, contact information for DHS Office of the Inspector General (OIG) and reporting numbers for the ICE Detention and Reporting and Information Line (DRIL) displayed in English and Spanish. The Auditor observed the I Speak poster and other local legal resources additionally posted.

During the onsite audit, the Auditor noted sight lines, potential blind spots, and camera locations throughout (b) (7)(E) . There were no detainees processed into FCJ during the onsite audit; however, the Auditor was able to view (b) (7)(E) of a pat search completed for the last detainee processed into the facility.

FCJ has (b) (7)(E) located throughout all areas of the facility that do not record sound, but have the capability to tilt, pan and zoom. The (b) (7)(E) is stored for (b) (7)(E) on a (b) (7)(E) . The Auditor viewed (b) (7)(E) (b) (7)(E)

The facility has 36 security staff positions with 19 male and 17 female staff, 1 full time contracted medical staff through American Correctional Healthcare (ACH) and 1 mental health practitioner that works 5 hours a week. The remaining staff consists of non-security administrative, maintenance, and food service all employed through the County. The facility has religious and programming volunteers that could have detainee contact.

The Auditor was provided with a staff roster for a random selection of formal interviews. The Auditor interviewed 15 staff members which consisted of the JA, the PSA Compliance Manager, Medical Nurse (1), Mental Health Practitioner (1), Human Resources (HR) staff (1), Investigative staff (1), Training Officer (TO) (1), Grievance Officer (GO) (1), Booking/Classification staff (1) and Jail Deputies (JD) (3). In addition, the Auditor interviewed 3 ICE staff (DOs (2) and the SDDO). There were no detainees housed at the facility during the audit.

The facility PAQ reported there were no facility investigators that have received specialized training on sexual abuse. There were no allegations of sexual abuse reported at SCJ during the audit period.

On June 29, 2023, an exit briefing was held in the JC's conference room. The ICE/OPR/ERAU TL opened the briefing. In attendance were:

(b) (6), (b) (7)(C) TL, ICS, ICE/OPR/ERAU
(b) (6), (b) (7)(C) SDDO, ERO, via telephone

(b) (6), (b) (7)(C) DO, ERO, via telephone
(b) (6), (b) (7)(C) JA, FCJ
(b) (6), (b) (7)(C) LT, PSA Compliance Manager, FCJ
(b) (6), (b) (7)(C) LT, FCJ
(b) (6), (b) (7)(C) APM, Creative Corrections, LLC, via telephone
Jodi Upshaw, Auditor, Creative Corrections, LLC

The Auditor spoke briefly about non-compliance in the areas of training and detainee access to outside resources. The Auditor informed those in attendance that final compliance determinations could not be made until a review of documentation, site review notes, and interviews were compiled. The Auditor recognized the facility for their hard work in preparing for the audit and thanked those in attendance for their cooperation.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 0

Number of Standards Met: 11

- §115.18 - Upgrades to facilities and technologies
- §115.34 - Specialized training: Investigations
- §115.54 - Third-party reporting
- §115.62 - Protection Duties
- §115.63 - Reporting to other Confinement Facilities
- §115.66 - Protection of detainees from contact with alleged abusers
- §115.72 - Evidentiary standard for administrative investigations
- §115.73 - Reporting to detainees
- §115.82 - Access to emergency medical and mental health services
- §115.87 - Data collection
- §115.201 - Scope of Audit

Number of Standards Not Met: 29

- §115.11 - Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator
- §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
- §115.31 - Staff Training
- §115.32 - Other Training
- §115.33 - Detainee Education
- §115.35 - Specialized training: Medical and mental health care
- §115.41 - Assessment for risk of victimization and abusiveness
- §115.42 - Use of assessment information
- §115.43 - Protective Custody
- §115.51 - Detainee Reporting
- §115.52 - Grievances
- §115.53 - Detainee access to outside confidential support services
- §115.61 - Staff and Agency Reporting Duties
- §115.64 - Responder 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
- §115.77 - Corrective action for contractors and volunteers
- §115.78 - Disciplinary sanctions for detainees
- §115.81 - Medical and mental health screening; history of sexual abuse

- §115.83 - Ongoing medical and mental health care for sexual abuse victims and abusers
- §115.86 - Sexual abuse incident review

Number of Standards Not Applicable: 1

- §115.14 - Juvenile and family detainees

PROVISIONS

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

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

Outcome: Does Not Meet Standard

Notes:

(c)(d): FCJ SAAPP mandates, "The Finney County Jail is committed to maintaining a "zero tolerance" toward sexual abuse and sexual harassment." Additionally, the "Finney County Jail will affirmatively act to prevent sexual abuse and assaults on detainees, provide prompt and effective intervention and treatment for victims of sexual abuse and assault, and control, discipline, and prosecute the perpetrators of sexual abuse and assault. The Finney County Jail will appoint an officer to serve as a PREA coordinator. This officer shall address each allegation and refer such allegation to the appropriate authority for investigation." During the onsite tour the Auditor observed the DHS-prescribed sexual assault awareness notice in the ICE processing room and the one open bay/dormitory housing unit in English and Spanish. The Auditor also observed the facility zero-tolerance policy in the facility's detainee handbook. The facility has appointed and employs a PSA Compliance Manager who serves as the facility point of contact for the agency PSA Coordinator. The Auditor reviewed the organizational chart and observed the PSA Compliance Manager reports to the JA and then to the Sheriff. Interview with the PSA Compliance Manager confirms that he is the point of contact for the facility and Agency PSA Coordinator. In addition, the PSA Compliance Manager confirmed he has sufficient time and the authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures. Interviews with three random deputies confirmed they were aware of the facility and Agency zero-tolerance policy toward all forms of sexual abuse. The facility provided the Auditor with evidence that the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit dated June 6, 2023. This revision has not been reviewed or approved by the Agency; therefore, the facility is not in compliance with subsection (c) of the standard.

Recommendation: The Auditor recommends that FCJ review the current SAAPP policy for additional edits prior to forwarding to ICE for review and approval. Many areas of the policy do not align with the DHS PREA standards.

Corrective Action:

Does Not Meet (c): A review of FCJ SAAPP dated June 6, 2023, confirms it has not been submitted to the Agency for review and approval. To become compliant, the facility must provide documentation that confirms the facility has submitted FCJ SAAPP dated June 6, 2023, to the Agency for review and approval as required by subsection (c) of the standard.

§115.13 - Detainee supervision and monitoring

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The facility will provide sufficient staffing to ensure that detainee supervision is performed in a manner that will deter and prevent sexual abuse. The use of electronic monitoring devices will be in place to assist and document events. The Facility is equipped with (b) (7)(E) [redacted]. The video camera system will be updated on a routine basis." A review of the facility PAQ indicated FCJ has 36 security staff working two 12-hour shifts, 7:00 a.m. – 7:00 p.m. and 7:00 p.m. – 7:00 a.m. during the audit period. During the on-site tour the Auditor observed appropriate staffing levels in the booking area, but when walking throughout the facility noticed staff infrequently. There are a total of (b) (7)(E) located throughout the facility that have pan, zoom and tilt (PTZ) functionality. (b) (7)(E) [redacted] Interview with the PSA Compliance Manager confirmed the facility does not utilize a staff to detainee ratio. A review of FCJ SAAPP policy confirmed it does not include the requirement that the facility develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs, nor does it require that these guidelines be reviewed at least annually. The facility does not utilize post orders and did not provide the Auditor with comprehensive detainee supervision guidelines which resulted in non-compliance with provision (b). Interviews with the JA and PSA Compliance Manager further confirmed that when determining adequate levels of detainee supervision and the need for video monitoring, the facility did not take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy the physical layout of the facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports and any other relevant factors, including but not limited to length of time detainees spend in agency custody. The facility did not provide documentation to the Auditor to confirm that when determining adequate levels of supervision, or when determining the need for video monitoring in 2022, all factors in subsection (c) of the standard were considered. As a result, the facility is non-compliant with provision (c).

(d): FCJ SAAPP mandates, "Assigned staff are to make security checks of all areas of responsibility on an irregular basis, and unannounced security inspections on all shifts with the goal of deterrence of detainee sexual abuse. Staff are prohibited from alerting others that unannounced security inspections are being conducted." The Auditor reviewed logs (b) (7)(E) for several days. The logs appeared to be a unit log documenting cell checks and activities during the shift. There were no notations in the logs reviewed by the Auditor for any unannounced security inspections; therefore, the facility is non-compliant with provision (d).

Corrective Action:

Does Not Meet (b)(c): The facility did not submit comprehensive detainee supervision guidelines for the Auditor to review nor could the facility provide the Auditor with documentation to confirm the facility considered all elements required by subsection (c) of the standard when determining adequate staffing levels or the need for video monitoring when updated in 2022. To become compliant, the facility must develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs, and establish a practice of reviewing those guidelines at least annually. The facility must also demonstrate that when determining adequate levels of detainee supervision and the need for video monitoring that they take into

consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in agency custody. Documentation of the comprehensive detainee supervision guidelines and any policy updates or procedures implemented to demonstrate compliance with 115.(c) must be provided to the Auditor for compliance review.

Does Not Meet (d): There were no notations in the logs reviewed by the Auditor for any unannounced security inspections. To become compliant the facility must implement a procedure of conducting unannounced security inspections for night as well as day shifts and provide the Auditor with documentation that these rounds are occurring as required.

§115.14 - Juvenile and family detainees

Outcome: Not Applicable

Notes:

(a)(b)(c)(d): According to the PAQ and interviews with the JA, the PSA Compliance Manager and three Deputies FCJ does not accept juvenile or family unit detainees; and therefore, the standard is not applicable.

Corrective Action:

No corrective action needed.

§115.15 - Limits to cross-gender viewing and searches

Outcome: Does Not Meet Standard

Notes:

(b)(c)(d): FCJ SAAPP mandates, "Cross-gender pat-down searches shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the search is required or in exigent circumstances. All cross-gender pat-down searches shall be documented." The facility reported that there have not been any cross gender pat down searches of a detainee conducted during the audit period. The Auditor reviewed a video of a male detainee processed into the facility and observed the pat-down search was not completed until a male staff member was available to conduct the search. Interviews with three deputies confirmed that cross gender pat down searches are not normally conducted due to an adequate ratio of male/female staff members on each shift. All staff confirmed that should a cross gender pat down be conducted it would be documented.

(e)(f): FCJ SAAPP mandates, "Cross-gender strip searches of cross-gender visual body cavity searches shall not be performed except in exigent circumstances, including consideration of officer safety or when performed by medical practitioners following authorization by the Jail Administrator. All cross-gender strip searches or cross-gender visual body cavity searches shall be documented." The Auditor reviewed a Finney County Jail Strip Search Form which requires staff to fill in the name of the detainee, sex, date/time, the name of the staff member, sex of staff member and the result of the search. Interviews with three deputies confirmed that they do not conduct cross-gender strip or visual body cavity searches. Staff further confirmed that should a strip search or

visual body cavity search be conducted it would be documented. FCJ does not house juvenile detainees.

(g): FCJ SAAPP mandates, "The Finney County Jail shall ensure that detainees may shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks." During the onsite review the Auditor observed staff of the opposite gender announce their presence upon entry in the housing units. Interviews with three deputies confirmed they are aware of this policy, and all stated they do announce.

(h): FCJ is not designated as a Family Resident Center; therefore, provision (h) is not applicable.

(i): FCJ SAAPP mandates, "Finney County Jail personnel shall not search or physically examine a transgender or intersex detainee solely to determine their genital status or if the genital status is unknown. This may be determined during private conversations with the detainee, by reviewing medical records, or by learning the information as part of a standard medical examination that all detainees undergo as part of intake, or other processing procedure conducted in private by a medical practitioner." Interviews with three deputies confirmed that cross gender strip or body cavity searches or searches to determine the detainee's genital status are not allowed. Interviews with medical confirmed that they have not had an instance of a detainee's gender being unknown, but should this situation arise medical would review medical records or learn the information as part of the intake medical examination.

(j): FCJ SAAPP policy does not reference training requirements for staff. The Auditor reviewed a Pat Down Search Performance Objective form that provides a step-by-step guide in how to conduct a pat down search. The performance objective does not include procedures for conducting cross-gender pat-down search or searches of transgender and intersex detainees. The performance objective also does not include that pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration for officer safety. Review of 13 staff files confirmed that staff had accomplished the pat down search performance objective; however, the performance objective is not in compliance with this subsection. The Auditor reviewed an email dated May 25, 2023, that directed staff that "Pat downs and strip searches on Transgender, Intersex, and Cross gender detainees will be conducted in a professional manner and by a staff member with the same genitalia as the detainee." The facility did not provide confirmation that all staff had acknowledged the email. Interview with the TO confirmed that upon hire all new staff would be trained on the email directive.

Corrective Action:

Does Not Meet (j): The performance objective utilized by newly hired staff does not include procedures for conducting cross-gender pat-down search or searches of transgender and intersex detainees and information that pat-down searches shall be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration for officer safety. To become compliant, the facility must implement training for security staff in the proper procedures for conducting pat-down searches, including cross-gender pat-down searches and searches of transgender and intersex detainees and that the searches will be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and agency policy, including consideration of officer safety. The training curriculum must be provided to the Auditor for compliance review. Staff training records indicating all staff have been trained on this new curriculum must be provided to the Auditor for compliance evaluation.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility will take appropriate steps 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 and sexual harassment. Such steps shall include providing access to interpreters who can communicate effectively, accurately, and impartially. The facility shall ensure that written materials are provided in formats or through methods that ensure effective communication with the following: Detainees who are deaf or hard of hearing, Those who are blind or have low vison, Those who have intellectual, psychiatric problems, Those with speech disabilities and Those with limited English proficiency." During the onsite audit the Auditor observed the DHS-prescribed sexual assault awareness notice, reporting numbers for the ICE DRIL and the OIG poster in the ICE processing room and the one open bay/dormitory housing unit in English and Spanish. The Auditor requested to review detainee files, but these files are kept electronically and the Auditor was told by the PSA Compliance Manager that the records could not be retrieved at that time. Interview with one DO confirmed that detainees are shown a PREA orientation video during ICE processing at the facility; however, the video is available in English and Spanish and has just been implemented recently. The DO further confirmed that ICE provides the ICE National Detainee Handbook and DHS-prescribed ICE Sexual Abuse Awareness (SAA) information pamphlet to each detainee and detainees are required to sign for receipt of this information in English or Spanish. While onsite the Auditor did not observe availability of the 14 required languages required for the ICE National Detainee Handbook: English, Spanish, Arabic, French, Simplified Chinese, Haitian Creole, Portuguese, Vietnamese, Punjabi, Hindi, Russian, Romanian, Turkish, and Bengali. The Auditor observed the SAA information pamphlet in the required 15 languages: Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian. Interview with booking/classification staff confirmed that the facility handbook is provided to detainees in English and Spanish only and they were unaware of how to access the additional languages. Interviews further confirmed that staff were not aware of needed resources or how to access resources to accommodate a detainee with a sight, hearing, psychiatric, learning disability or interpretation or translation of a language other than English or Spanish when providing PREA related information. The Auditor observed the ERO Language Services poster in the booking area, although staff stated they had not utilized this resource. Interviews with three deputies confirmed that staff would not utilize another detainee to provide interpretation for another detainee pertaining to allegations of sexual abuse.

Corrective Action:

Does Not Meet (a)(b)(c): In an interview with a DO it was confirmed that the Agency (ERO) provides the detainees with the DHS-prescribed SAA Information pamphlet, and the ICE National Detainee Handbook only in English and in Spanish. Interviews with booking staff confirmed the facility provides the detainee with a facility handbook only in English and Spanish. Booking staff further confirmed that they have not used the language line to interpret PREA related information for any detainee. To become compliant the facility must develop a practice that provides all detainees access and equal opportunity to the Agency's and facility's efforts to prevent, detect, and respond to sexual abuse. The facility must identify available resources to provide the information contained in the facility handbook to detainees who are blind or have limited sight, are deaf or hard of hearing, and for those who have an intellectual, psychiatric, or speech disability, or limited English proficient (LEP) can utilize. In addition, the facility must have available, either in printed copy or electronic for printing, the ICE National Detainee Handbook available in 14 of the most prevalent languages encountered by ICE (English, Spanish,

French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) for distribution to detainees. The facility must also train staff on the use of a designated language interpretation service, have information readily accessible to booking and floor staff and provide documentation the procedure has been implemented and training of appropriate staff. In addition, the facility must submit to the Auditor documentation for 10 detainees received during the CAP period who speak languages other than English or Spanish to confirm the new procedure has been implemented. If applicable, the submitted files should include a sampling of detainees who are LEP, deaf or hard of hearing, blind or have limited sight, or may have intellectual, psychiatric, or a speech disability.

§115.17 - Hiring and promotion decisions

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): The Federal Statute 731.202 (b), Executive Order 10450, ICE Personnel Security and Suitability Program Directive 6-7.0 and ICE Suitability Screening Requirements for Contractors Personnel Directive 6-8.0, collectively require anyone entering or remaining in government service undergo a thorough background examination for suitability and retention. The background investigation, depending on the clearance level, will include education checks, criminal records check, a financial check, residence and neighbor checks, and prior employment checks." ICE Directive 7-6.0 outlines "misconduct and criminal misconduct as grounds for unsuitability, including material omissions or making false or misleading statements in the application." The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that detailed candidate suitability for all applicants includes their obligation to disclose: any misconduct where he/she engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); any conviction of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent- or refuse; or any instance where he or she has been civilly or administratively adjudicated to have engaged in such activity." FCJ SAAPP mandates, "The Facility will not hire or promote anyone who may have contact with detainees, and will not enlist the services of any contractor who may have contact with detainees, Who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or; Who has been 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 consent or refuse; All new staff will be asked if there has ever been an allegation of PREA made against them. If a substantiated allegation is discovered or if the potential employee resigned during a pending investigation of alleged sexual abuse, prior institutional employers will be contacted to determine if the potential employee was either civilly or administratively adjudicated to have engaged in the activity described above; The facility will document the asking of PREA questions and include this fact in the personnel file of newly hired staff; Material omissions or materially false information will be grounds for termination or withdrawal of an offer of employment; Staff have a continuing affirmative duty to report any misconduct involving sexual abuse." A review of 13 FCJ staff files confirmed that initial background checks were conducted on all staff prior to hire. All staff files contained a continuing affirmative duty to report statement, but based on the dates signed and interviews, this procedure was implemented only a month prior to the onsite audit; additionally, there was no indicating the misconduct questions are being asked during interviews, prior to promotion, and during annual written reviews. A review of new applicant's personal history statement contains a statement that material omissions regarding such misconduct or the provision of materially false information

would be grounds for termination or withdrawal of an employment offer. Interview with the HR representative confirmed background checks are completed on all applicants prior to hire. There was no evidence to indicate that the facility contacts prior institutional employers of an applicant for employment to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse. The interview also indicated that should a facility contact FCJ for information regarding a former employee, the information would be given based on the current laws of Kansas which is by written request. There were no contractor or volunteer files available for the Auditor to review to confirm if proper screenings for prior criminal conduct were conducted. The PSO confirmed that background investigations for four ICE employees requested by the Auditor are current. Additionally, during interviews with the SDDO and two DOs the Auditor learned that one had been promoted within the prior 12 months but could not recall if he was asked the misconduct questions again during the promotional process; however, based on the established hiring and promotion procedures of the PSO as outlined in policy and as explained by the PSO Unit Chief, the Auditor has determined the Agency met substantial compliance.

Corrective Action:

Does Not Meet: (a)(b)(c)(d)(e): The facility does not have in place a requirement to ask applicants about prior misconduct outlined in provision (a). The facility has no documentation indicating that criminal history background checks are conducted on contractors prior to enlisting their services. The facility has no documentation indicating that proper screenings for volunteers are being conducted. The facility did not impose upon staff a continuing affirmative duty to disclose sexual misconduct during the audit period. To become compliant, the facility must provide the Auditor documentation for eight newly hired employees and two promoted employees that includes evidence of background checks; evidence that the misconduct questions have been asked; notification to employees of the continuing affirmative duty to report sexual misconduct; and evidence to confirm that the facility contacted prior institutional employers to obtain information regarding sexual misconduct or resignations during a sexual abuse investigation. The facility must provide the Auditor with documentation for two contractors indicating a background investigation has been conducted in accordance with provision (d). The facility must also provide documentation for two volunteers to provide evidence that the facility did not enlist the services of any volunteer who may have continuing contact with detainees who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997), who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity.

§115.18 - Upgrades to facilities and technologies

Outcome: Meets Standard

Notes:

(a): This subsection of the standard is not applicable. FCJ has not designed or acquired a new holding facility or planned a substantial expansion or modification of the existing facility.

(b): FCJ SAAPP mandates, "At such time as the Facility plans any expansions or upgrades to The Facility, such expansions or upgrades shall take into consideration, the need to accommodate inmate safety and prevent sexual abuse." Interview with the PSA Compliance Manager and the JA confirm that cameras were upgraded

approximately one year ago. During the installation the facility considered how such technology may enhance safety and security of the institution based on an interview with the PSA Compliance Manager and FA.

Corrective Action:

No corrective action needed.

§115.21 - Evidence protocols and forensic medical examinations

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 Sexual Abuse and Assault Prevention and Intervention (SAAPI), outlines the Agency's evidence and investigation protocols. Per policy 11062.2, "when a case is accepted by OPR, OPR coordinates investigative efforts with law enforcement and the facility's incident review personnel in accordance with OPR policies and procedures. OPR does not perform sex assault crime scene evidence collection. Evidence collection shall be performed by a partnering federal, state, or local law enforcement agency. The OPR will coordinate with the ICE ERO Field Office Director (FOD) and facility staff to ensure evidence is appropriately secured and preserved pending an investigation. If the allegation is not referred or accepted by DHS Office of Inspector General (OIG), OPR, or the local law enforcement agency, the agency would assign an administrative investigation to be conducted." FCJ SAAPP mandates, "The Facility is responsible for investigating allegations of sexual abuse and shall follow a uniform evidence protocol. All clothing and bedding will be collected. These items will be placed in a paper evidence bag and labeled according to procedure; All evidence will be turned over to the Investigator; Victim will be scheduled for an examination and/or treatment as necessary; The facility shall offer all detainees who experience sexual abuse access to forensic medical examinations with the victim's consent and without cost to the detainee and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Examinations shall be performed by a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forensic Examiner (SAFE) or a qualified medical practitioner if SANE or SAFE is not available; and The Facility shall develop a protocol, in conjunction with DHS on how best to utilize community resources and services to make available valuable expertise and support in the areas of a crisis intervention and victim advocacy." FCJ is utilizing the facility SAAPI policy for a uniform evidence protocol. A review of this policy confirms it has not been developed, reviewed, or approved in coordination with DHS. The Auditor reviewed an email between FCJ and Family Crisis Services, Inc, which stated in part that Family Crisis Services works with the FCSO to provide advocacy services to victims of sexual violence. Family Crisis Services additionally provides a 24-hour crisis line, referrals, and advocates. During the onsite the Auditor observed the Family Crisis Services telephone number and address posted in the open bay/dormitory housing unit. Interviews with the PSA Compliance Manager and medical staff confirmed that should a detainee require medical services they would be transported to St. Catherines Hospital for a SAFE/SANE examination where services would be provided at no cost to the detainee. The Auditor contacted Family Crisis Services and confirmed this organization would provide expertise and support in the areas of crisis intervention, counseling, information, and referrals as needed for a detainee. The Auditor additionally contacted an emergency room nurse at St. Catherines who confirmed that SANE/SAFE examinations would be conducted at the hospital. There were no allegations of sexual abuse reported at FCJ during the audit period. FCJ does not house juvenile detainees.

(e): FCJ SAAPP mandates, "Any outside investigating agency tasked with investigating allegations of sexual assault will follow all requirements of standard 115.21." Interview with the facility Investigator confirmed that he is an employee of FCSO and is responsible for conducting administrative sexual abuse investigations. Should the case be referred for criminal prosecution, the FCSO would investigate the case. He confirmed that both entities are part of the same agency; and therefore, are required to follow the requirements of subsection (a – d) of the standard.

Corrective Action:

Does Not Meet (a): A review of FCJ SAAPP confirms that the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit dated June 6, 2023, and has not submitted to the Agency for review and approval. Interview with the PSA Compliance Manager could not confirm FCJ SAAPP was developed in coordination with DHS. To become compliant, the facility must submit FCJ SAAPP dated June 6, 2023, to the Agency for review, coordination, and approval and submit documentation to the Auditor for compliance review.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): The Agency provided policy 11062.2, which states in part that; "when an alleged sexual abuse incident occurs in ERO custody, the FOD shall: a) Ensure that the appropriate law enforcement agency having jurisdiction for the investigation has been notified by the facility administrator of the alleged sexual abuse. The FOD shall notify the appropriate law enforcement agency directly if necessary. b) Notify ERO's Assistant Director for Field Operations telephonically within two hours of the alleged sexual abuse or as soon as practical thereafter, according to procedures outlined in the June 8, 2006, Memorandum from John P. Torres, Acting Director, Office of Detention and Removal Operations, regarding "Protocol on Reporting and Tracking of Assaults" (Torres Memorandum); and c) Notify the ICE Joint Intake Center (JIC) telephonically within two hours of the alleged sexual abuse and in writing within 24 hours via the ICE SEN Notification Database, according to procedures outlined in the Torres Memorandum. The JIC shall notify the DHS Office of Inspector General (OIG)." FCJ SAAPP states in part that the Facility shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Policy further mandates, "Retention of such reports will be for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. When a detainee(s) is alleged to be perpetrator, it is the facility administrator's responsibility to ensure that the incident is promptly referred to the appropriate law enforcement agency having jurisdiction for investigation and reported to ICE. When an employee, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse or assault, the following shall be notified immediately: the Facility Administrator; the Finney County Sheriff; and the respective Field Office Director. The Field Office Director shall notify: The Deputy Assistant Director, Detention Management Division, The ICE office of Professional Responsibility (OPR). OPR will refer to the matter to the DHS Office of the Inspector General (OIG). The facility administrator or Field Office Director shall also refer the matter to the FBI (or other appropriate law enforcement agency)." The Auditor reviewed the facility website https://wwwfinneycounty.org and confirmed the FCJ SAAPP evidence protocol is not posted resulting in non-compliance with provision (c). The Auditor reviewed a memorandum that stated should the FCSO investigate the case and the investigation would fall into compliance with section 115.21 a-d of the SAAPI policy. Interviews with the JA, PSA Compliance Manager and Investigator confirmed the

facility would investigate all allegations of sexual abuse and that FCJ would conduct an administrative investigation unless it was criminal or involved a staff member. Should a staff member be involved in an investigation the FCSO would investigate. The Auditor confirmed through interviews that appropriate notifications would be made to ICE and investigative authorities and ICE would make the appropriate notifications to the Joint Intake Center, the ICE Office of Professional responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director for an alleged detainee or staff perpetrator of detainee sexual abuse. Interview with the PSA Compliance Manager further confirmed sexual abuse records would be kept in his office in a locked cabinet, which the Auditor observed. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

Does Not Meet (c): The Auditor reviewed the facility website https://wwwfinneycounty.org and confirmed facility protocol is not posted on its website or otherwise made available to the public as required by subsection (c) of the standard. To become compliant the facility must post facility protocols to its website or otherwise make the protocol available to the public. To become compliant, the facility must ensure that facility protocols are made available to the public and provide documentation to the Auditor.

§115.31 - Staff Training

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): The Auditor reviewed FCJ SAAPP and it does not specifically address training requirements of staff who may have contact with detainees. The facility provided and the Auditor reviewed a New Jail Deputy Orientation checklist, one acknowledgement example that where a staff member had read the Finney County Jail/ICE Detainee Sexual Abuse and Assault Prevention Policy revised on April 11, 2023, and the ICE Prison Rape Elimination Act (PREA) Training for Contractors and Volunteers. Interview with the TO indicated that staff were trained just recently; however, sufficient documentation could not be provided. The interview with the TO further confirmed that new staff would be trained on the new FCJ SAAPP policy. Interviews with four staff confirmed that PREA training was completed within the last three months and had received no training prior. The Auditor reviewed 13 staff files and confirmed staff training was accomplished within three months of the onsite and consisted of a signed acknowledgement form of the FCJ SAAPP. However, the training curriculum submitted by the facility does not align with the information stated on the training records and the Auditor found this insufficient to confirm that staff had received training on the topics outlined in provisions (a). The facility has not demonstrated compliance with staff training requirements. The Auditor reviewed four ERO staff training records and found them current and compliant with the requirements of the standard. The Auditor also reviewed the ICE PREA Employee Training provided on the ERAU SharePoint and confirmed that all required topics are included.

Corrective Action:

Does Not Meet (a)(b)(c): Training records reviewed indicated staff had recently been trained; however, the training records did not align with the curriculum provided and the Auditor was unable to confirm that all topics required of provision (a) were covered in the training. To become compliant, the facility must implement a training curriculum that includes all elements required of this standard and provided to the Auditor for compliance review. After implementation, documentation must be provided that all staff have received this

training. Additionally, the facility must implement procedures to ensure that all newly hired staff receive this training and that all existing staff receive refresher training at least every two years.

§115.32 - Other Training

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility shall ensure that all volunteers and contractors who have contact with detainees have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection and response policies and procedures, volunteers will have a background check to insure no sexual misconduct." Interview with the TO confirmed that all volunteers and contractors who have contact with detainees are not trained. Interview with the PSA Compliance Manager also confirmed that contractors may have contact with detainees have not been trained according to the requirements of this standard.

Corrective Action:

Does Not Meet (a)(b)(c): The facility has not demonstrated that volunteers and other contractors have been trained on their responsibilities under the agency's and facility's sexual abuse prevention, detection, intervention and response policies and procedures. To become compliant the facility must develop procedures to ensure all volunteers and other contractors who have contact with detainees have been trained on their responsibilities under the agency's and facility's sexual abuse prevention, detection, intervention and response policies and procedures. Once developed and implemented, the facility must provide documentation of these procedures and evidence for two other contractors and two volunteers to indicate they have received the required training.

§115.33 - Detainee Education

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): FCJ SAAPP mandates, "During the intake Transactions detainees shall receive information explaining the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse and sexual harassment. The detainee receives information regarding the "zero tolerance" during the detainee screening process in booking. In cases of limited English proficiency (LEP) or hearing impairment, information on SAAPI will be provided, when possible, in a language or manner understood by the detainee. PREA statements and posters are placed in detainees living area. Detainees will be educated on prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings. Detainees will be educated on the right to receive treatment and counseling if subjected to sexual abuse. Detainees will be educated about self-protection and indicators of sexual abuse and definitions and examples of detainee sexual abuse, staff on detainee sexual abuse and coercive sexual activity. Detainees will also be educated on the prevention and intervention strategies. Detainees will be educated on the methods of reporting sexual abuse, including any staff member, including a staff member other than an immediate point-of-contact line officer, the DHS Office of Inspector General, and the Joint Intact Center. All detainees must sign in and acknowledge they understand the policy prior to their assignment to be a cell/pod." The intake process at FCJ consists of detainee education in the form of a PREA video watched in the ICE processing room and ICE staff presenting the detainee with the ICE National Detainee Handbook. The ICE National Detainee Handbook is available in 14 of the most prevalent languages

encountered by ICE (English, Spanish, French, Haitian Creole, Punjabi, Hindi, Arabic, Simplified Chinese, Russian, Turkish, Bengali, Romanian, Portuguese, and Vietnamese) and the DHS-prescribed SAA information pamphlet is available in Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Vietnamese, Turkish, and Ukrainian. The facility did not have these additional languages available for the Auditor's review. The facility provides the FCJ facility handbook to detainees and the educational materials are presented in English or Spanish only. FCJ provided and the Auditor reviewed five signed orientation acknowledgement forms indicating that the detainees had received the SAAPI pamphlet in English or Spanish. These forms were not dated; therefore, the Auditor was unable to confirm that this information was provided to detainees during the intake process as required. The Auditor also reviewed a Finney County Jail/ICE Detainee SAAPI Orientation form signed by the detainees indicating they had viewed the orientation video and received the PREA/SAAPI brochure. The Auditor requested documentation for additional detainees while onsite, but the PSA Compliance Manager advised the Auditor that these electronic documents could not be accessed at that time. During the onsite the Auditor observed the DHS-prescribed sexual assault awareness notice, the name of facility PSA Compliance Manager and a poster for Family Crisis Services in the housing unit. Should a detainee have hearing, visual, limited reading skills, psychiatric or learning disabilities interviews with staff confirmed they would speak slower or louder, be patient or use google translate, but were unaware of the resources available to accommodate a detainee with a sight, hearing, psychiatric, learning disability or interpretation or translation of a language other than English or Spanish.

Corrective Action:

Does Not Meet (a)(b)(c)(d)(e)(f): FCJ's orientation is not compliant with the requirements of this standard. ICE presents the detainee with the ICE Detainee National Handbook, SAAPI information pamphlet and a PREA video. The facility only provides the detainee with a facility handbook which does not include: information about the agency's and facility's zero-tolerance policies for all forms of sexual abuse, nor does it provide instruction on: prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of-contact line officer(e.g., the compliance manager or a mental health specialist), the DHS Office of Inspector General, and the Joint Intake Center; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. The facility does not provide the detainee notification, orientation, and instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to detainees who have limited reading skills. The facility was not able to access electronic detainee records for the Auditor to review. In order to become compliant, the facility must provide an orientation program to the Auditor that notifies the detainee about the agency's and facility's zero-tolerance policies for all forms of sexual abuse and provides instruction on: prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity; explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of-contact line officer(e.g., the compliance manager or a mental health specialist), the DHS Office of Inspector General, and the Joint Intake Center; information about self-protection and indicators of sexual abuse; prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. In order to become compliant with subsection (b) of this

standard, documentation must be provided that the orientation program is in formats accessible to detainees that are deaf, visually impaired or otherwise disabled as well as to detainees who have limited reading skills. The facility must also provide documentation that it has the capability to educate detainees in other languages besides English and Spanish. In order to become compliant with subsection (c) of this standard, the facility must provide documentation that detainees have participated in the orientation process and be able to access electronic documentation in the detainee file. In order to become compliant with subsections (e) and (f), the facility must have the DHS-prescribed Sexual Assault Awareness Notice and the ICE National Detainee Handbook available in a language that easily understood to the detainee. The facility should provide additional documentation that the DHS-prescribed SAAPI pamphlet can be provided to detainees in all 14 languages and the ICE National Detainee Handbook is provided and received by all detainees in all 15 of the required languages.

§115.34 - Specialized training: Investigations

Outcome: Meets Standard

Notes:

(a)(b): 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 Investigating Incidents of Sexual Abuse and Assault, which covers in depth investigative techniques, evidence collections, and covers all aspects to conduct 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; LGBTI, and disabled residents; and an overall view of the investigative process. The Agency provides rosters of trained investigators on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirement. FCJ SAAPP mandates, "In addition to the general training provided to all employees, the Facility shall ensure that, to the extant the Facility itself conducts sexual abuse investigations, its Investigators have received training in conducting such investigations in confinement settings." The Auditor reviewed a certification of completion from the National Institute of Corrections (NIC) for "PREA: Investigating Sexual Abuse in a Confinement Setting" for the facility investigator. The Auditor confirmed it complies with the specialized training required of this standard.

Corrective Action:

No corrective action needed.

§115.35 - Specialized training: Medical and mental health care

Outcome: Does Not Meet Standard

Notes:

(a): The facility does not employ DHS or Agency employees who serve as full and part-time medical or mental health practitioners, and therefore, this element of the standard is not applicable.

(b)(c): FCJ SAAPP mandates, "The Facility shall ensure that all full and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of

sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and How and to who, to report allegations or suspicions of sexual abuse and sexual harassment." The Auditor reviewed completed ACH training courses for the medical nurse. The course is listed as "Annual Training PREA" and not listed as the specialized medical and mental health care training required of the standard. Interview with the medical nurse confirmed that annual training has been completed, but not the specialized training. Interview with the Mental Health Practitioner confirmed that they had only been hired two weeks ago and have not completed the required training. The Auditor was not provided with training records or curriculum or a lesson plan for the required medical and mental health specialized training for review to confirm medical and mental health have been trained on how to detect and assess signs of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, how and to whom to report allegations or suspicions of sexual abuse and how to preserve physical evidence of sexual abuse. Medical staff employed by FCJ do not conduct medical forensic examinations. A review of FCJ SAAPP dated June 6, 2023, confirmed it has not been submitted to the Agency for review and approval.

Corrective Action:

Does Not Meet (b)(c): The facility did not provide training records or curriculum for the medical and mental health specialized training to confirm the contract medical and mental health staff have been trained and that the training includes all required elements of subsection (b) of the standard. In addition, the facility did not provide medical and mental health staff training records or course completion certificates to confirm specialized training has been received. Additionally, the facility has not submitted their FCJ SAAPP policy dated June 6, 2023, to the Agency for review and approval. To become compliant the facility must submit a copy of the specialized training curriculum utilized for medical and mental health staff, documentation that all medical and mental health staff have received the required specialized training; and evidence that the FCJ SAAPP has been submitted to the Agency for review and approval.

§115.41 - Assessment for risk of victimization and abusiveness

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f)(g): FCJ SAAPP mandates, "All Detainees shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other detainees or sexually abusive toward other detainees. During intake the detainee shall be classified within 12 hours of the admission into the facility utilizing several factors including criminal history, perpetrator history, victimization history and special vulnerabilities including LGBTQI+. The facility will reassess the risk of sexual victimization or abusiveness of an at-risk detainee every 90 days." Interview with Booking/Classification staff confirm that detainees are held separately in the booking area until classified and this process is completed within 12 hours of entering the facility. Booking/Classification staff and the PSA Compliance Manager confirmed in interviews that a detainee would not be disciplined for refusing to answer any questions on the assessment. The Auditor was provided a PREA Risk of Victimization Assessment tool the facility had recently started to utilize. Review of this form confirms the questions only apply to victimization and do not adequately assess a detainee for risk of abusiveness. Further interview with the Booking/Classification staff confirmed that reassessment is not completed at the 60-to-90-day requirement or at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. Additionally, interviews with

staff confirmed there is no control over information contained in the detainee electronic file and any staff can access the information. The Auditor requested to observe electronic detainee files to review screening documents, but the PSA Compliance Manager advised the electronic files could not be accessed at that time. There were no detainees housed at the facility during the onsite audit.

Corrective Action:

Does Not Meet (a)(c)(d)(e)(g): The facility just recently started to utilize the PREA Risk of Victimization Assessment and does not have a risk assessment tool to assess detainees for risk of abusiveness. To become compliant, the facility must implement a risk assessment tool that will assess detainees upon intake to identify those likely to be sexual aggressors or sexual abuse victims so they can be housed accordingly. This assessment tool must meet all elements of subsection (c) and (d) of this standard and be completed within twelve hours of admission to FCJ. The facility must provide the developed assessment tool to the Auditor for compliance review. Once the facility has implemented the new assessment tool, they must provide documentation of detainee assessments completed during intake, at the 60-to-90-days after initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization. Documentation must be provided to the Auditor for 10 detainee intakes during the CAP period. The facility must train appropriate staff on the requirements under this subsection and provide documentation that training has been completed. The facility must provide documentation that appropriate controls on the dissemination of sensitive information obtained during the assessment is not exploited to the detainee's detriment by staff or other detainees.

§115.42 - Use of assessment information

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility shall use information from the risk screening to inform housing, bed, education, and program assignments with the goal of keeping separate those detainees at high risk of being sexually victimized from those at high risk of being sexually abusive. Transgender and intersex detainees shall have an opportunity to shower separately from other detainees." The facility does not have a viable risk assessment tool required under standard 115.41 and subsequently will be not compliant with subsection (a) of this standard. In an interview with Booking/Classification staff it was confirmed that medical or mental health personnel are not consulted prior to making housing decisions for a transgender or intersex detainee. Interviews with booking/classification staff also confirmed that housing decisions would be made based on security and not a detainee's gender self-identification or an assessment of the effects of placement on the detainee's health and safety which is also not in compliance with this standard. Interviews with the JA, PSA Compliance Manager and three random staff confirm that a transgender or intersex detainee has not been housed at the facility during the audit period. Staff confirmed that a transgender or intersex detainee would be able to shower separately.

Corrective Action:

Does Not Meet (a)(b): The facility does not have a viable risk assessment required under standard 115.41 and subsequently will be not compliant with subsection (a) of this standard. To become compliant, the facility must provide documentation that a risk assessment developed under standard 115.41 is utilized to make individualized determinations about how to ensure the safety of each detainee. Once implemented the facility must train all booking, classification, medical and mental health staff on both new practices and provide training documentation to the Auditor. The facility must submit to the Auditor 10 detainee files to confirm that the new practice has been

implemented. If applicable, the facility must submit to the Auditor any detainee files that include detainees who are transgender or intersex to confirm the facility considered the detainee's gender self-identification when making assessment and housing decisions for a transgender or intersex detainee and reassessed a transgender or intersex detainee's placement and programming at least twice each year to review any threats to safety experienced by the detainee.

§115.43 - Protective Custody

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e): FCJ SAAPP mandates, "Detainees at high risk for sexual victimization shall not automatically be place in involuntary segregated housing unless an assessment of all available alternatives had been made. Detainees at high risk for sexual victimization may be placed in involuntary segregated housing if an assessment of all available alternatives indicates there is no available alternatives means of separation from likely abusers. Any use of segregated housing to protect a detainee who has allegedly suffered from sexual abuse shall be subject to the requirements listed herein." A review of FCJ SAAPP confirms it does not require a supervisory staff member to conduct a review after a detainee has spent seven days in administrative segregation and every week thereafter, for the first 30 days, and every 10 days thereafter, or the requirement to notify the appropriate ICE FOD no later than 72 hours after the initial placement into segregation whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault. This policy also does not require that an assignment to administrative segregation for this purpose should not ordinarily exceed 30 days. Further review of FCJ SAAPP also confirms there is no provision to provide detainees access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable. In addition, a review of FCJ SAAPP confirmed it has not been developed in consultation with the ICE ERO FOD having jurisdiction for the facility. The facility provided an ICE Administrative Segregation Order for the Auditor to review. This form has areas for the reason for placement and a brief outline of circumstances for the placement. The Auditor also reviewed a Protective Custody Request form in which a detainee could request protective custody. This form gives notification to the detainee they would be placed on a 23/1 lockdown status and their placement would not be completed until after 10 days even if they requested removal prior to the 10-day requirement. Interview with the JA and PSA Compliance Manager confirmed that detainees at high risk for sexual victimization would not be placed in involuntary segregated housing unless there was no suitable alternative and that the facility previously had not utilized the ICE Administrative Segregation Order. Additionally, the As a result, the facility is non-compliant with the requirements of (a)(b)(d)(c)(e). There were no allegations of sexual abuse at FCJ during the audit period.

Corrective Action:

Does Not Meet (a)(b)(d)(c)(e): A review of FCJ SAAPP confirms it does not require a supervisory staff member to conduct a review after the detainee has spent seven days in administrative segregation and every week thereafter, for the first 30 days, and every 10 days thereafter, or the requirement to notify the appropriate ICE FOD no later than 72 hours after the initial placement into segregation whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault. Additionally, the policy does not require that an assignment to administrative segregation for this purpose should not ordinarily exceed 30 days. . The FJC SAAPP included no provision to provide detainees access to programs, visitation, counsel, and other services available to the general population to the maximum extent practicable. To become compliant the facility

must update their written procedures (FCJ SAAPP) to include all elements of the standard and these procedures must be developed in consultation with the ICE ERO F having jurisdiction of the facility. The revised written procedures must be provided to the Auditor for compliance review along with evidence that these procedures were developed in consultation with the ICE ERO FOD. Once updated, the facility must train all affected staff on the updated policy and provide documented evidence of this training. If applicable, the facility must submit to the Auditor documentation for any detainee who is placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault during the CAP period for compliance review.

§115.51 - Detainee Reporting

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The Facility shall provide multiple internal ways for detainees to privately report sexual abuse and sexual harassment or violation of those responsible for such incidents. Detainees may report sexual abuse and sexual harassment by using the Inmate Communications Form (ICF) to report to the Administration staff or externally mailing to family member who can contact the Jail Administrator. Detainees can report sexual abuse and sexual harassment directly to detention and/or medical staff. Detainees have access to phone and any contact a family member to have them report the allegation to the Jail Administration. The facility shall provide detainees with access to outside victim advocates for emotional support services related to sexual abuse. Detainees shall be provided multiple ways to privately report retaliation for reporting sexual abuse, staff neglect or violations of responsibilities that may have contributed to an incident of sexual abuse. Facility staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document verbal reports. The facility has established a method to receive third-party reports of sexual abuse in its facility and makes it available to the public on how to report sexual abuse on behalf of a detainee." During the onsite audit the Auditor observed the DHS-prescribed sexual assault awareness notice, the DHS OIG poster and DRIL poster displayed in the open bay/dormitory housing unit. The Auditor also observed posters within the housing unit for Family Crisis Services. During the onsite the Auditor attempted to make a telephone call to the DHS OIG through a detainee telephone in the housing unit. The telephone number dialed would not connect and the Auditor was not able to complete the call. Interviews with three random staff confirmed that they would accept verbal reports, those in writing, anonymous report, and those from third parties; and any report received would be reported to supervision, and documented immediately.

Corrective Action:

Does Not meet (b): The facility provides information of one way to report a sexual abuse to a public or private entity that is not part of the agency and allows the detainee to remain anonymous if requested via the DHS OIG. These informational posters were observed in the detainee housing unit; however, during the audit, a call could not be completed through this method from the detainee phones. To become compliant, the facility must provide the Auditor with documentation of at least one method detainees can report sexual abuse to a public or private entity or office that is not part of the agency, and that they are able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous upon request. Evidence of a successful test call completion must be submitted for compliance review.

§115.52 - Grievances

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): FCJ 606 Inmate Grievances mandates, "All inmates shall be provided with a grievance process for resolving complaints arising from facility matters with at least one level of appeal. Inmates will receive information concerning the grievance procedure in the Inmate Handbook issued to them. Inmates may appeal the finding of a grievance to the Jail Administrator as the final level of appeal within five days of receiving the findings of the original grievance. The Jail Administrator will review the grievance and either confirm or deny it. If the Jail Administrator confirms the grievance, he/ she will initiate corrective actions. In either case, the inmate shall receive a written response to the appeal. Appeals related to sexual abuse allegations shall be confirmed or denied by the Jail Administrator within 10 calendar days. Inmates cannot file a grievance on behalf of another inmate, but an inmate may assist another inmate in the preparation of a grievance." Review of FCJ SAAPP, FCJ 606 Inmate Grievance, and the facility Inmate Handbook confirmed there was no information included for: allowing a detainee to file a formal grievance relating to sexual abuse at any time or in lieu of lodging an informal grievance or compliant, not imposing a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse, written procedures for identifying and handling time sensitive grievances that involve an immediate threat to detainee health, safety or welfare related to sexual abuse and directive that facility staff to bring medical emergencies to the immediate attention of proper medical personnel for further assessment. FCJ 606 Inmate Grievance states in part that the JA will confirm or deny a grievance related to sexual abuse allegations within 10 calendar days, which does not meet the 5-day requirement of subsection (e) of the standard. FCJ Inmate Handbook further states, "Initial grievances must be submitted no later than 10 calendar days after the incident the inmate is grieving about. Jail Staff will then have 10 business days to respond to the grievance." This information does not meet the requirement of subsections (a) or (b) of the standard. The Auditor reviewed the facility Inmate Handbook and could not confirm the grievance section notifies detainees of how PREA grievances are to be submitted, the appeal process, and time limits. Interview with the GO confirms that the FCJ has not had any allegations of sexual abuse during the audit period and has not received any grievances regarding an allegation of sexual abuse. The GO further indicated detainees are permitted to file a formal grievance related to sexual abuse at any time with no time limit imposed and that there are written procedures for handling time-sensitive grievances, but he would have to look them up. In addition, the GO confirmed that medical emergencies are brought to the immediate attention of medical staff and FCJ would allow a detainee's request for assistance from another person. Based on the date of the policy and interviews with the PSA Compliance Manager and GO, the Auditor determined this policy was newly established by the facility prior to the onsite audit and the process had not been utilized for a PREA grievance.

Corrective Action:

Does Not Meet (a)(b)(d)(e): A review of FCJ SAAPP, FCJ 606 and the Inmate Handbook confirms it does not include information for: allowing a detainee to file a formal grievance relating to sexual abuse at any time or in lieu of lodging an informal grievance or compliant, not imposing a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse, written procedures for identifying and handling time sensitive grievances that involve an immediate threat to detainee health, safety or welfare related to sexual abuse and directive that facility staff to bring medical emergencies to the immediate attention of proper medical personnel for further assessment. Written directive also does not include appropriate timelines for issuing a decision on the

grievance with 5 days of receipt and a response to an appeal of the grievance decision within 30 days nor procedures for identifying and handling time sensitive grievances that involve an immediate threat to detainee health, safety or welfare related to sexual abuse. Written directive only includes the requirement that a detainee can use assistance from another detainee to prepare a grievance, but do not include staff, family members or legal representative or that staff shall take reasonable steps to expedite requests from these other parties. To become compliant, FCJ 606 Inmate Grievances must be updated to include all elements of the standard. FCJ Inmate Handbook must also be updated to include the written process for filing a grievance at any time, emergency grievance, appeal timelines and requests for assistance by others. Once updated the facility must provide documentation to the Auditor confirming the update was completed. The facility must train all affected staff in the updated process and once completed submit to the Auditor documentation that the training was received. If applicable, the facility must submit to the Auditor any detainee grievances alleging sexual abuse that occur during the CAP to confirm the updated practice has been implemented.

§115.53 - Detainee access to outside confidential support services

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): FCJ SAAPP mandates, "Staff shall utilize available community resources and services to provide valuable expertise and support in areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse and assault perpetrators to address victims' needs most appropriately." The facility provided an email from Family Crisis Services acknowledging this organization will provide services to detainees of FCJ. The Auditor observed a poster for the Family Crisis Services in the open bay/dormitory housing unit with a telephone number and mailing address. Detainees are notified that all calls from the facility are subject to monitoring and recording under the "Telephones" section of the FCJ Inmate Handbook. Further review of the handbook confirms the facility does not provide information to the detainee about the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Interview with the PSA Compliance Manager confirmed that Family Crisis Services would be utilized for detainee support services as needed and all telephone calls are monitored and recorded. There were no sexual abuse allegations received within the audit period.

Corrective Action:

Does Not Meet (a)(d): A review of the facility handbook confirms the facility informs detainees of the extent to which communication with outside resources will be monitored, but it does not inform detainees the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws nor does it include the contact information for Family Crisis Services. During the onsite audit the Auditor confirmed that the posted signage related to Family Crisis Services was only available in English. The facility additionally must notify detainees the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws which was not included on the posted signage. The facility must document that the requirements have been implemented and provide said documentation to the Auditor for compliance.

Recommendation: The Auditor recommends that the facility provide the posted signage related to Family Crisis Services in both English and Spanish. Additionally, as part of the SAAPI program, the facility should have a method in place to have this information translated into other languages as needed, in accordance with requirements of 115.16,

§115.54 - Third-party reporting

Outcome: Meets Standard

Notes:

FCJ SAAPP mandates, "The facility has established a method to receive third-party reports of sexual abuse in its facility and makes it available to the public on how to report sexual abuse on behalf of a detainee." During the onsite audit the Auditor observed third party reporting posters within the facility but not posted in the front entry where visitors enter the facility. The Auditor reviewed FCJ's website https://wwwfinneycounty.org and did not observe any information for third party reporting. A corrective action was completed onsite, and the PSA Compliance Manager posted third party reporting information on the bulletin board in the facility lobby. The Auditor finds substantial compliance with this standard.

Corrective Action:

No corrective action needed.

§115.61 - Staff and Agency Reporting Duties

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): The Agency's policy 11062.2 mandates, "All ICE employees shall immediately report to a supervisor or a designated official any knowledge, suspicion, or information regarding an incident of sexual abuse or assault of an individual in ICE custody, retaliation against detainees or staff who reported or participated in an investigation about such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." In addition, ICE Directive 11062.2 states, "If alleged victim under the age of 18 or determined, after consultation with the relevant [Office of Principal Legal Advisor] OPLA Office of the Chief Counsel (OCC), to be a vulnerable adult under state or local vulnerable persons statute, reporting the allegation to the designated state of local services or local service agency as necessary under applicable mandatory reporting law; and to document his or her efforts taken under this section." FCJ SAAPP mandates, "Staff must report allegations or knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in the facility; retaliation against detainees or staff who report or participate in an investigation into such an incident; and any staff neglect or violation of responsibility that may have contributed to an incident of retaliation and staff shall be permitted to report an incident outside the chain of command." Review of FCJ SAAPP confirms that staff shall be permitted to report an incident outside the chain of command; however, policy does not specify a method staff may use and the Auditor did not observe informational signage during the onsite for staff to utilize. Further review of FCJ SAAPP confirmed the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit effective June 6, 2023, and has not submitted to the Agency for review and approval. Interviews with three deputies confirmed they were knowledgeable regarding their responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse and retaliation or staff neglect. Staff could not confirm information on how to make a report of sexual abuse outside the chain of command. Interviews with staff also confirmed they would not reveal any information regarding an allegation of sexual abuse to anyone other than to the extent necessary. Interview with the Investigator confirmed that if a victim is under 18 or considered a vulnerable adult under state law, the allegation would be reported to the designated State or local services agency. The facility has not had any sexual abuse reports during the audit period for review. The facility does not house juveniles.

Corrective Action:

Does Not Meet (a)(d): A review of FCJ SAAPP confirms staff will be trained on a method by which they can report outside of their chain of command; however, the policy does not specify the method staff would use and there is no informational signage posted at the facility. A review of FCJ SAAPI further confirmed the Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes to the policy prior to the onsite audit. The facility provided FCJ SAAPP dated June 6, 2023, for Auditor review. To become compliant, the facility must update FCJ SAAPP to include a method for staff to report an allegation of sexual abuse outside the chain of command, include this information in staff training or otherwise post informational signage for staff to utilize. All staff must be trained on this requirement and documentation provided to the Auditor of completed training. Appropriate staff must additionally be trained on the mandatory Agency reporting requirement if the victim is under the age of 18 or considered a vulnerable adult. The facility must provide the Auditor with documentation of this completed training. The facility must also submit the revised FCJ SAAPP to the Agency for review and approval and submit documentation to the Auditor that this has been completed.

§115.62 - Protection Duties

Outcome: Meets Standard

Notes:

FCJ SAAPP mandates, "Upon learning that an inmate is subject to a substantial risk of imminent sexual abuse, Facility staff shall take immediate action to protect the detainee." Interviews with the JA, PSA Compliance Manager and three deputies confirmed that any detainee at risk would be removed from the area immediately for their own safety. There were no allegations of sexual abuse reported at FCJ during the audit period.

Corrective Action:

No corrective action needed.

§115.63 - Reporting to other Confinement Facilities

Outcome: Meets Standard

Notes:

(a)(b)(c)(d): FCJ SAAPP mandates, "Upon receiving an allegation that a detainee was sexually abused while confined at another facility the Jail Administrator shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation." Interviews with the JA and PSA Compliance Manager confirm that if a detainee reported abuse while confined at another facility notification would be made immediately to the other facility. Interview with the JA further confirmed that should another facility contact FCJ about a sexual abuse that allegedly occurred at the facility, an investigation would be started, and notification made to ICE immediately. The JA further confirmed that initial notification would be made telephonically, but a follow up email would be sent. There were no allegations of sexual abuse reported at FCJ during the audit period.

Corrective Action:

No corrective action needed.

§115.64 - Responder Duties

Outcome: Does Not Meet Standard

Notes:

(a): FCJ SAAPP mandates, "Staff shall take immediate action to separate any detainee who alleges that he/she has been sexually abused or assaulted from the alleged assailant and shall refer the detainee for a medical examination and/or clinical assessment for potential negative symptoms. The first security staff member to respond to a report of sexual abuse, or his or her supervisor, shall preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a period that still allows for the collection of physical evidence, the first responder shall: Request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and Ensure the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating defecating, smoking, drinking, or eating." Interviews with three DOs confirmed that staff would separate the alleged victim from the abuser and protect the scene, but staff could not articulate first responder duties to request the detainee victim not take any action that could destroy physical evidence and ensure the alleged abuser does not take action that could destroy evidence. The facility did not have any reported sexual abuse allegations during the audit period to review.

(b): FCJ SAAPP mandates, "If the first staff responder is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff." The facility has no non-security staff, volunteers or contractors.

Corrective Action:

Does Not Meet (a)(b): Interviews with staff confirmed that the alleged victim and abuser would be separated, and scene protected, but staff could not articulate first responder duties to request the detainee victim not take any action that could destroy physical evidence and ensure the alleged abuser does not take action that could destroy evidence. To become compliant the facility must train/retrain all security and non-security staff on their first responder responsibilities. Once completed the facility must submit to the Auditor documentation that the training was received.

§115.65 - Coordinated Response

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): FCJ SAAPP mandates, "The facility uses a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a security staff member, and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise. If a victim of sexual abuse is transferred between facilities the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise." The facility utilizes FCJ SAAPP as their coordinated, multidisciplinary team approach to responding to sexual abuse. A review of this policy confirms the plan does not coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an

incident of sexual abuse. Further review of the policy confirms that the facility would not provide a DHS or non-DHS facility information pertaining to an incident or the detainee victim's potential need for services if the victim requests the information not to be shared. This statement contradicts subsection (c), in which the facility shall, as permitted by law, inform a receiving DHS facility of the detainee victim's need for potential services. Interview with the JA confirmed the facility would utilize FCJ SAAPP as a guide should an incident occur. Additionally, should a victim be transferred to any other facility information pertaining to the incident and victim's potential need for medical or social services would be provided. FCJ did not have any allegations of sexual abuse during the audit period.

Corrective Action:

Does Not Meet (a)(b)(c)(d): The Auditor's review of FCJ SAAPP confirms it does not include the coordinated actions to be taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in responding to an incident of sexual abuse. The facility would use FCJ SAAPP as a guide should an incident occur, but this policy does not specify actions of each team member. An interview confirmed that information would be given to a transferring facility of a detainee victim's need for potential services with no distinction between a DHS or non-DHS facility or the requirements of subsection (c) and (d). To become compliant, the facility must develop a 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. In addition, the facility must update policy to reflect the verbiage of subsection (c) and (d) and provide to the Auditor for compliance review. The facility must train affected staff of the newly developed and implemented institutional plan and provide documentation to the Auditor this training was completed.

§115.66 - Protection of detainees from contact with alleged abusers

Outcome: Meets Standard

Notes:

FCJ SAAPP mandates, "Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation." Interview with the JA confirmed that any staff member, contractor, or volunteer would be immediately removed from the facility pending the results of an investigation. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

No corrective action needed.

§115.67 - Agency protection against retaliation

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): Agency policy 11062.2 mandates, "ICE employees shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse or assault, or for participating in sexual activity as a result of force, coercion, threats, or fear of force." FCJ SAAPP mandates, "The facility shall take necessary measures to protect all detainees and staff that report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other

detainees and staff." The facility did not have any sexual abuse allegations reported during the audit period and subsequently did not had any sexual abuse grievances filed. Review of FCJ SAAPP further confirms that 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 investigators has not been considered. FCJ SAAPP additionally does not provide for monitoring for at 90 days following a report or the should the need arise over 90 days if there is a continuing need. Interview with the PSA Compliance Manager confirmed that the facility would monitor disciplinary only and this monitoring would be documented on an observation form. Interview with the JA confirmed that should staff retaliation occur, the staff member would immediately be counseled on the behavior.

Corrective Action:

Does Not Meet (b)(c): The facility does not consider 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 investigators. Although documenting retaliation monitoring on an observation form is acceptable, the PSA Compliance Manager could not articulate the need for monitoring for at least 90 days or longer if there is a demonstrated continuing need. To become compliant, the facility must implement a procedure to ensure retaliation monitoring is conducted for 90 days or longer if needed and it employs 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 investigators in addition to disciplinary report monitoring. Evidence of this procedure must be provided to the Auditor for compliance review, along with any documented retaliation monitoring resulting from allegations of sexual abuse that occurs during the CAP period, if applicable. Additionally, the facility must provide evidence that all affected staff have been trained on the new procedures.

§115.68 - Post-allegation protective custody

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): FCJ SAAPP policy does not reference post-allegation protective custody. The facility provided a segregation order for Auditor review but an interview with the PSA Compliance Manager could not articulate to the Auditor how and under what circumstances this form would be utilized. The form does not include areas to document that detainee placement represents the least restrictive housing option possible subject to the requirements of 115.43 or areas for the required placement reviews also required of standard 115.43. An interview with Booking/Classification staff confirmed that a reassessment is not completed following an incident of abuse or victimization. Interview with the JA indicated that should protective custody be needed the detainee victim would be housed in the least restrictive manner as possible and notification would be made to ICE when a detainee is held in administrative segregation over 72 hours. The JA further confirmed that a detainee would not be held for longer than five days in administrative segregation unless the detainee requested this placement. The facility did not have any reported allegations during the audit cycle.

Corrective Action:

Does Not Meet (c): The facility does not reassess detainees prior to their return to general population after an incident of sexual abuse. To become compliant the facility must implement a practice that requires detainee victims who are in protective custody after having been subjected to sexual abuse not be returned to the general

population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse. Once established the facility must document that the practice has been implemented and that all applicable staff have been trained on the new practice. If applicable, the facility must submit to the Auditor a reassessment prior to the detainee return to general population when a detainee was placed into administrative segregation due to an allegation of sexual abuse.

§115.71 - Criminal and administrative investigations

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(e)(f): FCJ SAAPP mandates, "When the Facility conducts its own investigations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third party and anonymous reports. The Facility shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The facility shall develop written procedures for administrative investigations, including provisions requiring: Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation. The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse and assault, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation." Review of FCJ SAAPP confirms that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Review of policy does not direct FCJ to consult with the appropriate investigative office within DHS prior to conducting an administrative investigation and interview with the PSA Compliance Manager confirms DHS is not consulted resulting in non-compliance with provision (b). FCJ has not developed written procedures for administrative investigations, including provisions requiring: Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. Such procedures shall govern the coordination and sequencing of administrative and

criminal investigations, in accordance with the first paragraph of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation. As a result, the facility does not meet provision (c). Review of completed training records confirmed the facility investigator has completed the required specialized training required of subsection (a) of this standard. Interview with the JA confirmed that any investigations would be completed and not terminated due to the departure of an alleged abuser or victim from the employment or control of the facility. The JA further confirmed that if FCSO completed the investigation, he would remain informed by speaking with the investigator daily. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

Does Not Meet (c): FCJ has not developed written procedures for administrative investigations, including provisions requiring: Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; Interviewing alleged victims, suspected perpetrators, and witnesses; Reviewing prior complaints and reports of sexual abuse and assault involving the suspected perpetrator; Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse and assault to submit to a polygraph; An effort to determine whether actions or failures to act at the facility contributed to the abuse; Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years. To become compliant, the facility must develop written procedures for administrative investigations to include all requirements of subsection (c). Once completed the facility must provide the procedures to the Auditor and train all affected staff of the new procedures. The facility must provide the Auditor with documentation of the completed training.

§115.72 - Evidentiary standard for administrative investigations

Outcome: Meets Standard

Notes:

ICE Policy 11062.2 states, “Administrative investigations imposes no standard higher than the preponderance of the evidence to substantiate an allegation of sexual abuse or assault.” Additionally, the ICE OPR Investigations Incidents of Sexual Abuse and Assault training required for investigators includes the evidentiary standard for administrative investigations.” FCJ SAAPP mandates, “The Facility shall impose no standard than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.” During an interview with the facility Investigator, it was confirmed that that when an administrative investigation is undertaken it imposes no standard higher than a preponderance of the evidence to determine whether allegations of sexual abuse are substantiated. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

No corrective action needed.

§115.73 - Reporting to detainees

Outcome: Meets Standard

Notes:

FCJ SAAPP mandates, "Following an investigation into a detainee's allegation(s) that he or she suffered sexual abuse in the Finney County Jail, the Facility shall inform the detainee as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded." Interviews with the JA and PSA Compliance Manager confirmed that once an investigation was completed notification would be made to the detainee if they were still housed at the facility. If the detainee has been transferred notification would be made to ICE/ERO. FCJ did not have any allegations of sexual abuse reported during the audit cycle.

Corrective Action:

No corrective action needed.

§115.76 - Disciplinary sanctions for staff

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d): FCJ SAAPP mandates, "Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies to the disciplinary provisions set forth in the county's personnel policies and procedures." A review of FCJ SAAPP confirms it does not contain the verbiage, "including removal from their federal service for allegations of sexual abuse or for violating Agency or facility sexual abuse policies" or "removal from Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer." However, as termination is greater than removal from Federal Service, the Auditor finds FCJ SAAPP wording in substantial compliance with the wording required by subsection (b) of the standard. Review of FCJ SAAPP confirms there is no provision for the facility to report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies unless the activity was clearly not criminal. Additionally, there is no provision for the facility to make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known. The Auditor was provided with a blank termination letter and blank letter for notification to law enforcement agencies that was implemented just prior to the onsite audit. The Agency reviewed and approved FCJ SAAPP on May 25, 2023; however, the facility made changes June 6, 2023, and this revision has not been submitted for review or approval by the Agency. FCJ has not had any sexual abuse allegations during the audit period. Interview with the JA confirmed that staff are subject to disciplinary action to include termination for substantiated allegations of sexual abuse or violations of agency or facility sexual abuse policies.

Corrective Action:

Does Not Meet (b)(c)(d): FCJ SAAPP dated June 6, 2023, has not been submitted for review or approval by the Agency. The facility recently implemented the written termination notice and the notice to a law enforcement agency of termination; however, had not developed procedures on how the facility would 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. To become compliant, the facility must submit the FCJ SAAPP with a revision date of June 6, 2023, for agency review and approval and provide evidence to the Auditor

for compliance review. The facility must provide the Auditor evidence of their procedure for notifying law enforcement agencies and reasonable efforts to report to any relevant licensing bodies for completed sexual abuse allegations that may occur during the CAP period, if applicable.

§115.77 - Corrective action for contractors and volunteers

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "Contractors suspected of perpetrating sexual abuse or assault shall be removed from all duties requiring detainee contact pending the outcome of an investigation. Any contractor or volunteer who has engaged in sexual abuse or assault shall be prohibited from contact with detainees. The facility takes appropriate remedial measures and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse or assault but have violated other sexual abuse policies. Incidents of substantiated sexual abuse by a contractor or volunteer shall be reported to law enforcement agencies unless the activity was clearly not criminal. The facility reports such incidents to the ICE/ERO regardless of whether the activity was criminal and shall make reasonable efforts to report such incidents to any relevant licensing bodies, to the extent known. All allegations or suspicions of sexual abuse will be investigated and reported in a timely manner." Interview with the JA confirmed that criminal incidents involving contractors would be reported to FCSO immediately for investigation. The contractor would be removed from any duties that involved detainee contact pending the outcome of an investigation. The incident would be reviewed to consider if other policies were violated prior to allowing reentry into the facility. Interview with the JA could not confirm that FCJ would notify, if appropriate, relevant licensing bodies as required of the standard for contractors and volunteers. The JA confirmed that if an incident involved a medical contractor (ACH), they would be notified.

Recommendation: FCJ SAAPP should be updated to include the terms contractor or volunteer. Current policy only addresses contractors, but the standard contains verbiage for contractors and volunteers.

Corrective Action:

Does Not Meet (a): The facility indicated they would notify ACH should an incident occur but could not articulate that relevant licensing bodies would be notified. To become compliant, the facility should implement a procedure to ensure that reasonable efforts are made to report contractor or volunteer misconduct to relevant licensing bodies. Once implemented the facility must provide the Auditor with evidence that the new procedure has been developed and implemented, and that affected staff have been advised of the procedure for compliance review.

§115.78 - Disciplinary sanctions for detainees

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f): FCJ SAAPP mandates, "Detainees shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the detainee engaged in detainee on-detainee sexual abuse following criminal finding of guilt for detainee-on-detainee sexual abuse. Such discipline shall be administered according to the guidelines set forth. Reports 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 allegation is not substantiated." Review of FCJ SAAPP policy confirms that there is no documented disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedures in place. Additionally, there is no indication the facility considers whether the detainee's mental disability contributed to the behavior or that the detainee will not be disciplined for sexual contact with staff unless there is a finding that the staff member did not consent to such contact. A review of the FCJ Handbook confirms there are major or minor violations but does not list prohibited actions. The handbook further details progressive penalties for a minor or major violation and appeals process. Interview with the JA confirmed that detainees would be subjected to progressive disciplinary sanctions following a finding of guilty in a disciplinary proceeding. The interview further confirmed that detainees would not be disciplined for sexual contact with a staff member unless staff did not consent to the contact or disciplined for making a good faith report. There were no sexual abuse allegations reported at FCJ during the audit period.

Corrective Action:

Does Not Meet (c)(d): The facility does not document the detainee disciplinary procedure either in FCJ SAAPP policy or within the facility handbook, which must include a system with progressive levels of reviews, appeals, procedures, and documentation procedures. FCJ does not consider during the disciplinary process if the detainee's mental disability contributed to the behavior. To become compliant, the facility must implement a disciplinary procedure and document this procedure in FCJ SAAPP policy or the facility handbook. The facility must also implement procedure to evaluate if a detainee's mental disability or mental illness contributed to the behavior when determining what type of sanction, if any, should be imposed. The facility must provide the Auditor with documentation of the newly implemented procedures and training records to indicate applicable staff have been trained on these new procedures. The facility must also provide the Auditor, as applicable, with any detainee disciplinary taken as a result of a substantiated sexual abuse allegation during the CAP period so the Auditor may assess compliance with the newly implemented procedure.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "If the screening process indicates that a detainee has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall contact the Facility's medical or mental health practitioner within 14 days of the detainee screening." The facility just recently started to utilize the PREA Risk of Victimization Assessment, which was determined in 115.41, does not include an assessment of detainees for risk of abusiveness. Interview with booking/classification staff confirmed that there is no procedure in place that requires detainees be referred to medical or mental health staff should the detainee disclose prior sexual victimization or records indicate a perpetration of sexual abuse. Review of the FCJ SAAPP confirms that it mandates that staff contact medical or mental health within 14 days of the detainee screening which is in conflict with the two-working day for medical and 72 hours for mental health requirement of the standard. Interview with the mental health practitioner confirmed the staff member had recently been hired two weeks prior to the onsite.

Corrective Action:

Does Not Meet (a)(b)(c): The facility does not utilize a risk assessment tool that is compliant with standard 115.41. To become compliant, the facility must develop a risk assessment pursuant to standard 115.41 that will adequately assess detainee risk for victimization or abusiveness. In addition, the facility must also implement

procedures to include the requirement to refer the detainee to a qualified medical or mental health practitioner for medical or mental health follow-up as appropriate. The procedure must also include the requirement that once the referral is made the medical follow-up must be initiated and the detainee must receive a medical evaluation no later than two working days from the date of assessment and if the referral is to mental health the detainee must receive a mental health evaluation within 72 hours after the referral. Once implemented the facility must train all booking, medical, and mental health staff on the implemented procedure and provide the Auditor with documentation that that the training was received. If applicable, the facility must provide documentation of referrals and subsequent evaluations for qualifying detainees during the CAP period.

§115.82 - Access to emergency medical and mental health services

Outcome: Meets Standard

Notes:

(a)(b): FCJ SAAPP mandates, "Detainee victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioner according to their professional judgment. Such services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperated with any investigation arising out of the incident." Interviews with the JA, PSA Compliance Manager and medical staff confirmed that detainees would receive emergent care at St. Catherines Hospital free of charge to include crisis intervention, emergency contraception and sexually transmitted infections prophylaxis. The facility did not have any sexual abuse allegations during the audit period for review.

Corrective Action:

No corrective action needed.

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

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c)(d)(e)(f)(g): FCJ SAAPP mandates, "The Facility shall offer ongoing medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility. The facility shall provide victims of sexually abusive vaginal penetration by a male abuser access to pregnancy test and timely access to all lawful pregnancy related medical services. All victims shall have access to sexually transmitted tests as medically appropriate. Such services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperated with any investigation arising out of the incident." Interview with the medical nurse confirms that should a detainee receive treatment at St. Catherines Hospital, the treatment plan would be continued at the facility and that FCJ would provide health services consistent with the community level of care. Additionally, treatment would be provided free of cost whether or not the detainee chose not to name the abuser or cooperate with any investigation. Interview with the mental health practitioner confirmed that they had recently started employment with FCJ and has not provided evaluations for detainee victims of abuse. Additionally, she was not aware of the requirement to provide an evaluation to victims of prior sexual abuse while in immigration detention or the requirement to attempt to conduct an evaluation of known detainee-on-detainee abusers. There were no allegations of sexual abuse reported during the audit period.

Corrective Action:

Does Not Meet (b)(g): Facility staff could not articulate the component requirements (b) and (g) of this standard. To become compliant, the facility must implement a procedure that ensures medical and mental health evaluations, as appropriate, and treatment is provided to detainee who have been victims of sexual abuse while in immigration detention. Documentation where detainee victims of sexual abuse are offered evaluations, treatment, and follow-up services, including treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody must be provided to the Auditor for compliance review, if applicable. Additionally, the facility should provide documentation to the Auditor that the facility has implemented a procedure for detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated to receive timely and comprehensive information about lawful pregnancy-related medical services and timely access to all lawful pregnancy-related medical services. Additionally, the facility must implement a procedure that ensures a mental health evaluation is attempted of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Once implemented, documentation of an evaluation of this nature is to be provided to the Auditor for compliance review, as applicable.

§115.86 - Sexual abuse incident review

Outcome: Does Not Meet Standard

Notes:

(a)(b)(c): FCJ SAAPP mandates, "The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The Facility shall collect accurate, uniform date for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The Jail Administrator/designee shall review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training." The facility reported it did not have any allegations of sexual abuse during the audit period. Review of FCJ SAAPP confirms that facility policy is in conflict with subsection (a) of the standard in that a sexual abuse incident review shall be completed at the conclusion of every allegation. The facility provided an email sent to the SDDO just prior to the onsite with an attachment entitled Negative Report Exhibit; however, the report was not provided for the Auditor to review. An interview with the PSA Compliance Manager confirmed the facility does not complete an annual negative report if the facility has not had a reported allegation of sexual abuse during the reporting period.

Corrective Action:

Does Not Meet (a)(b)(c): The facility procedures do not include an incident review of unfounded sexual abuse allegations. The facility must implement a procedure to ensure that all incidents of sexual abuse are reviewed at the conclusion of the investigation, and that a written report be prepared within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse for those that are substantiated or unsubstantiated. The facility must provide the Auditor evidence of implementation of these procedures for compliance review, and documentation of any reviews conducted, as applicable, for investigations closed within the CAP period. Additionally, the facility must provide evidence that notification is made to the FOD and PSA Coordinator for any new closed sexual abuse investigations that occur during the CAP period for compliance review. In addition,

the facility must provide documentation that current year annual report, or negative report, was prepared and forwarded to the ICE FOD and Agency PSA Coordinator as required of this standard.

§115.87 - Data collection

Outcome: Meets Standard

Notes:

(a): FCJ SAAPP mandates, "The Jail Administrator/designee shall ensure that data collected pursuant to this policy are securely retained and shall maintain such data for at least 10 years after the fate of initial collection unless Federal, State, or local law requires otherwise." Interview with the PSA Compliance Manager confirmed that case records associated with claims of sexual abuse would be secured in a locked cabinet in his office indefinitely. FCJ has not had any allegations of sexual abuse reported during the audit period.

Corrective Action:

No corrective action needed.

§115.201 - Scope of Audit

Outcome: Meets Standard

Notes:

(d)(e)(i)(j): The Auditor was able to observe all areas of the audited facility. All policies, memorandums, staff files, records and other relevant documentation was provided for review to complete a thorough audit. Audit notice signs were posted in the ICE processing room and the one open bay/dormitory housing unit in in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor did not receive correspondence from any detainee, staff, or outside entity prior to the on-site review.

Corrective Action:

No corrective action needed.

AUDITOR CERTIFICATION:

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

Jodi Upshaw 8/25/2023

Auditor's Signature & Date

(b) (6), (b) (7)(C) 8/28/2023

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 8/25/2023

Assistant Program Manager's Signature & Date