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

Homeland Security

AUDITOR INFORMATION			
Name of Auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
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PROGRAM MANAGER INFORMATION			
Name of PM:	(b) (6), (b) (7)(C)	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	409-866-[redacted]
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		
FIELD OFFICE INFORMATION			
Name of Field Office:	Dallas		
Field Office Director:	Marcos D Charles		
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)		
Field Office HQ physical address:	801 North Stemmons Freeway, Dallas Tx 75207		
Mailing address: *(if different from above)*			
INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Garvin County Detention Facility (GCDC)		
Physical address:	201 West Grant Pauls Valley, OK 73075		
Mailing address: *(if different from above)*			
Telephone number:	405.238.7591		
Facility type:	IGSA		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Sheriff
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	405-238-[redacted]
Facility PSA Compliance Manager			
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Undersheriff
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	405-238-[redacted]

FINAL DETERMINATION

SUMMARY OF AUDIT FINDINGS:

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

During the audit, the Auditor found GCDC met 31 standards, had 1 standard (115.31) that exceeded, had 2 standards (115.14, 115.18) that were non-applicable, and 7 non-compliant standards (115.16, 115.22. 115.33, 115.34, 115.41, 115.42 and 115.86). As a result of the facility being out of compliance with 7 standards, the facility entered into a 180-day corrective action period which began on November 12, 2022, and ended on May 15, 2023. The purpose of the corrective action period is for the facility to develop and implement a Corrective Action Plan (CAP) to bring these standards into compliance.

The Auditor received notification of the first CAP via email on November 16, 2022, from ERAU. The initial CAP was reviewed, and the auditor partially agreed with the CAP recommendations as submitted. The Auditor noted in the comment section of each of these CAPs the additional requirements necessary to become compliant each of these standards. The Auditor reviewed the CAP documents submitted over the CAP period and the final CAP documents submitted on May 2, 2023, that were provided by the facility to demonstrate compliance with the deficient standards found during the site visit. The facility demonstrated compliance with the seven standards found non-compliant at the time of the site visit.

Number of Standards Met: 7

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

§115.22 Policies to ensure investigation of allegations and appropriate agency

§115.33 Detainee education

§115.34 Specialized training: Investigations

§115.41 Assessment for risk of victimization and abusiveness.

§115.42 Use of assessment information

§115.86 Sexual abuse incident reviews

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

(a)(b)(c) The GCSOP policy requires the facility ensure that reasonable step(s) are taken to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. The policy further requires officers to use the Language Line Services for interpretation. Inmate interpreter services will not be used. At the time of the site visit, there were no detainee arrivals or detainees present at GCDC. An intake officer briefed the Auditor about the detainee arrival process. According to him, each detainee arriving at GCDC receives an initial briefing on sexual safety through a manuscript through an interpreter if he/she speaks a language not provided by a staff interpreter. He or she also receives the GCDC Facility Handbook, available in Spanish and English, the DHS-prescribed SAA information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed SAA information pamphlet is available in 15 languages (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Turkish, Ukrainian, and Vietnamese). 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). The intake officer also stated that if GCDC were to receive a detainee either deaf or with limited hearing they would determine if he/she could read as most of their sexual safety information is in written format. If the detainee is unable to read, the information would be read to them either by staff or through an interpreter. If they can read the information would be provided to them in written material in one of the available languages. If they were to encounter a detainee with limited sight or blindness, a staff member would provide the detainee orientation information to him or her as outlined in the manuscript. The Auditor was also told that if staff were to encounter a detainee with low intellect, mental health concerns, or limited reading skills, staff would assess the detainee to determine their specific needs and then provide information orally, in written format or in a manner that ensures their understanding of the material. This intake staff officer indicated that they encounter limited English proficient (LEP) detainees routinely and utilize their contracted interpretive service line to assist them with interviews if a staff interpreter is not available. The Auditor reviewed these materials issued to detainees, including the manuscript and their availability, during the site visit. The acting PSA Compliance Manager indicated that the facility, until the PREA pre-audit, was not complying with each of the required (a)(b) subparts as they did not know what was needed or how to acquire it. According to the acting PSA Compliance Manager, some of the material, required by policy to be provided, including the National ICE Handbook in different languages, the SAA pamphlet in different languages and consulate information was not provided until after the pre-audit was completed. The Auditor reviewed eight detainee detention files. Seven of these detainees arrived prior to the pre-audit. Six of those detainees were LEP. One of those LEP detainees was processed after the pre-audit was completed. The review of his detention file demonstrated compliance to the standard and policy requirement. The seven other files, for the audit period, were deficient on what was provided and two of the files contained no detainee signature for receipt of the arrival materials. The subpart (c) requirement for the standard requires that upon agency determination and consistent with DHS policy, the use of a detainee interpreter requested by the detainee victim may be appropriate. The facility failed to provide any policy, or agency determination demonstrating compliance with this subpart requirement.

Does Not Meet (b)(c): Of the eight files reviewed by the Auditor, there was only one detainee arrival since the completed pre-audit that demonstrated standard compliance. This one file was for an LEP detainee, but the facility only demonstrated compliance with one of the six LEP detainee files reviewed by the Auditor. To achieve compliance, the Auditor would like to see at least five examples demonstrating that LEP detainees have an equal opportunity to participate in or benefit from all aspects of the agency and facility efforts to prevent, detect, and respond to sexual abuse, with at least one example where the language is not covered by the ICE National Detainee Handbook being addressed. GCDC must also demonstrate the subpart (c) requirement allowing the use of detainee interpreters if requested by the detainee victim upon agency determination and consistent with DHS policy.

Corrective Action (b): The Auditor received notification of the initial CAP from ERAU on November 16, 2022. The manuscript was approved with the Auditor on the initial submission of the CAP with the Auditor requesting five examples of the manuscript use, with the assistance of an interpreter, for detainees who speak a language not covered by the ICE National Detainee Handbook. In April 2023, the Auditor received the final CAP from GCDC. The facility indicated that during

the 180-day CAP period it had only received one limited English-speaking detainee that required the use of an interpreter to allow the detainee to have an equal opportunity to participate in or benefit from all aspects of the agency and facility efforts to prevent, detect, and respond to sexual abuse. The documentation provided noted the use of a Spanish interpreter for this LEP detainee arriving at the facility on February 1, 2023, to provide the SAAPI information. The Auditor waived the additional four examples as the facility had no other LEP detainees at the facility during the CAP period.

Corrective Action (c): On April 25, 2023, the Auditor was provided the updated GCDC PREA policy documenting the subpart (c) requirement, "in matters relating to allegations of sexual abuse, the agency and each facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse." The facility is now compliant with the standard.

§115. 22 - Policies to ensure investigation of allegations and appropriate agency oversight
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(c) Standard subpart (c) requires the facility and agency post their investigative protocols on their web site. The Auditor found the agency protocols on their web site (www.ICE.gov/prea), but the GCDC web site (https://garvincountysheriff.net/) did not have them posted.

Does Not Meet (c): The facility must post the required investigative protocols on their website.

Corrective Action (c): On April 13, 2023, the GCDC website was viewed by the Auditor. The website provides the minimum investigative protocols to meet the standard subpart requirement. The facility is now compliant with the standard.

§115. 33 - Detainee education
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(e)(f) The GCSOP policy requires during the detainee intake process, detainees be notified of the facility's zero tolerance policy on sexual abuse and assault through the orientation program and detainee handbook. The information includes, at a minimum: the facility's zero-tolerance policy for all forms of sexual abuse or assault; the name of the facility acting PSA Compliance Manager, and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, to the DHS/Office of Inspector General (OIG) and the JIC; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. GCDC is also required to document detainee participation in these education sessions. As noted in 115.16, upon arrival detainees are provided an initial briefing on sexual safety through a manuscript. He or she also receives the GCDC Facility Handbook, in Spanish and English, the DHS-prescribed SAA information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed SAA information pamphlet is available in 15 languages (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Turkish and Ukrainian). 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). The intake officer also stated that if GCDC were to receive a detainee either deaf or with limited hearing they would determine if he/she could read as most of their sexual safety information in written. If they were to encounter a detainee with limited sight or blindness, a staff member would provide the detainee orientation and sexual safety video information to him or her as outlined in the manuscript. The Auditor was also told that if staff were to encounter a detainee with low intellect, mental health concerns, or limited reading skills, staff would assess the detainee to determine their specific needs and then provide information orally, written format or in a manner that ensures their understanding of the material. This intake staff officer indicated that they deal with LEP detainees routinely and utilize their contracted interpretive service to assist them with interviews if a staff interpreter is not available. The Auditor reviewed these orientation materials including the manuscript and their availability during the site visit. The acting PSA Compliance Manager indicated that the facility, until the PREA pre-audit, was not complying with each of the required (a)(b)(c) subparts as it did not know what was needed or how to acquire it. The Auditor reviewed eight

detainee detention files. Seven prior to the facility pre-audit and one after it was completed. The one file after the pre-audit did demonstrate compliance with the standard subpart requirements. The seven other files, for the audit period, were deficient on what was provided, and two files contained no detainee signature for receipt of any information. The Auditor reviewed the GCDC manuscript that is provided to each detainee since the facility pre-audit. The information in this manuscript addresses each of the six subpart (a) requirements. There were no detainees present during the site visit to interview.

Does Not Meet (a)(b)(c): The facility only demonstrated compliance with one detainee detention file for the audit period. The facility can provide the same files submitted for the 115.16 corrective action but must ensure the 115.33 subparts (a)(b)(c) are appropriately documented.

Corrective Action (a)(b)(c): The Auditor received notification of the initial CAP from ERAU on November 16, 2022. The manuscript was approved by the Auditor, outlining the informational requirements in subpart (a). The Auditor requested five examples of the manuscript use, with the assistance of an interpreter, for detainees who speak a language not covered by the ICE National Detainee Handbook. In April 2023, the Auditor received the final CAP from GCDC. The facility indicated that during the 180-day CAP period it had only received one limited English-speaking detainee that required the use of an interpreter to allow the detainee to have an equal opportunity to participate in or benefit from all aspects of the agency and facility efforts to prevent, detect, and respond to sexual abuse. The signed documentation provided noted the use of a Spanish interpreter for this LEP detainee arriving at the facility on February 1, 2023, to provide the required information. The Auditor waived the requirement for the additional four examples as no other new detainees were housed at the facility during the CAP period. The facility is now compliant.

§115. 34 - Specialized training: Investigations
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b) The GCSOP policy requires that in addition to the general training provided to all employees, GCDC will ensure that, to the extent it conducts sexual abuse investigations, its investigators have received training in conducting investigations. 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 Auditor reviewed the ICE OPR Investigating Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The agency provides rosters of trained investigators and the specialized training curriculum on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirements. The Auditor interviewed the Undersheriff who conducts investigations at GCDC. He is a sworn Law Enforcement Officer with over 26 years of experience and training. He indicated in the interview that his training, over the years, has included cross-agency coordination; however, the facility was unable to provide documentation that the Undersheriff's training included specialized training on sexual abuse and cross agency coordination. There were no investigative files during the audit period for review.

Does Not Meet (a)(b): The facility needs to provide the Auditor with documentation that the designated Investigator was provided training on investigating sexual abuse and cross agency coordination.

Corrective Action (a)(b): The Auditor received notification of the initial CAP from ERAU on November 16, 2022. The facility provided training documentation for Effective Cross-Agency Coordination Training for the Undersheriff who is the designated investigator. Additionally, the facility provided the complete training record for the Undersheriff dating back to 2003; the records identified various comprehensive training modules covering investigative technique and sexual assault response. The Auditor accepted this evidence of training meets the requirements of this standard and the facility has demonstrated compliance.

§115. 41 - Assessment for risk of victimization and abusiveness
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a)(b)(c)(d) The GCSOP policy requires all inmates be assessed during the intake screening and upon transfer from another outside facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. The

information from the risk screening form is utilized for housing, bed, work, education, and program assignments. Such assessments will be conducted using both the existing digital classification system and paper systems. The risk assessment is part of the classification process and must be completed within 12 hours of arrival. The assessment tool was reviewed by the Auditor and met all the subpart (c) and (d) requirements. The policy also requires detainee reassessments be completed within 60-90 days from arrival at the facility and his/her risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness. The initial risk assessment and subsequent assessments are typically performed by the medical staff during the time medical staff is present during the day. Intake staff have been trained to perform these assessments in their absence. The Auditor reviewed eight detainee files while on site. The risk assessments were completed upon arrival; however, the risk form being used was not the current form provided to the Auditor during the site visit, meeting all of the subpart (c)(d) requirements. According to the acting PSA Compliance Manager, he was not informed of the information required in the assessment tool until after the pre-audit. He also stated that detainees are never placed in general population until the classification process is complete. The new tool has not been utilized since it was updated.

Does Not Meet (a)(b)(c)(d): The facility was not utilizing the proper assessment tool. Because the facility assessment tool was missing required elements of this standard provision the housing assignments have not included consideration of the required information from the assessment tool. The Auditor will need to see five examples of the updated risk assessment tool being utilized.

Corrective Action: (a)(b)(c)(d): The Auditor received notification of the initial CAP from ERAU on November 16, 2022. The Auditor partially concurred with the CAP. The Auditor requested to review copies of five examples of the facility utilizing the updated risk assessment tool being utilized. The Auditor was provided an updated CAP on January 31, 2023, containing five examples of detainee vulnerability assessments utilizing the new assessment tool. The documentation provided meets the (a)(b)(c)(d) subpart requirements of the standard. The facility is now compliant.

§115. 42 - Use of assessment information
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) The GCSOP policy requires GCDC make individualized determinations about how to ensure the safety of each inmate through the use of information from the risk screening form to notify housing, bed, work, education, and program assignments. It also requires the facility to keep separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. The Classification staff member and Nursing Supervisor confirmed this use and purpose of the assessment form. As noted in 115.41, the Auditor reviewed eight detainee files while on site. The risk assessments were completed upon arrival; however, the risk form being used was not the current form meeting all of the subpart (c)(d) requirements. According to the acting PSA Compliance Manager, he was not informed of the information required in the assessment tool until after the pre-audit. The new tool has not been utilized since it was updated; therefore, the assessment use requirements under the subpart (a) requirements could not have been met.

Does Not Meet (a): The facility was not utilizing an assessment tool addressing all the 115.41 subpart (c) and (d) requirements. Not utilizing all the required information from this document did not allow for this standard subpart (a) requirement. The Auditor will need to see five examples of the current risk assessment tool, generated after the pre audit, being utilized in making individualized determinations as required in subpart (a).

Corrective Action (a): The Auditor received notification of the initial CAP from ERAU on November 16, 2022. The Auditor partially concurred with the CAP. The Auditor needed to see five examples of the current risk assessment tool being utilized in making individualized determinations as required in subpart (a). The CAP documentation supplied on January 31, 2023, provided the Auditor with the five examples of completed detainee vulnerability assessments by GCDC. Based on the facility demonstrating the risk assessments were individualized determinations for bed and program assignments the facility is now compliant with the subpart (a) requirement.

(b) The GCSOP policy requires in deciding whether to assign a transgender or intersex inmate to housing and programming assignments, classification will consider on a case-by-case basis whether a placement would ensure the inmates health and safety, and whether the placement would present management or security problems or taking into consideration the detainees own views with respect to their own safety will be given serious consideration. The policy further requires all placement and programming assignments for each transgender or intersex inmate will be reassessed by the Classification Officer at least twice each year to review any threats to safety experienced by the inmate. The Classification Officer will document these reviews. This policy also states that "All transgender and intersex inmates will be housed in medical, unless another safe and secure option is available." The acting PSA Compliance Manager confirmed all the policy requirements of

the subpart including the policy requirement of placement in the medical unit. He also stated that their placement in the medical unit is not punishment. However, the standard requires an individualized assessment for transgender and intersex detainees to include medical and mental health practitioners' participation. Their specific placement guidelines are in conflict with the subpart requirements because it appears individual determinations are not being made.

Does Not Meet (b): The facility needs to demonstrate that it makes individualized assessments for transgender and intersex detainees with regard to housing and not establish the placement of all transgender and intersex detainees in medical as the general rule.

Corrective Action (b): The Auditor received notification of the initial CAP from ERAU on November 16, 2022. The Auditor did not concur with the Projected/Corrective Action made by the facility. The facility needed to demonstrate how it makes individualized assessments for transgender and intersex detainees with regard to housing and not establish the placement of all transgender and intersex detainees in the medical unit as the general rule as was told to the Auditor. During the May 2023 CAP submission of documentation to the Auditor, the updated PREA policy reflects all the required subpart (c) standard requirements. The facility is now compliant with the standard.

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

(c) The standard requires each facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and FOD or his or her designee, who shall transmit it to the ICE PSA Coordinator. As noted throughout the report, GCDC had no incidents of sexual abuse for the audit period. It did not provide a negative report with a distribution to those noted in subpart (c).

Does Not Meet (c): The facility must prepare a negative report for the annual reporting period and provide to the Auditor for compliance review. Additionally, documentation of distribution to the parties noted in the subpart (c) must be provided for compliance review.

Corrective Action (c): The Auditor received notification of the initial CAP from ERAU on November 16, 2022. The Auditor partially concurred with the CAP. The Auditor accepted the information that will be provided in a review; however, item number one in the facility's response was still inconsistent with the DHS PREA standard 115.86(a). A review is required for every investigation of sexual abuse, including any deemed unfounded. The GCSO updated PREA policy was reviewed by the Auditor/APM on May 2, 2023, and found the language about conducting incident reviews on all allegations is now consistent with 115.86 (a). Additionally, the facility provided the negative annual report with the distribution to the required individuals for the Auditor's review. The facility has demonstrated compliance 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.

Thomas Eisenschmidt May 11, 2023
Auditor's Signature & Date

(b) (6), (b) (7)(C) May 24, 2023
Assistant Program Manager's Signature & Date

(b) (6), (b) (7)(C) May 24, 2023
Program Manager's Signature & Date

PREA Audit: Subpart A
DHS Immigration Detention Facilities
Audit Report

Homeland Security

AUDIT DATES			
From:	9/20/2022	**To:**	9/22/2022
AUDITOR INFORMATION			
Name of auditor:	Thomas Eisenschmidt	**Organization:**	Creative Corrections, LLC
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	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 number:**	409-866-(b) (6), (b)
AGENCY INFORMATION			
Name of agency:	U.S. Immigration and Customs Enforcement (ICE)		

FIELD OFFICE INFORMATION	
Name of Field Office:	Dallas
Field Office Director:	Mary B DeAnda-Ybarra
ERO PREA Field Coordinator:	(b) (6), (b) (7)(C)
Field Office HQ physical address:	801 North Stemmons Freeway, Dallas Tx
Mailing address: (if different from above)	Click or tap here to enter text.

INFORMATION ABOUT THE FACILITY BEING AUDITED			
Basic Information About the Facility			
Name of facility:	Garvin County Detention Facility (GCDC)		
Physical address:	201 West Grant Pauls Valley, OK 73075		
Mailing address: (if different from above)	Click or tap here to enter text.		
Telephone number:	405.238.7591		
Facility type:	IGSA		
PREA Incorporation Date:	2/10/2020		
Facility Leadership			
Name of Officer in Charge:	(b) (6), (b) (7)(C)	**Title:**	Sheriff
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	405.238(b) (6), (b)
Name of PSA Compliance Manager:	(b) (6), (b) (7)(C)	**Title:**	Undersheriff
Email address:	(b) (6), (b) (7)(C)	**Telephone number:**	405.238(b) (6), (b)

ICE HQ USE ONLY	
Form Key:	29
Revision Date:	02/24/2020
Notes:	Click or tap here to enter text.

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 Garvin County Detention Center (GCDC) was conducted on September 20, 2022, through September 22, 2022, by U.S. Department of Justice (DOJ) and DHS certified PREA Auditor, Thomas Eisenschmidt 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 Program Manager's role is to provide oversight to the ICE PREA audit process and liaison with the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) during the audit report review process. The purpose of the audit was to determine compliance with the DHS PREA Standards for the audit period of February 10, 2020, through September 22, 2022. This was the facility's first PREA audit. The GCDC is a County operated facility and operates under contract with the DHS/ICE, Office of Enforcement and Removal Operations (ERO). It provides custody for County inmates and ICE male and female adult detainees, the latter while pending immigration review or deportation. According to the Pre-Audit Questionnaire (PAQ), the top three nationalities held at the GCDC are from Mexico, Venezuela, and Cuba. The facility does not house juveniles or family detainees. The facility is located in Pauls Valley, Oklahoma.

On September 20, 2022, an entrance briefing was held in the GCDC conference room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C), opened the briefing and then turned it over to the Auditor. In attendance were:

Garvin County Staff

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

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

ICE Staff

(b) (6), (b) (7)(C), Inspections and Compliance Specialist (ICS), OPR/ERAU

(b) (6), (b) (7)(C), ICS, OPR/ERAU

(b) (6), (b) (7)(C), ICS, OPR/ERAU

(b) (6), (b) (7)(C), ERO Assistant Field Office Director (AFOD)

(b) (6), (b) (7)(C), ERO Supervisory Detention and Deportation Officer (SDDO)

Creative Corrections

Thomas Eisenschmidt, Certified PREA Auditor

The Auditor introduced himself and then provided an overview of the audit process and the methodology to be used to demonstrate PREA compliance with those present. Approximately three weeks prior to the audit, ERAU Team Lead, (b) (6), (b) (7)(C), provided the Auditor with the facility's Pre-Audit Questionnaire (PAQ), agency and facility policies, and other pertinent documents through ERAU's SharePoint site. The main policy that provides facility direction for PREA is the Garvin County Sheriff's Office PREA Policy (GCSOP). All documentation provided prior to the audit, policies, and the PAQ were reviewed by the Auditor. A tentative daily schedule was provided by the Auditor for the interviews with staff and detainees. 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 and in daily practice. He further explained compliance with the PREA standards will be determined based on the review of policy and procedures, observations made during the facility tour, provided documentation review, and conducting both staff and detainee interviews.

On the first day of the audit and for the entire site visit, there were no detainees housed at the GCDC. The current contract is for the housing of 10 detainees to include no more than 2 females in that 10. The detainee in-processing area is the hallway between where detainees arrive at GCDC and the medical office where the classification process takes place. Detainees remain here for a short time until taken into the medical area where the classification and intake process occur. Once this process is completed and the detainees are cleared for general population, they are moved to either the male or female housing location. The Auditor observed in each of the living areas posters consisting of the consulate contact information, the Rape, Abuse & Incest National Network (RAINN) advocate contact number, the DHS-prescribed ICE Sexual Abuse Awareness (SAA) information pamphlet and the DHS ICE Zero Tolerance for Sexual Abuse poster with phone and other contact information. The facility has two housing units for ICE detainees that have cameras. Unit number 4 Housing for males that has 20 beds and unit number 2 Housing for females that has two beds. Each of these areas has toilets, congregate showers with curtains, a television, telephones, and a kiosk. Both these housing units have staff posted immediately outside of the area. Each living area has gender specific supervision. Male staff cannot be on a female unit and female staff cannot be on a male unit except in an emergency or if the Supervisor is a different gender. If it becomes necessary for any other cross-gender individual to enter either living area, they are required to announce themselves prior to entering.

The medical unit has one bed, and the facility has one segregation cell. (b) (7)(E) [redacted]. The Auditor reviewed each camera assigned to areas that monitored ICE detainees and found no privacy concerns. According to the PAQ and the interview with the acting PSA Compliance Manager, there are 20 County staff at GCDC. They include the Undersheriff, 13 Detention Deputies, 3 medical staff (Turn Key), 1 mental health staff (Turn Key), and 2 clerical positions. Volunteers have not been at the facility for over two years.

At the conclusion of the tour, the Auditor was provided with staff rosters and randomly selected personnel from each shift to participate in the formal interviews. There were 6 random staff and 5 specialized staff performing 14 specialized functions interviewed. Those specialized interviews included the Undersheriff, acting PSA Compliance Manager, Training Coordinator, Retaliation Monitor staff member, Incident Review Team member, Intake staff, Classification staff, Non-security first responder, Criminal Investigator, Administrative Investigator, Grievance Coordinator, AFOD, Nursing Supervisor, and SDDO. There were no detainees assigned to the facility at the time of the site visit. There were no allegations of sexual abuse reported at GCDC for the audit period.

On September 22, 2022, an exit briefing was held in the GCDC Conference Room. The ICE ERAU Team Lead, (b) (6), (b) (7)(C) opened the briefing and then turned it over to the Auditor. In attendance were:

Garvin County Staff
(b) (6), (b) (7)(C), Undersheriff
(b) (6), (b) (7)(C), Sergeant

ICE Staff
(b) (6), (b) (7)(C), ICS, OPR/ERAU
(b) (6), (b) (7)(C), ICS, OPR/ERAU
(b) (6), (b) (7)(C), ICS, OPR/ERAU
(b) (6), (b) (7)(C), AFOD -via telephone
(b) (6), (b) (7)(C), SDDO -via telephone

Creative Corrections
Thomas Eisenschmidt, Certified PREA Auditor

The Auditor spoke briefly about the staff knowledge of the GCDC PREA zero-tolerance policy. The Auditor informed those present that it was too early in the process to formalize an outcome of the audit and that he would need to review his findings and interviews conducted prior to making a final determination on compliance for the standards. The Auditor thanked ERAU, ERO and the Garvin staff for their cooperation during the site visit.

SUMMARY OF AUDIT FINDINGS

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

Number of Standards Exceeded: 1
§115.31 Staff training

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

Number of Standards Met: 31
§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
§115.17 Hiring and promotion decisions
§115.21 Evidence protocols and forensic medical examinations
§115.32 Other training
§115.43 Protective custody
§115.51 Detainee reporting
§115.52 Grievances
§115.53 Detainee access to outside confidential support services
§115.54 Third-party reporting
§115.61 Staff reporting duties
§115.62 Protection duties
§115.63 Reporting to other confinement facilities
§115.64 Responder duties
§115.65 Coordinated response
§115.66 Protection of detainees from contact with alleged abusers
§115.67 Agency protection against retaliation
§115.68 Post-allegation protective custody
§115.71 Criminal and administrative investigations
§115.72 Evidentiary standard for administrative investigations
§115.73 Reporting to detainees
§115.76 Disciplinary sanctions for staff
§115.77 Corrective action for contractors and volunteers
§115.78 Disciplinary sanctions for detainees
§115.81 Medical and mental health assessments; history of sexual abuse
§115.82 Access to emergency medical and mental health services
§115.83 Ongoing medical and mental health care for sexual abuse victims and abusers
§115.86 Sexual abuse incident reviews
§115.87 Data collection
§115.201 Scope of audits

Number of Standards Not Met: 7
§115.16 Accommodating detainees with disabilities and detainees who are limited English proficient
§115.22 Policies to ensure investigation of allegations and appropriate agency oversight
§115.33 Detainee education
§115.34 Specialized training: Investigations
§115.41 Assessment for risk of victimization and abusiveness
§115.42 Use of assessment information
§115.86 Sexual abuse incident reviews

PROVISIONS

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

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

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

Notes:

(c) The Auditor determined compliance with this subpart based on review of the GCSOP policy that requires GCDC maintain a zero-tolerance standard for the incidences of inmate rape and sex-related offenses and attempts thereof and will make every effort to prevent these incidents. The policy outlines their approach to preventing, detecting, and responding to such conduct through orientations and training for detainees and staff. The Undersheriff, who has overall responsibility for Jail operations, confirmed that this policy was reviewed and approved by the agency and provided the Auditor with documentation of this policy review by the ERO AFOD. The informal and formal questioning of staff during the site visit confirmed their awareness of the facility's zero-tolerance policy on sexual abuse. There were no detainees present at the facility during the audit site visit.

(d) The Auditor determined compliance with this subpart of the standard based on the interview with the facility designated acting PSA Compliance Manager. He confirmed that he serves as the facility point of contact for the ICE PSA Coordinator and has sufficient time and authority to oversee GCDC efforts to comply with their sexual abuse prevention and intervention policy. A review of the facility organizational chart confirmed his position as Jail Administrator (acting PSA Compliance Manager) is a direct report to the Undersheriff.

Recommendation (c): The Auditor recommends the facility update the GCSOP policy to include detainee instead of inmate, throughout the policy where applicable to detainees.

§115.13 - Detainee supervision and monitoring.

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

Notes:

(a)(b)(c) The Auditor was provided the staffing levels and post orders for supervision positions for each of the two 12-hour shifts at GCDC. The Auditor also was provided and reviewed the facility medical staff rosters. The interviews with the Undersheriff and each of the shift supervisors confirmed that GCDC utilizes direct supervision along with video monitoring for detainees. They confirmed anytime a detainee is present in an area, a staff member will also be present. The interview with the Undersheriff confirmed that all elements of provision (c) were taken into consideration in determining appropriate levels of staffing and that the number of security positions was established by the County and ICE during the contract discussions based on the number of detainees GCDC would receive. As noted earlier, there were no detainees present at the time of the site visit, but the staffing numbers appeared appropriate to the Auditor based on the number of detainees (10) that the facility would accept. The facility completed their annual detainee supervision guideline review for 2021.

(d) The Auditor determined compliance with this subpart based on review of the GCSOP policy that requires supervisors conduct and document unannounced rounds on each shift, in all detainee areas to identify and deter staff sexual abuse. The policy also prohibits staff members from alerting other staff as to when or where these rounds are occurring, unless related to the legitimate operational needs of the facility. The interviews conducted with each shift supervisor confirmed their responsibility to conduct these rounds. They also indicated that these rounds are made at random times and random locations. The Auditor reviewed random examples of these completed rounds in compliance with the subpart (d) requirements. The rounds are documented in the Offender Data Information System (ODIS). Each of the 6 random security staff interviewed confirmed supervisors make frequent rounds in their areas and acknowledged their understanding of the policy restriction prohibiting them from alerting other staff that supervisors were making rounds.

§115.14 - Juvenile and family detainees.

Outcome: Not Applicable (provide explanation in notes)

Notes:

GCDC does not accept juveniles or family detainees. This was confirmed in the PAQ and in interviews conducted with the Undersheriff and the acting PSA Compliance Manager. The standard therefore is not applicable.

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

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

Notes:

(b)(c)(d)(e)(f) The Auditor determined compliance with this subpart based on review of the GCSOP policy that requires all cross-gender searches be documented. GCDC employees, by policy, are also prohibited from conducting cross-gender strip searches or cross-gender visual body cavity searches. Body cavity searches are only conducted by medical practitioners. According to the acting PSA Compliance Manager and the random staff (male and female) interviews conducted, cross-gender pat searches are prohibited at GCDC except in exigent circumstances. The Undersheriff and acting PSA Compliance Manager confirmed all cross-gender searches, strip searches and body cavity searches, if performed, would be logged into the Offender Data Information System (ODIS). The

Facility reported no such searches during the audit period. The Auditor interviewed 6 security staff (3 females and 3 males) during the site visit. Each was aware of the policy requirements for conducting and documenting any cross-gender pat searches or strip searches if performed and the prohibition against conducting body cavity searches.

(g) The Auditor determined compliance with this subpart based on review of the GCSOP policy, that requires, GCDC to ensure that detainees are able to shower, perform bodily functions, and change their clothes without being viewed by any staff, except in the event of exigent circumstance or when such viewing is incidental to a cell checks, in connection with a medical examination or monitored bowel movement. The policy also requires cross-gender staff, upon entering an area where detainees are likely to be changing their clothing, performing bodily functions, or showering, to announce themselves prior to entering any area detainees are likely to be changing their clothing, performing bodily functions, or showering. The staffing at the GCDC is always a minimum of one male to supervise the male detainee housing and one female line staff member to supervise the female housing unit. Except during supervisory rounds, the staff presence in each of the housing areas is the same gender as the detainee. Line staff interviews acknowledged their responsibility if they entered an opposite gender living unit to announce themselves prior to entering. The Auditor also observed these opposite gender announcements being made during the tour. The review of the camera system and observations during the site visit revealed no privacy concerns with the shower or toilet areas. The random staff interviewed confirmed their knowledge of the subpart (g) requirements.

(h) This subsection is non-applicable. GCDC is not a Family Residential Facility.

(i) The Auditor determined compliance with this subpart of the standard based on the GCSOP policy, interviews with the Training Coordinator and the six random security staff. The policy states the subpart (i) prohibition. The Training Coordinator confirmed that search training each staff member receives includes the same prohibition of physically examining a detainee for the sole purpose of determining their genital characteristics. The six random security staff confirmed to the Auditor awareness of this prohibition and stated that the search training they receive covers this restriction. They also stated that they would follow the subpart (i) procedures, that are also covered in their training, should it become necessary to determine a detainee's gender.

(j) The Auditor determined compliance with this subpart of the standard based on the GCSOP policy that requires, pat searches, cross-gender searches, searches of transgender detainees and searches of intersex detainees be conducted in a professional manner and in the least intrusive manner, consistent with security needs and in consideration of the officer's safety. The Auditor was provided and reviewed the search training curriculum for security staff. This curriculum covered proper techniques for conducting all pat searches including cross-gender, transgender, and intersex detainees in the least intrusive, professional, and respectful manner, that addressed the standard requirements. The Auditor reviewed seven security staff training files and found completed search training documentation in each of their files. As noted earlier, there were no detainees present at the facility for the Auditor to interview.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c) The GCSOP policy requires the facility ensure that reasonable step(s) are taken to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. The policy further requires officers to use the Language Line Services for interpretation. Inmate interpreter services will not be used. At the time of the site visit, there were no detainee arrivals or detainees present at GCDC. An intake officer briefed the Auditor about the detainee arrival process. According to him, each detainee arriving at GCDC receives an initial briefing on sexual safety through a manuscript through an interpreter if he/she speaks a language not provided by a staff interpreter. He or she also receives the GCDC Facility Handbook, available in Spanish and English, the DHS-prescribed SAA information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed SAA information pamphlet is available in 15 languages (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Turkish, Ukrainian, and Vietnamese). 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). The intake officer also stated that if GCDC were to receive a detainee either deaf or with limited hearing they would determine if he/she could read as most of their sexual safety information is in written format. If the detainee is unable to read, the information would be read to them either by staff or through an interpreter. If they can read the information would be provided to them in written material in one of the available languages. If they were to encounter a detainee with limited sight or blindness, a staff member would provide the detainee orientation information to him or her as outlined in the manuscript. The Auditor was also told that if staff were to encounter a detainee with low intellect, mental health concerns, or limited reading skills, staff would assess the detainee to determine their specific needs and then provide information orally, in written format or in a manner that ensures their understanding of the material. This intake staff officer indicated that they encounter limited English proficient (LEP) detainees routinely and utilize their contracted interpretive service line to assist them with interviews if a staff interpreter is not available. The Auditor reviewed these materials issued to detainees, including the manuscript and their availability, during the site visit. The acting PSA Compliance Manager indicated that the facility, until the PREA pre-audit, was not complying with each of the required (a)(b) subparts as they did not know what was needed or how to acquire it. According to the acting PSA Compliance Manager, some of the material, required by policy to be provided, including the National ICE Handbook in different languages, the SAA pamphlet in different languages and consulate information was not provided until after the pre-audit was completed. The Auditor reviewed eight detainee detention files. Seven of these detainees arrived prior to the pre-audit. Six of those

detainees were LEP. One of those LEP detainees was processed after the pre-audit was completed. The review of his detention file demonstrated compliance to the standard and policy requirement. The seven other files, for the audit period, were deficient on what was provided and two of the files contained no detainee signature for receipt of the arrival materials. The subpart (c) requirement for the standard requires that upon agency determination and consistent with DHS policy, the use of a detainee interpreter requested by the detainee victim may be appropriate. The facility failed to provide any policy, or agency determination demonstrating compliance with this subpart requirement.

Does Not Meet (b)(c): Of the eight files reviewed by the Auditor, there was only one detainee arrival since the completed pre-audit that demonstrated standard compliance. This one file was for an LEP detainee, but the facility only demonstrated compliance with one of the six LEP detainee files reviewed by the Auditor. To achieve compliance, the Auditor would like to see at least five examples demonstrating that LEP detainees have an equal opportunity to participate in or benefit from all aspects of the agency and facility efforts to prevent, detect and respond to sexual abuse, with at least one example where the language is not covered by the ICE National Detainee Handbook being addressed. GCDC must also demonstrate the subpart (c) requirement allowing the use of detainee interpreters if requested by the detainee victim upon agency determination and consistent with DHS policy.

§115.17 - Hiring and promotion decisions.

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

Notes:

(a)(b)(c)(e)(f) The Auditor determined compliance with these subparts of the standard based on review of Executive Order 10450 (Security Requirements for Government Employment), Office of Personal Management Section Part 731, and ICE Directives 6-7.0, ICE Personnel Security and Suitability Program Directive, and 6-8.0, ICE Suitability Screening Requirements for Contractor Personnel Directive and the GCSOP policy that collectively require, to the extent permitted by law, to decline to hire or promote anyone who may have contact with detainees, and decline to enlist the services of any contractor, or volunteer, who may have 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); 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 has been civilly or administratively adjudicated to have engaged in the activity as outlined above. GCSO will not hire or promote anyone who may have contact with inmates and will not enlist the services of any contractor or volunteer, who may have contact with inmates, who engaged in any of the above-mentioned misconduct. The Unit Chief of OPR Personnel Security Operations (PSO) informed Auditors, who attended virtual training in November 2021, that 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. The Undersheriff is responsible for all hiring at the GCDC. During his interview, he detailed the hiring procedure. He indicated the facility follows the ICE hiring guideline for all employee candidates. He indicated that when a vacancy occurs, the job is posted. The individual submits an application and if he/she meets the position criteria, an interview is scheduled. During the interview, the individual is asked directly about any misconduct outlined in subpart (a) of the standard. If he/she responds affirmatively to those questions, the person does not go any further in the hiring process. Once the interview is concluded, a National Crime Information Center (NCIC) background is conducted. If that investigation is successful, the individual goes through the ICE hiring and approval process and is not hired until GCDC receives the approval from ICE. He also confirmed that during the GCSO background investigation, the person's entire employment record and references would be scrutinized. Material omissions of any subpart (a) incidents or providing false information would be a basis for termination or withdrawal of any offer of employment. He also stated that as a condition of employment and as outlined in policy, each employee has a continuing affirmative duty to disclose to GCDC any misconduct outlined in subpart (a). The Undersheriff stated that if an employer requested information on a former employee, dismissed for sexual abuse, that agency would be referred to the County Attorney for information. As noted earlier in the report, six random security staff were interviewed, and each was aware of this duty to report. The Auditor also reviewed 10 employee files and found background approvals to hire the staff member as well as a signed self-declaration that the employee had not engaged in behavior outlined in subpart (a) of the standard and as required by policy. One of the 10 files reviewed was a current promotion. The Auditor noted a current disclosure form was present in this individual's file as well. The Auditor determined compliance with subpart (c) of the standard based on the Undersheriff's interview that confirmed GCDC is not an immigration-only detention facility; therefore, the required 5-year background recheck component of the subpart (c) is not applicable.

(d) The auditor determined through an interview with the Undersheriff that the facility has only one contracted position and the position does not meet definition of a contractor related component (d) of this standard as the position does not include routine contact with detainees.

§115.18 - Upgrades to facilities and technologies.

Outcome: Not Applicable (provide explanation in notes)

Notes:

This standard is not applicable as the Undersheriff and PAQ confirmed that GCDC did not expand the facility or add additional video equipment during the audit period.

§115.21 - Evidence protocols and forensic medical examinations.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires GCDC follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. This policy, as noted earlier, was approved by the AFOD. The interview with the Undersheriff, who conducts the administrative investigations, confirmed the investigation protocols outlined in policy and subpart (a) are utilized at GCDC to maximize the potential for obtaining useable physical evidence. The Undersheriff also noted that the criminal investigation would be conducted by a trained law enforcement Officer from the Garvin County Sheriff Office. As a criminal investigator as well, he confirmed during any criminal investigation, uniform evidence protocols would be used to maximize obtaining useable physical evidence. The agency's Policy 11062.2, Sexual Abuse and Assault Prevention and Intervention, outlines the agency's evidence and investigation protocols. The Auditor training provided in November 2021 by ICE indicated that 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. As noted earlier, there were no allegations of sexual abuse reported at GCDC for the audit period.

(b)(c)(d) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires the facility attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, GCDC will provide these services by a qualified staff member from a community-based organization or a qualified agency staff member. The facility has no written MOU with a rape crisis center. The acting PSA Compliance Manager indicated GCDC has no local victim advocate service agency in their area and utilizes a national victim advocate, Rape, Abuse & Incest National Network, (RAINN) for emotional support, crisis intervention services, information, and referrals. The RAINN web site indicates that they offer both the technology infrastructure and the victim services expertise to provide quality, anonymous, and confidential crisis intervention services in English and Spanish, via telephone and online. This national victim advocate contact information was observed by the Auditor in the detainee living areas by the telephone.

The policy also requires GCDC offer all victims of sexual abuse access to forensic medical examinations without financial cost, where evidentiary or medically appropriate. Such examinations will be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The GCDC Nursing Supervisor confirmed that although there is no MOU with the Norman Medical Center (NMC), detainee victims would be sent there for a forensic examination, if agreed to by the victim, by a SANE practitioner at no cost to the detainee. The Auditor called the NMC and spoke with a Nursing Supervisor. He informed the Auditor that the forensic examination would be done at their hospital for sexual assaults occurring at GCDC. NMC contracts that specific service with the Women's' Resource Center. The Auditor called this Center and spoke with the day Supervisor. She confirmed the agreement with the NMC to provide a SANE practitioner for any forensic examination. She also indicated that the Center also sends a victim advocate to the hospital on every occasion. The victim can choose to speak with them and have the advocate accompany them during the procedure and any police interviews. She also stated the facility had no forensic examinations during the audit period. The acting PSA Compliance Manager also indicated that GCDC had tried to enter into a MOU with the NMC but has had no success.

(e) The Auditor determined compliance with this subpart of the standard based on the interview with the Undersheriff. He indicated that the GCSO, of which he is part of, would conduct both the criminal and administrative investigation of sexual abuse at GCDC. He indicated every allegation would be reported and reviewed by a Detective, from the Sheriff's Office, for any criminal charges. The Detective would follow evidence protocols received during the police training. The Undersheriff indicated whichever detective conducted the investigation they would comply with subparts (a) through (d) of the standard. If no criminal charges are made, he (Undersheriff) would conduct an administrative investigation. There were no allegations of sexual abuse reported during the audit period.

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

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(d) The Auditor determined compliance with these subparts of the standard based on review of the GCSOP policy that requires, GCDC ensure that an administrative and/or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. This policy also requires GCDC document investigations in written reports that include a description of the physical and testimonial evidence, the reasoning behind the credibility assessments, and investigative facts and findings and retain these written reports for as long as the alleged abuser is incarcerated or employed by the GCDC, plus five years. The policy further stipulates GCDC supervisors report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to Jail investigators. If the incidents involve an ICE detainee, ERO will be notified. Additionally, according to the Auditor training received in November 2021, all allegations are to be reported to the Joint Intake Center (JIC), where the allegation will be assessed to determine if it falls within the PREA purview. The PREA allegations are referred to OIG or OPR. OIG has the first right of refusal on all employee, volunteer, or contractor on detainee sexual abuse allegations. Once the allegation is reviewed and accepted by DHS OIG, the OPR would not investigate so there is no possible intervention. If refused by DHS OIG, the allegation is referred to OPR. All detainee-on-detainee allegations are referred to the OPR for assessing criminality. Once the allegation is reviewed and accepted by the OPR investigator, the investigation is conducted by OPR, who will decide on the investigative process. If OPR investigates the allegation,

the investigation is conducted in accordance with OPR policies and procedures and coordination with law enforcement and facility staff. If allegations are not criminal in nature, the allegations are referred to the OPR field office or the ERO Administrative Investigative Inquiry Unit (AIU) for action, and the agency would assign an administrative investigation to be completed.

(c) Standard subpart (c) requires the facility and agency post their investigative protocols on their web site. The Auditor found the agency protocols on their web site (www.ICE.gov/prea), but the GCDC web site (https://garvincountysheriff.net/) did not have them posted.

Does Not Meet (c): The facility must post the required investigative protocols on their web site.

(e)(f) The Auditor determined compliance with these standard subparts based on the acting PSA Compliance Manager and Undersheriff interviews that confirmed every allegation of sexual abuse involving a staff member, contractor, or volunteer or in which a detainee is involved requires an immediate notification to ICE. Both indicated that notification is made to the ERO AFOD. The interview with the AFOD confirmed, upon any notification, he would make all the appropriate ICE notifications required under these two subparts. There were no allegations reported at GCDC for the audit period.

§115.31 - Staff training.

Outcome: Exceeds Standard (substantially exceeds requirement of standard)

Notes:

(a)(b)(c) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy, interviews with six security staff, the Training Coordinator and review of the staff training curriculum. The information provided in the PREA training included: detainees and staff be free from sexual abuse, and from retaliation for reporting sexual abuse; recognition of situations where sexual abuse and/or assault may occur; how to avoid inappropriate relationships with detainees; working with vulnerable populations and addressing their potential vulnerability in the general population; recognition of the physical, behavioral and emotional signs of sexual abuse and/or assault and ways to prevent and respond; the requirement to limit reporting of sexual abuse and assault to personnel with a need-to-know in order to make decisions concerning the detainee victim's welfare, and for law enforcement/investigative purposes; the investigation process and how to ensure that evidence is not destroyed; prevention, recognition and appropriate response to allegations or suspicions of sexual assault involving detainees with mental or physical disabilities; how to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, (LGBTI) or gender nonconforming detainees; instruction on reporting knowledge or suspicion of sexual abuse and/or assault; and instruction on documentation and referral procedures of all allegations or suspicion of sexual abuse and or assault. The Auditor reviewed 10 staff training files and found completed PREA training acknowledgement documents in each file. The Auditor interviewed six random staff, who detailed their PREA training to include the subpart (a) requirements. The Auditor feels the facility exceeds the standard, as the standard requires refresher training every two years and the facility documentation and interviews confirmed training refresher is annual.

§115.32 – Other training.

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

Notes:

(a)(b)(c) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires GCDC ensure that all volunteers and contractors who have contact with inmates (or enter the secure portion of the facility) have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The policy also requires GCDC maintain documentation confirming that temporary contractors, regular contractors, and volunteers understand the training they have received. During the audit period, according to the acting PSA Compliance Manager, GCDC had no contractors meeting the (d) subpart definition or volunteers. The Training Coordinator confirmed that all volunteers and those contractors meeting the subpart (d) definition would receive the US Customs and Immigration Enforcement PREA Implementation Training.

§115.33 – Detainee education.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(e)(f) The GCSOP policy requires during the detainee intake process, detainees be notified of the facility's zero tolerance policy on sexual abuse and assault through the orientation program and detainee handbook. The information includes, at a minimum: the facility's zero-tolerance policy for all forms of sexual abuse or assault; the name of the facility acting PSA Compliance Manager, and information about how to contact him/her; prevention and intervention strategies; definitions and examples of detainee-on-detainee sexual abuse and assault, staff-on-detainee sexual abuse and assault and coercive sexual activity; explanation of methods for reporting sexual abuse or assault, including one or more staff members other than an immediate point-of-contact line officer, to the DHS/Office of Inspector General (OIG) and the JIC; information about self-protection and indicators of sexual abuse and assault; prohibition against retaliation, including an explanation that reporting an assault shall not negatively impact the detainee's immigration proceedings; and the right of a detainee who has been subjected to sexual abuse to receive treatment and counseling. GCDC is also required to document detainee participation in these education sessions. As noted in 115.16, upon arrival detainees are provided an initial briefing on sexual safety through a manuscript. He or she also receives the GCDC Facility Handbook, in Spanish and English, the DHS-prescribed SAA information pamphlet, and the ICE National Detainee Handbook. The DHS-prescribed SAA information pamphlet is available in 15 languages (Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Portuguese, Punjabi, Romanian, Russian, Spanish, Turkish and Ukrainian). 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). The intake officer also stated that if GCDC were to receive a detainee either deaf or with limited hearing they would determine if he/she could read as most of their sexual safety information in written. If they were to encounter a detainee with limited sight or blindness, a staff member would provide the detainee orientation and sexual safety video information to him or her as outlined in the manuscript. The Auditor was also told that if staff were to encounter a detainee with low intellect, mental health concerns, or limited reading skills, staff would assess the detainee to determine their specific needs and then provide information orally, written format or in a manner that ensures their understanding of the material. This intake staff officer indicated that they deal with LEP detainees routinely and utilize their contracted interpretive service to assist them with interviews if a staff interpreter is not available. The Auditor reviewed these orientation materials including the manuscript and their availability during the site visit. The acting PSA Compliance Manager indicated that the facility, until the PREA pre-audit, was not complying with each of the required (a)(b)(c) subparts as it did not know what was needed or how to acquire it. The Auditor reviewed eight detainee detention files. Seven prior to the facility pre-audit and one after it was completed. The one file after the pre-audit did demonstrate compliance with the standard subpart requirements. The seven other files, for the audit period, were deficient on what was provided, and two files contained no detainee signature for receipt of any information. The Auditor reviewed the GCDC manuscript that is provided to each detainee since the facility pre-audit. The information in this manuscript addresses each of the six subpart (a) requirements. There were no detainees present during the site visit to interview.

Does Not Meet (a)(b)(c): The facility only demonstrated compliance with one detainee detention file for the audit period. The facility can provide the same files submitted for the 115.16 corrective action but must ensure the 115.33 subparts (a)(b)(c) are appropriately documented.

(d) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires the facility shall post the DHS-prescribed sexual abuse and assault awareness notice with the name of the PSA Compliance Manager and information about local organization(s) that can assist detainees who have been victims of sexual abuse or assault, including mailing addresses and telephone numbers. During the tour of GCDC, the Auditor observed the DHS-prescribed sexual assault awareness notice posted with the name of the acting PSA Compliance Manager included, and the RAINN contact information, in the detainee housing units.

§115.34 - Specialized training: Investigations.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) The GCSOP policy requires that in addition to the general training provided to all employees, GCDC will ensure that, to the extent it conducts sexual abuse investigations, its investigators have received training in conducting investigations. 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 Auditor reviewed the ICE OPR Investigating Incidents of Sexual Abuse and Assault training curriculum and found the curriculum to cover in-depth investigative techniques, evidence collection, and all aspects to conduct an investigation of sexual abuse in a confinement setting. The agency also offers Fact Finders Training, which provides information needed to conduct the initial investigation at the facility to determine if a sexual abuse incident has taken place and whether to complete an administrative investigation. This training includes topics related to interacting with traumatized victims; best practices for interacting with LEP; LGBTI, and disabled detainees; and an overall view of the investigative process. The agency provides rosters of trained investigators and the specialized training curriculum on OPR's SharePoint site for Auditors' review; this documentation is in accordance with the standard's requirements. The Auditor interviewed the Undersheriff who conducts investigations at GCDC. He is a sworn Law Enforcement Officer with over 26 years of experience and training. He indicated in the interview that his training, over the years, has included cross-agency coordination; however, the facility was unable to provide documentation that the Undersheriff's training included specialized training on sexual abuse and cross agency coordination. There were no investigative files during the audit period for review.

Does Not Meet (a)(b): The facility needs to provide the Auditor with documentation that the designated Investigator was provided training on investigating sexual abuse and cross agency coordination.

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

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

Notes:

(a)(b) This subpart is not applicable as the GCDC medical unit is not staffed by DHS or agency employees.

(c) GCDC medical is contracted through Turn Key. The interview with the Nursing Supervisor confirmed that all detainees needing forensic examination and sexual abuse services are sent to NMC. She also stated the staff are prohibited from performing those services and the staff only prepare the detainee for transport. She also stated that she and the rest of the medical staff receives the required subpart (b) training through her company. These training records were not on site or available to the Auditor for review. The GCSOP policy was approved by the AFOD.

§115.41 - Assessment for risk of victimization and abusiveness.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b)(c)(d) The GCSOP policy requires all inmates be assessed during the intake screening and upon transfer from another outside facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. The information from the risk screening form is utilized for housing, bed, work, education, and program assignments. Such assessments will be conducted using both the existing digital classification system and paper systems. The risk assessment is part of the classification process and must be completed within 12 hours of arrival. The assessment tool was reviewed by the Auditor and met all the subpart (c) and (d) requirements. The policy also requires detainee reassessments be completed within 60-90 days from arrival at the facility and his/her risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness. The initial risk assessment and subsequent assessments are typically performed by the medical staff during the time medical staff is present during the day. Intake staff have been trained to perform these assessments in their absence. The Auditor reviewed eight detainee files while on site. The risk assessments were completed upon arrival; however, the risk form being used was not the current form provided to the Auditor during the site visit, meeting all of the subpart (c)(d) requirements. According to the acting PSA Compliance Manager, he was not informed of the information required in the assessment tool until after the pre-audit. He also stated that detainees are never placed in general population until the classification process is complete. The new tool has not been utilized since it was updated.

Does Not Meet (a)(b)(c)(d): As noted the facility was not utilizing the proper assessment tool. Because the facility assessment tool was missing required elements of this standard, provision the housing assignments have not included consideration of the required information from the assessment tool. The Auditor will need to see five examples of the updated risk assessment tool being utilized.

(e) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires a detainee's risk level will be reassessed by the Classification Officer when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness. Detainee's will be reassessed within 60-90 days from the detainee's arrival at the facility. The acting PSA Compliance Manager and Nursing Supervisor confirmed during interviews that reassessments would be completed within 60-90 days and as otherwise required under subpart (e) and policy. During the detainee file review there were no detainees held at the facility long enough for the 60-90 day reassessment. There were no allegations of sexual assault during the audit period either.

(f) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires that inmates not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked about mental, physical, or developmental disability, or being gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, or previously experienced sexual victimization, or the detainee's own perception of vulnerability. The acting PSA Compliance Manager, the Nursing Supervisor and the intake officer confirmed detainees are not disciplined for refusing to answer any of the questions asked from the risk assessment form.

(g) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires GCDC control the dissemination within the facility responses to questions asked in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates. The forms are kept under double lock and a restricted issue key according to the acting PSA Compliance Manager in the Jail Administrator's Office.

§115.42 - Use of assessment information.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a) The GCSOP policy requires GCDC make individualized determinations about how to ensure the safety of each inmate through the use of information from the risk screening form to notify housing, bed, work, education, and program assignments. It also requires the facility to keep separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. The Classification staff member and Nursing Supervisor confirmed this use and purpose of the assessment form. As noted in 115.41, the Auditor reviewed eight detainee files while on site. The risk assessments were completed upon arrival; however, the risk form being used was not the current form meeting all of the subpart (c)(d) requirements. According to the acting PSA Compliance Manager, he was not informed of the information required in the assessment tool until after the pre-audit. The new tool has not been utilized since it was updated; therefore, the assessment use requirements under the subpart (a) requirements could not have been met.

Does Not Meet (a): The facility was not utilizing an assessment tool addressing all the 115.41 subpart (c) and (d) requirements. Not utilizing all the required information from this document did not allow for this standard subpart (a) requirement. The Auditor will need to see five examples of the current risk assessment tool, generated after the pre audit, being utilized in making individualized determinations as required in subpart (a).

(b) The GCSOP policy requires in deciding whether to assign a transgender or intersex inmate to housing and programming assignments, classification will consider on a case-by-case basis whether a placement would ensure the inmates health and safety, and whether the placement would present management or security problems or taking into consideration the detainees own views with respect to their own safety will be given serious consideration. The policy further requires all placement and programming assignments for each transgender or intersex inmate will be reassessed by the Classification Officer at least twice each year to review any threats to safety experienced by the inmate. The Classification Officer will document these reviews. This policy also states that "All transgender and intersex inmates will be housed in medical, unless another safe and secure option is available." The acting PSA Compliance Manager confirmed all the policy requirements of the subpart including the policy requirement of placement in the medical

unit. He also stated that their placement in the medical unit is not punishment. However, the standard requires an individualized assessment for transgender and intersex detainees to include medical and mental health practitioners' participation. Their specific placement guidelines are in conflict with the subpart requirements because it appears individual determinations are not being made.

Does Not Meet (b): The facility needs to demonstrate that it makes individualized assessments for transgender and intersex detainees with regard to housing and not establish the placement of all transgender and intersex detainees in medical as the general rule.

(c) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires transgender and intersex inmates be given the opportunity to shower separately from other inmates. The interview with the acting PSA Compliance Manager and the random staff confirmed transgender and intersex detainees would be allowed to shower separate from the other detainees and they would make times available when others were not present. The facility had no transgender or intersex detainee housed at GCDC during the audit period.

§115.43 - Protective custody.

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

Notes:

(a)(b)(c) The GCSOP policy requires inmates at an elevated risk for sexual victimization should not be placed in involuntary segregated housing unless an assessment of all available alternative housing options have been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If classification cannot conduct such an assessment immediately, classification may hold the inmate in involuntary segregated housing (medical) for less than 24 hours while completing the assessment. The 115.41 standard requires the initial classification be completed within 12 hours of the detainee arrival not 24 hours. The 115.43 standard details administrative segregation use for vulnerable detainees. The policy also states inmates placed in segregated housing for this purpose will have access to programs, privileges, education, and work opportunities to the extent possible. If classification restricts access to programs, privileges, education, or work opportunities, classification will document: the opportunities that have been limited; the duration of the limitation; and the reasons for such limitations. The policy also requires Classification assign such inmates to involuntary segregated housing only until an alternative means of separation from likely abusers can be arranged, and such an assignment will not exceed a period of 30 days. GCDC has only one segregation cell. The interview with the Undersheriff confirmed the use of this cell would be his last resort. He indicated he would utilize either the medical bed or work with ICE to have the detainee moved. He also stated that segregation has not been used for this purpose during the audit period.

(d)(e) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires Supervisory staff conduct a review within 72 hours of the detainee's placement in administrative confinement to determine whether confinement is still warranted and further requires Supervisory staff conduct, at a minimum, an identical review after the detainee has spent seven days in administrative confinement, and every week thereafter for the first 30 days, and every 10 days thereafter. This policy also requires the ICE FOD be notified no later than 72 hours after the initial placement of any detainee into restrictive housing based on his/her vulnerability. The Undersheriff confirmed that the placement of any vulnerable detainee in segregation would require the supervisory review process and the notification to the FOD within 72 hours. As noted earlier, this policy was reviewed by the AFOD. GCDC has had no vulnerable detainees placed in segregation during the audit period.

§115.51 - Detainee reporting.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires GCDC provide internal and external ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The internal reporting means for reporting sexual abuse for detainees include: the kiosk; the Grievance process to the Jail Administrator; verbally or written to any staff member; handwritten request; to another detainee or to the acting PSA Compliance Manager. ICE has established the following external reporting methods: directly report to the DHS OIG complaint hotline toll-free telephone number at 1-800-323-8603 anonymously; Contact the ICE Detention and Reporting Information Line (DRIL) toll-free telephone number 1-888-351-4024 or 9116#; Tell an ICE/ERO staff member who visits the facility; Write a letter reporting the sexual misconduct to the ICE [OIC], ICE AFOD, or ICE FOD; File a written formal request to ICE; Contact ICE OPR JIC toll-free hotline number 1-877-246-8253; By mail to DHS OIG, Office of Investigations Hotline; 245 Murray Drive, SW, Building 410/Mail Stop 0305, Washington, DC 20528. During the tour of the facility, the Auditor observed this reporting information along with the consular contact information prominently displayed through the facility including by the detainee telephones. The Auditor tested the reporting lines, during the site visit, and found them operational. There were no detainees present during the site visit nor any investigative files to review for allegations during the audit period.

(c) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires employees, temporary contractors, regular contractors, and volunteers, accept reports from inmates and detainees made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports. The Auditor interviewed six random staff who confirmed their knowledge of the facility policy requirement that they are to accept and immediately report allegations of sexual

abuse regardless of how the report was made and that all verbal reports from detainees or third parties must be documented in writing to their supervisors for investigation referral. There were no allegations of sexual abuse made at GCDC during the audit period

§115.52 - Grievances.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that outlines the filing of sexual abuse allegations through the grievance process. The policy states that the facility shall not impose a time limit on when an inmate may submit a grievance regarding an allegation of sexual abuse. The facility has established procedures for the filing of an emergency grievance alleging sexual abuse. The policy also requires that any such grievance submitted by a detainee have a decision rendered within 5 days of receipt of that grievance, and if appealed, a decision within 30 days. This policy requires staff bring medical emergencies to the immediate attention of proper medical personnel for further assessment and that third parties, including fellow inmates, staff members, family members, attorneys, and outside advocates, are permitted to assist detainees in filing requests for administrative remedies relating to allegations of sexual abuse. Staff are also required to take reasonable steps to expedite requests for assistance from these other parties. The Auditor interviewed the Grievance staff member during the site visit. He informed the Auditor that he would accept all grievances alleging sexual assault, regardless of when it happened, and provide the detainee a decision within five days, and if appealed, a decision within 30 days. He also stated that this type of grievance would be handled as an emergency grievance with no time limit on the submission of a sexual abuse allegation. He also stated he would ensure medical emergencies are referred to the medical department immediately. He further stated at the end of the grievance process he would notify the AFOD, who in turn makes all ICE notifications. The facility had no sexual abuse allegations reported through the grievance process during the audit period.

§115.53 - Detainee access to outside confidential support services.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires GCDC provide inmates with access to outside victim advocates for emotional support services related to sexual abuse by giving inmates mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between inmates and these organizations, in as confidential a manner as possible. As noted in standard 115.21, GCDC has no local community victim advocates available, but utilizes the national advocacy RAINN for emotional support, crisis intervention services, information, and referrals. The RAINN web site indicates that they offer both the technology infrastructure and the victim services expertise to provide quality, anonymous, and confidential crisis intervention services in English and Spanish, via telephone and online. During the tour, the Auditor observed the telephone contact information posted in each of the detainee living areas for RAINN. At the side of this contact information, is the notation that calls to the provided telephone number are subject to recording and monitoring.

§115.54 - Third-party reporting.

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

Notes:

The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires GCDC establish a method to receive third-party reports of sexual abuse and sexual harassment and distribute publicly, information on how to report sexual abuse and sexual harassment on behalf of an inmate. At the entrance to the GCDC facility is contact information for the DHSOIG, where third party allegations of sexual abuse on behalf of a detainee may be sent. The facility had no allegations of sexual abuse for the audit period.

§115.61 – Staff reporting duties.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires employees, temporary contractors, regular contractors and volunteers report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; 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 to their immediate supervisor or appropriate personnel. Staff may report allegations to anyone outside of their command or agency. The policy also requires staff, contractors or volunteers that become aware of alleged sexual abuse immediately follow the reporting requirements set forth in policy and procedures. Apart from initial reporting to supervisor(s) or Jail Investigations, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, to make treatment, investigation, and other security and management/law enforcement decisions and to help protect the safety of the victim or prevent further victimization of other inmates/detainees or staff in the facility. The six random staff and one non-security staff interviewed confirmed their responsibilities of reporting sexual abuse as required in policy. Each was also aware of their ability to report allegations of sexual assault and other misconduct to anyone outside of their chain of command if necessary. As noted earlier, the GCSOP policy was approved by the AFOD.

(d) The Auditor determined compliance with this subpart of the standard after the interview with the Undersheriff. He confirmed GCDC does not accept ICE juveniles. He also stated that any vulnerable detainee alleging sexual assault would have the incident

reported to the detectives for criminal investigation and to the County Legal Department for proper notification(s) to any designated agencies. GCDC has had no instances of sexual assault of a vulnerable detainee during the audit period.

§115.62 - Protection duties.

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

Notes:

The Auditor determined compliance with the standard based on the review of the GCSOP policy that requires when staff learn that an inmate is subject to a substantial risk of imminent sexual abuse, they take immediate action to protect the inmate. The Auditor questioned the Undersheriff and six random staff about the handling of detainees at risk of imminent sexual abuse. Each of them stated that if they became aware that a detainee was subject to a substantial risk of imminent sexual abuse, they would take immediate action to mitigate the threat to the detainee, which would initially require removing him/her from the area. There were no allegations of sexual assault made during the audit period or detainees at risk of imminent sexual abuse.

§115.63 - Reporting to other confinement facilities.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires the facility upon receiving an allegation that an inmate was sexually abused while confined at another facility, the Jail Administrator must notify the head of the facility or appropriate office of the agency where the alleged abuse occurred no later than 72 hours after receiving the allegation. The policy also requires the facility document that they have provided such notification. GCDC on receiving such a notification will ensure that the allegation is investigated in accordance with these standards. The Undersheriff, acting PSA Compliance Manager, and review of the PAQ confirmed GCDC did not receive any reports of sexual abuse from a detainee on arrival at GCDC occurring somewhere else nor were they ever contacted by another facility informing them a detainee made an allegation of sexual abuse occurring at GCDC. The Undersheriff confirmed if an allegation was reported to have occurred at GCDC from another facility he would direct an investigation be conducted and the AFOD notified within 72 hours. The interview with the AFOD confirmed that he makes all required notifications to ICE personnel as required by the standard.

§115.64 - Responder duties.

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

Notes:

(a) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires the first security staff member to respond to a report of sexual abuse will: separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; if the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating unless medically required; and if the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The Auditor interviewed six random security staff, and each was questioned about responding to allegations of sexual abuse. Each detailed their response as outlined in subpart (a). There were no allegations made during the audit period.

(b) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires if the first staff responder is not a detention officer, the responder will request that the alleged victim not take any actions that could destroy physical evidence and then notify the detention officer or supervisor. During the site visit, the Auditor interviewed one non-security staff member about responding to a sexual abuse allegation. He stated that he would ensure the victim did not destroy any potential evidence and immediately notify a security staff member of the situation. There were no allegations of sexual abuse reported during the audit period.

§115.65 - Coordinated response.

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on the interview with the Undersheriff who stated that the institutional plan for the coordinated actions taken by staff in response to any sexual abuse allegations is the GCSOP policy. He further stated that this policy details the responsibilities for security staff, non-security staff, medical staff, and mental health practitioners for any sexual abuse allegation. The specialized staff informed the Auditor of their specific roles for sexual abuse allegations as outlined in the GCSOP policy. The review of the policy details the responsibilities and actions for first responders, investigators, supervisors, and medical staff in responding to allegations of sexual abuse. There were no allegations of sexual assault at GCDC during the audit period.

(c)(d) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires if a victim is transferred from a DHS immigration detention facility to a facility not covered by the DHS PREA standards the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victims potential need for medical or social services unless the victim request otherwise. The Nursing Supervisor confirmed, that unless prohibited by law or at the request of the detainee victim being transferred to a facility not covered by the DHS PREA standards, GCDC would notify the receiving facility of the potential need for medical or social services and detainee victims being transferred between all other subpart A or B facilities would be

told of the detainee victim's potential need for medical as permitted by law. She also confirmed that GCDC had no such transfers during the audit period.

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

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

Notes:

The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires staff suspected of sexual abuse will be removed from all contact with detainees until the conclusion of the investigation. The interview with the Undersheriff confirmed that any staff, contractor, or volunteer under investigation for an allegation of sexual abuse will be removed from detainee contact until the investigation is completed. The facility had no allegations of sexual assault during the audit period.

§115.67 - Agency protection against retaliation.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires GCDC protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff. The acting PSA Compliance Manager is required to monitor, in writing, inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations to ensure they are protected from retaliation by other inmates or staff. The policy further requires the facility utilize multiple protection measures, such as housing changes or transfers for inmate victims or abusers, removal of alleged staff or inmate abusers from contact with victims, and emotional support services for inmates or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The facility is required by policy to conduct retaliation monitoring for at least 90 days following a report of sexual abuse. The interview with the acting PSA Compliance Manager confirmed retaliation monitoring would include a face-to-face meeting with the staff member or the detainee at least monthly for a period of 90 days unless the situation required it continue beyond the 90 days. He also confirmed the meetings would be documented and he would offer emotional support to both staff and detainees contacting mental health if needed. His monitoring for detainees would include reviewing misconduct reports and questions to other staff members about behavior concerns they may have observed. He also confirmed he would ask of any concerns the detainee may have. He also stated that when monitoring staff retaliation, his review would include performance reviews, time off refusals, or shift changes. There were no allegations during the audit period; and therefore, no retaliation monitoring required.

§115.68 – Post-allegation protective custody.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires victims of sexual abuse be placed in a supportive environment that represents the least restrictive housing option possible. Detainee victims shall not be held for longer than five days in any type of administrative confinement, except in highly unusual circumstances or at the request of the detainee. 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 as a result of the sexual abuse. The FOD shall be notified whenever a detainee victim has been held in administrative confinement for 72 hours. The Undersheriff interview confirmed that the placement of any detainee victim of sexual abuse in segregation would be his last resort and require the notification to the FOD within 72 hours. He also stated a new risk assessment would be conducted prior to placing the detainee back into general population if he/she was placed in segregation.

§115.71 – Criminal and administrative investigations.

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

Notes:

(a)(b)(c)e)(f) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy and interview with the Undersheriff. The Undersheriff confirmed all allegations are reported to the Sheriff for a criminal investigation. Once a determination has been made that the allegation is not criminal, an administrative investigation would be completed upon every allegation of sexual abuse regardless of the criminal investigation finding. He stated he would assist and remain in contact with the Detectives conducting the criminal investigation, to stay updated on the progress of the investigation. He also indicated the administrative investigation, conducted by him, is completed regardless of the departure of the alleged abuser or victim from the facility or agency's employment or control. The review of the policy confirmed that when conducting allegation investigations of sexual abuse and sexual harassment, GCDC will do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports by investigators who have received special training in sexual abuse investigations. The policy also requires that the investigator gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interview alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse involving the suspected perpetrator. The policy further requires the credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and not be determined by the person's status as inmate or staff. The policy also requires that the investigator will not require an inmate who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. The policy further requires an effort to determine whether staff actions or failures to act contributed to the abuse and requires the facility retain all written reports for as long

as the alleged abuser is incarcerated or employed by the GCSO, plus five years. There were no allegations of sexual abuse at GCDC during the audit period. The policy was approved by the AFOD.

§115.72 - Evidentiary standard for administrative investigations.

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

Notes:

The Auditor determined compliance with the standard based on the review of the GCSOP policy that requires GCDC investigators will impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Agency Policy 11062.2 states, "The OPR shall conduct either an OPR review or investigation, in accordance with OPR policies and procedures. Administrative investigations impose no standard higher than a preponderance of the evidence to substantiate an allegation of sexual abuse." The interview with the Undersheriff confirmed the evidence standard he would utilize when determining the outcome of a sexual abuse case is the preponderance of evidence. There were no allegations of sexual abuse reported at GCDC for the audit period.

§115.73 - Reporting to detainees.

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

Notes:

The Auditor determined compliance with the standard based on the review of the GCSOP policy that requires following an investigation into an inmate's allegation of sexual abuse, the investigator will inform the inmate as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The Undersheriff confirmed the policy notification requirement to the detainee and indicated it would be followed on every allegation investigation. The facility has no allegations of sexual abuse during the audit period.

§115.76 – Disciplinary sanctions for staff.

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

Notes:

(a)(b)(c)(d) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires all employees be subject to disciplinary sanctions up to and including termination, and criminal prosecution for violating agency sexual abuse or sexual harassment policies. Termination will be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. The policy further requires that all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The Undersheriff confirmed removal from County employment and Federal Service would be the presumptive discipline for any staff member who has engaged in or attempted or threatened to engage in sexual abuse or failed to follow the zero-tolerance policy. He also indicated that law enforcement is immediately notified upon every allegation of sexual abuse and that the facility would notify the appropriate licensing bodies upon substantiated allegations involving licensed staff. GCDC had no allegations of sexual abuse during the audit period. As noted earlier in the report, the GCSOP policy was reviewed by the AFOD.

§115.77 - Corrective action for contractors and volunteers.

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires any temporary contractor, regular contractor, or volunteer who engages in sexual abuse will be prohibited from contact with inmates and will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The policy further requires the facility take immediate remedial measures and prohibit further contact with inmates. The Undersheriff confirmed removal from County employment and Federal Service would be the presumptive discipline for contractors or volunteers who engaged in or attempted or threatened to engage in sexual abuse or failed to follow the zero-tolerance policy. He also stated that law enforcement and licensing bodies would be notified in cases involving substantiated allegations involving contractors and volunteers. He also stated that consideration would be given to prohibit detainee contact for those contractors or volunteers who did not engage in sexual abuse but violated other provisions of the GCSOP policy. GCDC had no allegations of sexual assault during the audit period.

§115.78 - Disciplinary sanctions for detainees.

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires inmates be subject to disciplinary sanctions pursuant to the formal disciplinary process following an administrative finding that the inmate engaged in inmate-on-inmate sexual abuse or following a criminal finding of guilt for inmate-on inmate sexual abuse, as defined in GCDC policy and the Inmate Handbook. The policy also states that inmates with substantiated allegations against staff will not be disciplined if staff consented. It also requires sanctions be commensurate with the nature and circumstances of the abuse committed, the inmate's disciplinary history, and the sanctions imposed for comparable offenses by other inmates with similar histories. It requires the disciplinary process consider whether an inmate's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. For the purpose of disciplinary action, any report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred will not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The interview with the Undersheriff and the acting PSA Compliance Manager confirmed that the discipline process for detainees is intended to encourage detainee conformance to facility rules and regulations. It includes a system that allows for progressive levels of reviews, appeals,

procedures, and documented procedures. They also indicated that detainees could appeal their dispositions through the grievance process and indicated detainees having a diagnosed mental illness or mental disability, or demonstrated symptoms of mental illness or mental disability, his/her competency would be discussed with a mental health practitioner prior to any hearing. There were no allegations at GCDC during the audit period.

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

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

Notes:

(a)(b)(c) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires if the risk screening from 115.41 indicates that a person has previously perpetrated sexual abuse or experienced sexual abuse victimization, whether it occurred in an institutional setting or in the community, medical staff will ensure that the inmate is offered a follow-up meeting with a mental health practitioner within 72 hours of the intake screening. As noted earlier, medical performs the initial assessment upon arrival of every detainee at GCDC. The intake staff interview confirmed when medical is unavailable to conduct the 115.41 assessment, they perform it. Any detainee that experienced prior sexual victimization or perpetrated sexual abuse would be referred to medical. The interview with the Nursing Supervisor confirmed that if a detainee discloses any prior victimization to medical staff, upon arrival, he/she is referred to the mental health staff for follow up and is seen within 72 hours. If intake staff makes the referral to medical, the detainee would be seen within two working days. She and the acting PSA Compliance Manager informed the Auditor that no detainees have arrived at GCDC disclosing prior victimization during the audit period.

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

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

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The policy also requires the nature and scope of services offered are determined by medical and mental health practitioners according to their professional judgment. Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. As noted earlier, forensic exams are not performed at GCDC. The GCDC Nursing Supervisor confirmed detainees are stabilized by medical staff and prepared for transport to NMC. She also confirmed that GCDC, except for the forensic examination, can provide all other services for any alleged victim of sexual assault, including emergency medical treatment and crisis intervention services, emergency contraception including sexually transmitted infections prophylaxis. She also stated medical and mental health services would be provided without cost and performed within professionally accepted standards of care. The facility PAQ and Nursing Supervisor confirmed there were no detainees sent out for a forensic examination during the audit period.

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

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

Notes:

(a)(b)(c)(d)(e)(f) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy that requires the facility offer medical treatment and mental health evaluations to all inmates who have been victimized by sexual abuse. The follow-up treatment services must include treatment plans and when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The policy also requires the facility provide such victims with medical and mental health services consistent with the community level of care. Inmate victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests and if pregnancy results victims will receive timely and comprehensive information about all lawful pregnancy-related medical services. Inmate victims of sexual abuse will be offered tests for sexually transmitted infections as medically appropriate. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The interview with the GCDC Nursing Supervisor confirmed detainees, who experience sexual abuse while in detention, receive a medical and mental health evaluation and follow up treatment as needed. She also confirmed that all services provided to detainee victims of sexual abuse are consistent with the community-level of care and the evaluation and treatment is without cost to the detainee, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. There were no allegations of sexual abuse reported during the audit period.

(g) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires a mental health evaluation of all known abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. The interview with the GCDC Nursing Supervisor confirmed that all known abusers as well as those detainees found to have perpetrated sexual abuse at the conclusion of an investigation would be offered an evaluation and follow up treatment. There were no allegations of sexual abuse at GCDC during the audit period and the facility has not received any known abusers during the audit period.

§115.86 - Sexual abuse incident reviews.

Outcome: Does not Meet Standard (requires corrective action)

Notes:

(a)(b) The Auditor determined compliance with these subparts of the standard based on the review of the GCSOP policy and interviews with staff. The interview with the Undersheriff and the acting PSA Compliance Manager confirmed an incident review would be

conducted and documented within 30 days of the investigation conclusion regardless of the finding. Their policy requires the facility conduct a sexual abuse incident review, by a review team, at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The review team includes upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners and the team consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The policy also requires the review team examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepare a report of its findings, including but not necessarily limited to determinations and any recommendations for improvement, and submit such report to the facility head and agency PREA coordinator. GCDC is also required by policy to implement the review teams recommendations for improvement or document its reasons for not doing so. The Auditor interviewed one of the staff that participates in the incident review. He confirmed a review is conducted at the conclusion of every investigation of sexual abuse within 30 days of the completed investigation considering the subpart (b) requirements. He also confirmed that copies of these reviews would be provided to all parties required by the standard. There were no incidents of sexual abuse reported during the audit period.

Recommendation (a): The Auditor recommends the facility update the GCSOP policy to align with the requirements of subpart (a). As currently written, the policy indicates an incident review is not completed on unfounded allegations. Nonetheless, the interviews with the acting PSA Compliance Manager and Undersheriff interviews confirmed an incident review will be completed on all investigations.

(c) The standard requires each facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention, and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and FOD or his or her designee, who shall transmit it to the ICE PSA Coordinator. As noted throughout the report, GCDC had no incidents of sexual abuse for the audit period. It did not provide a negative report with a distribution to those noted in subpart (c).

Does Not Meet (c): The facility must prepare a negative report for the annual reporting period and provide to the Auditor for compliance review. Additionally, documentation of distribution to the parties noted in the subpart (c) must be provided for compliance review.

§115.87 - Data collection.
Outcome: Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
Notes:

(a) The Auditor determined compliance with this subpart of the standard based on the review of the GCSOP policy that requires all case records associated with claims of sexual abuse or sexual harassment including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release and/or counseling are retained for at least 10 years. The Auditor observed the location where the GCDC staff secures these documents and found them under a double lock and restricted key.

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

(d) The Auditor was allowed access to GCDC and able to revisit areas of the facility as needed during the site visit.
(e) The Auditor was provided with and allowed to view all relevant documentation as requested.
(i) Formal interviews with staff and contractors were conducted in a private confidential setting.
(j) The Auditor observed audit notices posted throughout the facility in English, Spanish, Punjabi, Hindi, Simplified Chinese, Portuguese, French, Haitian, Creole, Bengali, Arabic, Russian, and Vietnamese. The Auditor received no staff, detainee, or other party correspondence.

AUDITOR CERTIFICATION

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

SUMMARY OF AUDIT FINDINGS (Use the Update Outcome Summary button, Do Not Manually Enter)	
Number of standards exceeded:	1
Number of standards met:	31
Number of standards not met:	7
Number of standards N/A:	2
Number of standard outcomes not selected (out of 41):	0

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

Thomas Eisenschmidt 11/6/2022

Auditor's Signature & Date

(b) (6), (b) (7)(C) 11/16/2022

Program Manager's Signature & Date

(b) (6), (b) (7)(C) 11/16/2022

Assistant Program Manager's Signature & Date